Inspector General

Texas Health and Human Services

20D0108

OIG Quarterly Report

Quarter 3, Fiscal Year 2020

Table of Contents

Executive Summary

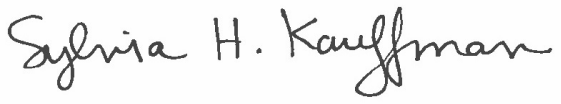
I am pleased to present the third quarterly report for fiscal year 2020, summarizing the excellent work this office has performed during this period, to Governor Greg Abbott, Acting Executive Commissioner Phil Wilson, the Texas Legislature and the citizens of Texas.

During the third quarter, the OIG recovered more than $212 million. In addition, another nearly $50 million was identified for potential future recoveries, and almost $28 million was achieved in cost avoidance by deterring potentially questionable spending before it occurs. I am incredibly proud of my team for achieving these excellent results during an unprecedented time of disruption caused by the COVID-19 pandemic.

When Governor Abbott on March 13 declared a state of disaster for all counties in Texas, the OIG took steps to ensure that we could continue our work while prioritizing the health and safety of our employees, as well as help our stakeholders in this time of uncertainty. We quickly moved to teleworking, keeping the office running while staff worked safely from home. Our operations staff maintained important continuity of essential business functions. We adjusted reporting deadlines for providers and managed care organizations to help them focus on Medicaid patients, and we temporarily suspended on-site nursing home claims reviews. We created and regularly update a webpage with information, links and warnings of fraudulent activities related to the pandemic. You can read more about how the OIG responded to the crisis in the Program Integrity Spotlight on page 15.

That the OIG is producing outstanding results both at work and at home during the pandemic is a testament to our amazing OIG team, which is committed to our core values — Accountability, Integrity, Collaboration and Excellence. OIG employees are collaborating with our state and federal partners to ensure that funds dedicated to providing services to those who need them are spent only for their intended purpose. And they will continue to do so as we all cautiously navigate the course of the pandemic. I am honored to work with them.

Respectfully,



Sylvia Hernandez Kauffman
Inspector General

Quarter 3 Results

Dollars recovered

Audit	
Collections	$646,633
Inspections	
WIC collections	$18,956
Benefits Program Integrity	
Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC)	$19,904,335
Voluntary repayments by beneficiaries	$44,114
Total	**$19,948,449**
Medicaid Program Integrity	
Provider overpayments	$1,945,619
Acute care provider overpayments	$2,050,485
Hospital overpayments	$3,966,989
Nursing facility overpayments	$553,811
Recovery Audit Contractor recoveries	$13,520,127
Total	**$22,037,031**
Third Party Recoveries	
TPR recoveries	$169,446,354
Peace Officers	
EBT Trafficking retailer overpayments	$113,592
Total dollars recovered	**$212,211,015**

Dollars identified for recovery

Audit	
Provider overpayments	$47,381
Inspections	
WIC vendor monitoring	$21
Benefits Program Integrity	
Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, WIC)	$15,629,586
Medicaid Program Integrity	
MCO identified overpayments	$12,207,262
Acute care provider overpayments	$2,334,688
Hospital overpayments	$5,836,612
Nursing facility overpayments	$107,318
Recovery Audit Contractor identified	$12,326,629
Total	**$32,812,509**
Peace Officers	
EBT trafficking	$1,317,703
Total dollars identified for recovery	**$49,807,200**

Cost avoidance

Inspections	
WIC vendor monitoring	$508
Benefits Program Integrity	
Client disqualifications	$1,426,439
Medicaid Program Integrity	
Medicaid provider exclusions	$5,189,862
Medical Reviews	
Pharmacy Lock-In	$725,477
Third Party Recoveries	
Front-end claims denials	$20,341,416
Peace Officers	
Disability determination services	$123,384
Total cost avoidance	**$27,807,086**

Liquidated damages

Dollars recovered	$993,325

How we measure results

An investigation, audit, inspection or review that is performed, managed or coordinated by the OIG can result in:

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

Dollars identified for recovery: This is a measure of the total potential overpayments resulting from activities of the Office of Inspector General. These potential overpayments have not actually been collected at this point (and notice not necessarily sent to providers, contractors and/or managed care organizations). These potential overpayments are estimates prior to further analysis or additional information submitted by the subject of the potential recovery.

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

Liquidated damages: The OIG recommends that HHS assess liquidated damages when managed care organizations (MCOs) and dental maintenance organizations are found to be non-compliant with program integrity requirements in their contracts. Liquidated damages are not intended to be a penalty but are intended to be reasonable estimates of HHS's projected financial loss and damage resulting from an MCO's nonperformance.

Trends

Medicaid Program Integrity

Medicaid Program Integrity (MPI) continues to receive a high number of complaints and managed care organization (MCO) referrals related to personal care attendants. Complainants report forged documentation and attendants colluding with clients to bill and share payments for services not rendered. For example, claiming attendant care services were provided during a time when a patient was hospitalized is a common allegation of wrongdoing. OIG Litigation excluded eight attendant care workers from Texas Medicaid this quarter. The investigations identified attendants clocking in and out while a Medicaid client was at a nursing home or hospitalized. In addition, some attendants submitted claims for reimbursement on overlapping hours of personal assistant services for multiple Medicaid clients. Another attendant continued to submit claims for reimbursement for dates of services after the Medicaid client's date of death. The OIG continues to investigate attendant care cases and recommend administrative action based on findings.

Hospital ER injection/infusions cases

MPI's Provider Field Investigation continues to pursue cases resulting from a hospital initiative. The MPI initiative monitors data to identify hospital outpatient facilities that billed and were paid separately for injections/infusions when the same services were already covered by another billing code paid on the same dates of service. Additionally, the administration of an injection is not reimbursable to outpatient hospital providers.

A sample of case results for MPI for this quarter include:

- **Private duty nursing settlement.** The OIG settled allegations against a Dallas home health agency. From the period of March 2014 to June 2018, in some instances the provider submitted some bills for and was

Types of allegations received by MPI

Attendants	49%
Physician (individual/group/clinic)	11%
Home health agency	10%
Dental	6%
Pharmacy	4%
Durable medical equipment	3%
Hospital	3%
Managed care organization	2%
Nursing facility	2%
Adult day care	2%
Lab/radiology/X-ray	2%
Therapy (counseling)	1%
Therapy (physical/occupational/speech)	1%

7 other categories at less than 1%

Types of MPI field provider investigations

Hospital	29%
Physician (individual/group/clinic)	16%
Dental	16%
Pharmacy	11%
Home health agency	8%
Attendants	5%
Adult day care	5%
Therapy (physical/occupational/speech)	3%
Durable medical equipment	3%
Case management	2%
Nursing facility	2%

Referrals to MPI

MCO/DMO referrals	106
OIG Fraud Hotline referrals	123

Note: Referrals through our website and fraud hotline, as referenced in the Allegations chart above, go through a preliminary investigation. Cases that meet evidence requirements are moved to full-scale investigation, as referenced in the Investigations chart. Explore more MPI case details in the Performance chart on page 9.

paid for more than the maximum allowable amount of 96 units of private duty nursing per patient per day. Furthermore, in some instances, the provider also submitted double claims for the same date of service. To resolve these allegations, the provider agreed to a settlement amount of $694,673 to repay those errors.

- **Settlements reached following self-reports.** MPI Provider Field Investigations initiated three cases against providers in San Antonio and Jasper who were identified as part of the Exclusion Review Project. The project identifies Texas Medicaid providers who employ individuals or entities who have been excluded from participating in the Texas Medicaid program. The providers were given the opportunity to self-identify the errors and submitted reports to include the time the excluded individuals were employed. All current providers, as well as those applying to participate in state health care programs, must screen their employees and contractors every month to determine whether they are excluded individuals or entities. The total amount settled in the third quarter to resolve these violations was $163,532.
- **El Paso pediatric settlement.** The OIG settled allegations against an El Paso pediatric clinic for inappropriately submitting bills for medical services after hours, which resulted in a higher reimbursement. The MPI investigation of claims filed between 2015 and 2018 identified the provider billed for a more expensive service code instead of the appropriate lower service code. To resolve these allegations, the provider agreed to a settlement of $114,154.

Benefits Program Integrity

The Benefits Program Integrity (BPI) division completed 4,674 investigations involving some form of benefit recipient overpayment or fraud allegation. Eighty-seven percent of all investigations completed involved unreported income or an issue with the reported household composition. Household composition cases usually deal with an unreported household member who has income or could also include a reported household member who does not actually live in the same residence. Both instances cause the household to receive more benefits than they are eligible for.

BPI completed 274 investigations where fraud was determined. BPI referred 35 investigations for prosecution and 239 for an administrative disqualification hearing. Ninety five percent of fraud investigations completed involved either unreported income or an issue with the reported household composition.

A sample of cases worked by BPI this quarter include:

- **Falsifying SNAP application.** BPI investigated a client in Val Verde County who submitted falsified SNAP applications from February 2014 to February 2019. The client claimed only she and her children lived in the household. The BPI investigator verified through a variety of sources that the client's husband lived in the household and had income. The client confessed to fraud in April and agreed to pay $45,668 with a 12-month disqualification from SNAP.
- **Failing to report income.** In May, BPI resolved a case in Cherokee County where a client submitted falsified SNAP applications by failing to report income from her children's father. A BPI investigator gathered evidence from a variety of sources to prove the client's husband lived in the household and had income. The fraud was substantiated through an administrative disqualification hearing, and the client ultimately agreed to pay $11,905 and received a 12-month disqualification from SNAP.
- **Excessive SNAP benefits.** Based on an interstate data match, BPI investigated a client in Bexar County who received SNAP benefits in both Texas and Louisiana for several months in 2019. This case was deemed a client error, as the client was approved for SNAP benefits

in Texas without disclosing they were receiving benefits from Louisiana, where the client resided at the time. Since the client should not have received SNAP benefits in Texas while residing in Louisiana, the client signed a repayment agreement in March for $5,299. The amount will be recouped from the current SNAP benefit allotment they now receive as a Texas resident.

Electronic Benefits Transfer

This quarter, the Electronic Benefits Transfer (EBT) Trafficking Unit completed 116 investigations, discovering $1,316,953 in fraudulently used SNAP benefits, and presented another 72 investigations for either administrative disqualification hearings (37) or prosecution (35).

Trends identified by the unit include:

- **Mobile vendors.** EBT Trafficking continues to see an increase in cases involving mobile vendors and their acceptance of SNAP benefits. These mobile vendors will create a credit account for a recipient by acquiring the recipient's SNAP benefits information and personal pin numbers. Possession of this information is a violation by the mobile vendor, and it is a violation for the recipient to provide the data.
- **Law enforcement collaboration.** EBT Trafficking has experienced an increase of requests for assistance by law enforcement agencies throughout the state. These requests pertain to current or former SNAP recipients and involve providing information to assist in investigating persons involved in criminal activity and locating fugitives with arrest warrants; EBT is also asked to provide investigative assistance with cases that include an element of SNAP trafficking.

A sample case worked by EBT this quarter includes:

- **Undercover investigation.** The EBT Trafficking Unit received a complaint against a San Antonio retailer, accused of fraudulently accepting and using SNAP benefits. EBT investigators conducted four separate undercover operations and successfully purchased ineligible items, such as tobacco and alcohol, and exchanged SNAP benefits for cash. Investigators obtained confessions from three SNAP recipients involved in the scheme who admitted to trafficking benefits. The case was submitted to the Bexar County District Attorney for prosecution and referred to the U.S. Department of Agriculture to disqualify the retailer from the SNAP program.
- **SNAP clients and restaurant owner accused of fraud.** The OIG received a referral from a loss prevention officer at a large retail store, accusing SNAP recipients of making high dollar purchases to help stock a Fort Worth restaurant. EBT Trafficking Unit Investigators determined that between 2016 and 2019, four recipients repeatedly allowed a restaurant owner to fraudulently use the clients' SNAP benefits to purchase items for his restaurant in exchange for $61,078 in cash. Investigators submitted cases on the SNAP recipients and the restaurant owner to the Tarrant County District Attorney's Office for prosecution.
- **SNAP trafficking referred for criminal prosecution.** The EBT Trafficking Unit continues work on a SNAP trafficking case in Cameron County. During the third quarter, investigators completed cases on 34 recipients involved in a scheme that resulted in $467,991 in fraud. Investigators say the recipients were active participants in a scheme with a retailer, swiping their SNAP benefits cards at a register without making a purchase and later receiving a percentage of the "sale" in cash. Three criminal cases were submitted to the Cameron County District Attorney's Office for prosecution.

Internal Affairs

Internal Affairs (IA) worked 39 active investigations in the third quarter, and 37 investigations were closed during the quarter. IA processed 92 referrals this quarter and investigated 36 of those

referrals. The remaining were forwarded to the appropriate business areas, including the Office of the Independent Ombudsman for State Supported Living Centers, DFPS Office of Consumer Relations and HHS Complaint and Incident Intake.

Trends identified by IA include:

- **Falsifying information.** While the percentage of cases closed relating to allegations of falsifying information or documents associated with Child Protective Services (CPS) caseworkers has remained the same in comparison to previous quarters, the percentage of cases opened has decreased since the previous quarter. This decrease is due to IA now referring most perjury allegations to district attorney offices where the alleged perjury occurred. IA provides investigative support to DFPS Office of Consumer Relations in matters related to or associated with criminal or gross misconduct of its employees in the delivery of health and human services.

Sample of cases concluded by IA this quarter:

- **Improper vendor invoices.** IA investigated an allegation that HHS personnel submitted fake work orders, created fictitious invoices and used state funds to purchase materials for personal use through a maintenance contractor. Although the investigation yielded no direct evidence of these allegations, areas of concern were identified including that the vendor submitted invoices that lacked sufficient detail to comply with HHS contract requirements and HHS personnel did not adequately monitor performance of the vendor under the contract.
- **Employee misconduct.** IA investigated an allegation against a CPS worker whose spouse was found to have received benefits to which she was not entitled. The investigation showed the CPS employee was likely aware his income was not being reported. This allegation was sustained.

Open IA cases by type

Falsifying information/documents	13%
Vital records fraud	13%
Conflict of interest	10%
Unprofessional conduct	10%
Privacy incident/breach	10%
Law enforcement assist	10%
Contract fraud	5%
Travel fraud	5%
Theft	5%
Other	19%

State Centers Investigations Team

The State Center Investigations Team (SCIT) opened 152 investigations and completed 187 investigations in the third quarter, with an average completion time of 18.6 days. This compares to 168 opened investigations and 169 completed investigations in the third quarter of fiscal year 2019.

A recent SCIT case involved an assault at the North Texas State Hospital. An employee was accused of assaulting a client in a restraint chair, causing minor facial injuries. Subsequent interviews and review of video by the SCIT investigator confirmed the allegation. The case was referred to the Wichita County District Attorney for prosecution. The court accepted a guilty plea to a state jail felony of injury to a disabled person. The OIG received the court disposition, or notice of the decision, in the third quarter. As part of the plea agreement, the accused received three years deferred adjudication with court costs and fines imposed.

Rule Proposals

Administrative enforcement

Proposed amendments to 1 TAC §371.1603 and §371.1715, related to administrative enforcement, were adopted on April 30, 2020 and published in the May 15, 2020 issue of the Texas Register. The adopted rules clarify the factors that the agency applies when determining the seriousness, prevalence of error, harm or potential harm of a violation, as required by statute. The amendments add examples of mitigating factors and clarify that a person potentially subject to an enforcement action may introduce such mitigating factors in any contested case, as well as during the agency's informal resolution process. The rule amendments also clarify that the agency assesses penalties in accordance with relevant law, particularly Texas Human Resource Code Section 32.039. These rules became effective on May 20, 2020.

MCO audit coordination

Proposed amendments to 1 TAC §371.37 related to managed care organization (MCO) audit coordination, along with the HHS companion rule 1 TAC §353.6, were published in the Texas Register for formal public comment from March 13, 2020 through April 13, 2020. The proposed rules clarify OIG and HHS Medicaid and CHIP Services Department roles and jurisdiction related to audits of MCOs. The amendment to 1 TAC §371.37 adds new detail that describes the coordination — in planning and performance — between OIG and HHS when OIG plans and conducts MCO audits. OIG received comments from three stakeholders during the formal comment period and will provide responses to those comments in the fourth quarter of 2020.

Policy Recommendations

The OIG conducted an audit of Medicaid managed care risk group assignments for nursing facility risk groups to determine (a) whether selected STAR+PLUS members were properly categorized in nursing facility risk groups and (b) the potential impact on capitation payments to managed care organizations.

A nursing facility capitation rate is a fixed amount Texas Medicaid pays MCOs monthly for each individual enrolled in the MCO residing in a nursing facility, depending on the member's assigned risk group. Additional details about risk groups are found in the audit summary on page 11.

As a result of the audits, the OIG made the following recommendations:

Develop and implement a strategy for adjusting inaccurate nursing facility risk group assignments

During the audit period, HHS paid at least one month of nursing facility capitation in a month for which the managed care organization paid no corresponding nursing facility claim for 12,965 Medicaid members. For most of the members tested, HHS should have made lower capitation payments. The capitation payments, however, would have been based on lower non-nursing facility rates if the members had been assigned to the correct risk group. The corresponding capitation payments for these members totaled $137 million.

Auditors recommended that MCS should coordinate with HHS Actuarial Analysis to develop and implement a strategy for adjusting inaccurate nursing facility risk group assignments of STAR+PLUS members without (a) adversely impacting the actuarial soundness of rates and (b) inappropriately compensating MCOs.

Update nursing facility authorization rules in HHS's online authorization system

In some instances, HHS will pay for services beyond what is covered through managed care and, in those cases, HHS pays claims directly to the service provider. These additional services do not include services already covered by the MCO contract. For example, HHS pays for hospice care directly to a hospice provider through payment of a fee-for-service claim, in addition to a capitation payment for the same Medicaid member to the MCO. In situations like these, the capitation payment HHS pays the MCO is lower than the standard nursing facility capitation payment to account for HHS paying for hospice care.

In order for a nursing facility fee-for-service claim to be paid, there must be an open authorization for nursing facility daily, and there must also be a resource utilization group (RUG) level assigned to the member that corresponds to the service date on the claim. HHS is not applying the fee-for-service criteria when assigning STAR+PLUS members to nursing facility risk groups, which could result in HHS paying a claim at a level for in-patient care for a member who does not reside in a nursing home. Auditors recommended that MCS, in coordination with HHS IT, should update the nursing facility authorization rules in its online service authorization system to be dependent on RUG effective dates.

Determine where authority to enforce Texas Administrative Code requirements for nursing facilities resides or should reside

Nursing facility risk groups are designed to include only members who are authorized to reside in a nursing facility. The Texas Administrative Code requires nursing facilities to inform HHS when a resident is admitted to or discharged from a nursing facility or when certain eligibility changes occur. Nursing facilities are required to submit this notice within 72 hours of the change, and HHS relies on this information to help ensure members are assigned to the correct managed care risk group. When an authorization for daily care at a nursing facility is not updated by the nursing facility and remains erroneously open in the Service Authorization System Online (SASO), information results in the member being incorrectly assigned to a nursing facility risk group.

Auditors recommended that HHS should determine where authority to enforce Texas Administrative Code requirements for nursing facilities resides or should reside.

Analyze the cause of and improve prevention and detection of inaccurate non-nursing facility risk group assignments

Auditors identified members who were categorized in non-nursing facility risk groups, but for whom the MCOs had paid nursing facility claims despite not receiving the nursing facility capitation payments from HHS.

Auditors recommended that MCS, in coordination with HHS IT and other applicable business areas, should perform root cause analysis and take appropriate action to improve prevention and detection of inaccurate non-nursing facility risk group assignments. Until a root cause analysis is performed to determine whether additional members were affected or further actions are needed, incorrect risk group categorizations and associated capitation underpayments will continue.

Agency Highlights

Texas dentist permanently excluded from Medicaid

OIG Litigation successfully argued in a contested hearing for the permanent exclusion of a Dallas dentist. The OIG presented evidence that the dentist misrepresented and omitted information on his Texas Medicaid enrollment application, submitted multiple false claims for reimbursement for dental work not performed and failed to comply with health care standards and maintain required documentation. The administrative law judge agreed that the multiple violations of Medicaid rules subjected the dental provider to sanctions, with sufficient severity to warrant his permanent exclusion from Medicaid.

Occupational therapy assistant excluded for 10 years

An occupational therapy assistant (OTA) was excluded from Medicaid participation for 10 years, effective April 28. The OTA falsified billing records, causing the employer to bill for services which were not rendered. A patient's family verified that not only did the OTA falsify the time records, but also falsified some of the signatures on the time records. The OTA's employer paid back $35,720 in payments and reported the OTA to the OIG. The employer fully cooperated, and with their assistance, the OIG was able to exclude this OTA for ten years.

MPI investigates possible fraud in allergy services

OIG data analytics continues to play a proactive role in detecting potential fraud, waste and abuse (FWA). In May, MPI utilized data analytics during a Fraud Detection Operation (FDO) to focus on providers whose billing patterns exhibit potential indicators of FWA. This quarter the OIG's Data and Technology Team used algorithms to identify allergy providers who appeared to be outliers among their peers related to allergy testing and immunology services. Based on this methodology, the FDO focused on four providers in the Amarillo area. The preliminary investigative findings are pending.

Quarter 3 performance

Audit reports issued	4
Audits in progress	23
Inspections reports issued	0
Inspections in progress	7
Investigations completed (BPI, IA, Peace Officer)	5,014
Investigations opened	4,156
Medicaid provider investigations completed	
Preliminary	502
Full-scale	63
MPI cases transferred to full-scale investigation	38
MPI cases referred to Medicaid Fraud Control Unit	106
Hospital claims reviewed	5,929
Nursing facility reviews completed	45
Medicaid and CHIP provider enrollment screenings performed	22,763
Medicaid providers excluded	65
Fraud hotline calls answered	5,491

OIG investigating vitamin infusions in nursing facilities

The Nursing Facility Utilization Review (NFUR) unit evaluates whether facilities correctly assess residents' needs, provide the appropriate level of care and maintain the required documentation. The NFUR team examined intravenous therapy (IV) vitamin infusion in nursing homes.

NFUR determined nursing facilities used outside vendors to administer IV vitamin infusions to residents to increase Medicaid reimbursements. In addition, the outside vendors administered IV vitamin infusions 1) without signed physician orders or supporting physician notes, 2) without

notating the amount, dosage, and flow rate, and 3) without post assessment documentation as required by Medicaid policy. NFUR referred the case to the OIG Provider Investigations unit for a full-scale investigation.

OIG expands external data sources

The OIG continues to leverage state agency partnerships to further our mission. The Texas Department of Licensing and Regulation and OIG are working together to integrate license and supervisory relationship data for speech language pathologists and audiologists; integrating the data will enhance OIG analytics and detection of potential program violations. Also, the Data and Technology Team (DAT) frequently accesses Texas Secretary of State data to support ongoing investigations of potential FWA. To further support these efforts, DAT is setting up a process with the secretary of state to exchange large volume record sets. This will increase efficiencies by allowing the OIG to feed large datasets into our algorithms and evaluate many entities simultaneously in support of investigations.

OIG improves data analytics

DAT fraud analytics continues to refine its data analysis methods to efficiently handle the resource demands related to processing large datasets. The completed phases of enhancements have produced significantly faster analytics processes that support data mining of Medicaid claims data for potential fraud, waste or abuse. For example, a data query of 21 million dental services previously took 11.5 hours to return; now the task requires slightly more than 10 minutes. These advancements improve the timeliness of monitoring billing trends, which is critical to detecting emerging concerns. Further phases of this project will focus on other areas of billing within the Medicaid program.

Medical Services collaborates to digitize records

In May, Medical Services collaborated with the Texas Medicaid & Healthcare Partnership (TMHP) via virtual meetings to complete the Digital Scanning Support project. It is estimated that the OIG receives 40,000–50,000 medical records annually from a variety of healthcare providers. This project utilizes TMHP technology to help Medical Services reduce the amount of paper medical records received by converting to electronic medical records. This conversion from paper to electronic helps reduce time and save space while conducting utilization reviews. TMHP is the contracted claims administrator for Texas Medicaid.

Dental team improves efficiency

This quarter the OIG Dental Team collaborated with external contract dental consultants to begin using probe samples to complete dental cases. Probe sampling is the method of reviewing a small random number of dental claims to draw a conclusion about the characteristic for the entire population. The results of the probe sample can determine if a full review of the entire population is required. Through this focused effort, the dental team was able to significantly reduce the dental case load and concentrate on more impactful cases.

OIG reviews MCO cost avoidance and waste prevention

As required by House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services (HHS), Rider 114), the OIG conducted a review of managed care organization (MCO) cost avoidance and waste prevention activities. Currently MCOs report recoveries to the OIG, but this reporting does not capture the value of the MCOs' work proactively preventing ineligible payments for health care services. The OIG collaborated with Medicaid and CHIP Services and MCOs to develop a definition, criteria and guidelines to capture the value of cost avoidance and waste prevention activities utilized by MCOs. The OIG included its findings, recommendations and review of the OIG's resources and identified incidences of fraud, waste and abuse in Medicaid managed care in the report issued to the Legislative Budget Board and the governor's office. It is also available on the OIG's website.

Inspections moves to Audit Division

The Inspections Team joined the Audit team in May. The Audit division was renamed the Audit and Inspections Division. Inspections are closely aligned with audits and ensure accountability and integrity in the delivery of state health and human services programs. This change allows better coordination and collaboration between our auditors and inspectors, utilizing the unique skill sets of each group to enhance the value of OIG reports.

Connect with the OIG on social media

The OIG is now on LinkedIn (hhsc-office-of-inspector-general). Social media allows us to reach a wider audience and connect with people who may be affected by but not realize the impact of our work. LinkedIn provides an additional opportunity to engage with current and future employees, providers, vendors and program partners. The new profile is a place to highlight the issues and results pertaining to our work preventing and detecting fraud, waste and abuse in Texas Medicaid delivery. The OIG is also active on Facebook (TxOIG) and Twitter (@TexasOIG).

Completed Reports

Audit

Medicaid STAR+PLUS Nursing Facility Risk Groups: Reporting Errors Caused Incorrect Risk Group Assignments. The OIG conducted an audit of Medicaid managed care risk group assignments for nursing facility risk groups to determine (a) whether selected STAR+PLUS members were properly categorized in nursing facility risk groups and (b) the potential impact on capitation payments to managed care organizations. A nursing facility capitation rate is a fixed amount Texas Medicaid pays MCOs monthly for each individual enrolled in the MCO residing in a nursing facility, depending on the member's assigned risk group. There are three nursing facility risk groups in STAR+PLUS. Nursing facility risk groups are the risk groups in STAR+PLUS with the highest projected medical utilization costs, and consequently the highest capitation rates. The audit aimed to determine whether patients were either assigned to a nursing facility risk group when they were not in a nursing home or if they were not assigned to a nursing facility risk group when they should have been.

Auditors concluded that HHS paid $1.38 million in capitation overpayments to managed care organizations for Medicaid recipients not eligible for managed care, such as those requiring hospice services or residing in a Texas State Veterans Home and whose claims should be paid on a fee-for-service basis. Nursing facilities did not always submit resident transaction notices as required, and HHS did not enforce that requirement.

Auditors offered recommendations to MCS, which, if implemented, will prevent managed care capitation from being paid for fee-for-service clients and improve the accuracy of nursing facility risk group assignments and corresponding payments to managed care organizations in the future.

Security Controls over Confidential HHS System Information – El Paso Health. The OIG completed an audit of El Paso Health. The objectives of the audit were to assess the design and effectiveness of selected security controls over confidential HHS System information stored and processed by El Paso Health, as well as business continuity and disaster recovery plans for operations relating to the processing and storage of confidential HHS System information by El Paso Health.

Audit results indicated that El Paso Health complied with HHS Information Security requirements related to information security oversight, information system monitoring, risk management, and workforce training, business

continuity and disaster recovery planning, information system monitoring and physical security. El Paso Health also complied with requirements related to business continuity and disaster recovery planning. However, El Paso Health should further strengthen controls related to user access, configuration management and media protection.

Auditors offered recommendations to El Paso Health which, if implemented, will result in El Paso Health strengthening its user account management and risk management control areas. El Paso Health concurred with the audit recommendations and indicated it will address the audit issues.

Tarrytown Expocare – A Texas Vendor Drug Program Provider. The OIG completed an audit of Tarrytown Expocare, a Texas Vendor Drug Program (VDP) provider. The audit objectives were to determine whether Tarrytown Expocare properly billed the VDP for Medicaid claims submitted, and whether Tarrytown Expocare complied with selected contractual and Texas Administrative Code requirements.

As permitted by Texas Administrative Code § 371.35(a), auditors used sampling and extrapolation as part of the audit. Audit results indicated that there were exceptions related to claims validity and national drug code usage, controlled substances, and drug acquisition. Of the 224 claims tested, there were 39 unsupported claims with 40 exceptions totaling $1,429. The unsupported claims represent Medicaid overpayments to Tarrytown Expocare. By extrapolating the results to the population of claims within the scope of the audit, OIG determined that the exceptions represented an overpayment for the population of $47,381. Auditors offered recommendations to Tarrytown Expocare which, if implemented, will correct deficiencies in compliance with contractual and Texas Administrative Code requirements.

Medicaid and CHIP MCO Special Investigative Units—Molina Healthcare of Texas. The OIG completed an audit of Molina Healthcare of Texas' special investigative unit (SIU) performance to evaluate the SIU's effectiveness at preventing, detecting and investigating fraud, waste and abuse and reporting reliable information on SIU activities, results and recoveries. Molina is an MCO contracted to provide Medicaid and CHIP health care services in Texas.

MCOs are required to establish an SIU to investigate fraudulent claims and other program waste and abuse by members and service providers. Molina's SIU referred 62 reports of suspected fraud, waste or abuse to OIG during the audit period, which ran from September 1, 2017, through August 31, 2019; the audit also included a review of relevant SIU activities through the end of fieldwork in November 2019. Molina had a fraud, waste and abuse plan in place that was supplemented by written policies and procedures, as well as internal and external resources dedicated to its SIU function. In addition, Molina maintained a fraud, waste and abuse hotline, submitted the monthly report of open cases timely, conducted recipient verifications and accurately reported SIU recovery amounts to HHS. Overall, Molina complied with training requirements. However, the audit determined Molina should strengthen its processes related to referrals and preliminary investigations to comply with Texas Administrative Code and Molina's fraud, waste and abuse plan.

The OIG recommended to Molina that it should include required topics in its online member content, perform background research on agencies as well as individuals reported, and conduct all preliminary investigations and report referrals to OIG in a timely manner.

Stakeholder Outreach

Medical Services meets with stakeholders

The Nursing Facility Utilization Review (NFUR) unit held its quarterly stakeholder meeting in March. Discussion included reviewing the Restorative Nursing Program, Texas State Resource Utilization Groups Training, the correct Activity of Daily Living coding and onsite review common errors and recent updates. In efforts to reduce the spread of COVID-19 through social distancing, the Hospital Utilization Review unit held its virtual quarterly stakeholder meeting in April. Discussion included assessing the impact of COVID-19 on the review process and providing updates on fee-for-service sample record requests, SharePoint file sharing, quality control and the digital scanning project.

OIG publishes educational articles for providers

In May, OIG Chief Pharmacy Officer Catherine Coney, R. Ph. collaborated with the OIG Communications Team and Medical Services to publish an article in Texas Pharmacy, the official magazine for the Texas Pharmacy Association. The article is titled "New PMP Requirement Complements OIG Lock-In Program to Fight Prescription Drug Abuse." It describes how the OIG reviews referrals and data to determine if a person who receives Medicaid benefits meets the criteria for lock-in to a single designated pharmacy and/or prescriber. The article highlights the year-over-year increase in program participation and the resulting cost savings to taxpayers.

OIG Chief Dental Officer Dr. Janice Reardon collaborated with the OIG Communications Team to publish an article for the summer issue of Texas Dental Association's TDA Today. The piece described the dental team's work performing onsite examinations to assist fraud investigations. The dental team uses their knowledge and experience to reveal potential program violations by performing clinical exams that compare dental work performed with what was billed to Medicaid.

OIG meets with MCOs

The OIG conducted an OIG Medical Services Coordination Call with MCOs on April 7 to discuss the work of the Medical Services division in managed care and updates related to extended deadlines and other information due to COVID-19. The OIG also shared the deadline extension information packet developed by Communications with stakeholder groups, including the Texas Association of Health Plans and the Texas Association of Community Health Plans.

Conferences and Presentations

- OIG employees attended a webinar in April focused on current and anticipated national trends related to COVID-19 FWA schemes. The webinar was hosted by the National Health Care Anti-fraud Association. Participants from across the nation discussed how the pandemic creates opportunities for an increase in FWA.
- Newly hired nurse reviewers attended Nursing Facility Utilization Review (NFUR) in-person training in March and Hospital Utilization Review (HUR) virtual training in May. This training is designed to familiarize nurse reviewers with the tools, resources and equipment necessary to conduct retrospective utilization reviews of nursing facilities and hospital inpatient claims for Medicaid services.
- In May, nurse reviewers also attended virtual training in the fundamentals of diagnosis code assignment and procedures by using conventions, instructions and sequencing guidelines from the Official Guidelines for Coding and Reporting. These trainings are part of the OIG's FWA prevention efforts that include attending education and training programs necessary to operate efficiently, effectively and ethically.
- In May, the BPI Intake Unit conducted a training for all BPI intake personnel. The training was designed to increase the number of referrals completed by effectively utilizing the Waste, Abuse and Fraud Reporting System (WAFERS). BPI intake investigators learned how to compare information from WAFERS to client data in the Texas Integrated Eligibility Redesign System. Investigators were also trained on how to address allegations of clients selling SNAP benefits for cash or other ineligible items.
- Professional Development has continued offering employee orientation sessions. Distance learning platforms have allowed for expanded participation by regional staff. New Employee Orientation is presented once per month. Topics covered in orientation include: a senior staff welcoming message outlining the vision, mission, and values of OIG; an overview of the roles and responsibilities of each division and their individual units; both HHS and OIG staff resources and contacts; the Emergency Action Plan for our Austin location; and OIG travel policies and procedures. OIG orientation ensures all new employees have a solid foundation to develop programmatic knowledge, skills and abilities.

Training summary

Trainings conducted this quarter	32

Program Integrity Spotlight

OIG responds to COVID-19 pandemic

When Governor Abbott issued the state of disaster declaration on March 13, the OIG took steps to ensure that the agency continued its work while helping our stakeholders in the time of uncertainty. The OIG deployed existing technology to allow staff to work from home to ensure their safety. The agency also adjusted reporting deadlines for providers and managed care organizations to help them focus on patients. Staff across the OIG quickly responded to emerging fraud, waste and abuse schemes during the pandemic.

Assisting providers

To assist providers in maintaining focus on their patients, the OIG changed a variety of processes and extended timeframes for information and data requests and management responses. The Audit and Inspections Division paused new audits and inspections between March 19, 2020 and May 1, 2020. Medical Services in March halted onsite nursing facility reviews and notified providers that deadline extensions were granted for medical records requests, reconsiderations and identified recoupment payments.

Two deadline extensions may impact MPI's completion time for full Medicaid fraud or abuse investigations. Data requests sent by the OIG to the managed care organization (MCOs) and dental maintenance organizations (DMOs) were initially extended from 5 to 30 days; the extension was revised to 10 days effective June 1. MCO information or record requests were extended from 5 days to 30 days. The COVID-19 related extensions are posted on the OIG website and are updated frequently.

While new audits and inspections are now proceeding, our teams are working carefully to ensure minimal impact to audit clients whenever possible. The OIG continues to work closely with all audit clients to extend response times when needed. The OIG is utilizing virtual meeting technology to conduct audit and inspection interviews, walk-throughs and testing.

OIG Fraud Hotline

Providing continuity of service for the Fraud Hotline was a priority when the OIG transitioned employees from working in the office to working at home during the pandemic. Operations staff quickly deployed new software and training to allow all Fraud Hotline staff to telework.

Staff continue to answer calls concerning fraud, waste and abuse and route the resulting reports to investigations as appropriate. The Fraud Hotline answered 5,491 calls during the third quarter, compared with 6,354 calls in the second quarter. Hotline staff transferred 1,262 reports of fraud, waste and abuse (FWA) to investigations in the third quarter.

Fraud alerts and educational guides

MPI collaborated with OIG's Communications Team to launch a public COVID-19 fraud alert section on the OIG website and publish social media posts to inform the public about the various COVID-19 FWA schemes and how to protect themselves from becoming a victim.

With the increase of benefit applications due to COVID-19's effect on the economy, the OIG produced web content to further educate applicants and benefit recipients on the appropriate use of SNAP, Medicaid and Temporary Assistance to Needy Families benefits. The fraud prevention initiative was a collaboration between BPI, Policy and the Communications Team. The electronic resources provide clients with tips on how to properly apply for benefits with accurate information, examples of misusing benefits, and contact information for reporting suspected FWA. In addition, information for SNAP retailers was included to help prevent trafficking and help promote an understanding of ways to appropriately use SNAP benefits to purchase eligible food items. The new guides are available in English and Spanish; they are posted on the OIG

website's resources page.

WIC digital technology

In response to COVID-19, the Women, Infants and Children (WIC) Vendor Monitoring Unit (VMU) adjusted their mission to increase the number of remote inventory audits. The remote audits were in place of the in-person covert compliance buys and on-site overt store reviews typically used to ensure vendors are following WIC rules.

An inventory audit is a comparison of a vendor's paid claims and their purchase invoices for WIC food items. The audit determines if the vendor had a sufficient inventory of WIC food items to justify their submitted claims.

Using digital technology, the OIG WIC team now remotely accesses individual vendor redemptions to initiate inventory audits. Results are then uploaded into the new WIC SharePoint case tracking system. A new policy was also developed to increase the number of transactions previously required in identifying incidents of noncompliance.

Training during the pandemic

Operations Professional Development (PD) has been an active resource for training in the virtual environment, assisting divisions in continuing core skills development and connecting staff to external resources to continue reducing FWA. PD has lead training and Explore OIG sessions across several virtual platforms; the team developed instructional videos to further encourage productive staff project meetings, interviews and discussions.

PD supported virtual meetings for the quarterly Medical Services stakeholder and MPI Special Investigative Unit updates. The team also assisted OIG participation in two national webcasts focused on new FWA schemes that arose in the pandemic.

Tracking program integrity issues and trends

OIG's Third Party Recoveries (TPL) is currently tracking an Agile project initiated by Texas Medicaid & Healthcare Partnership (TMHP) and Texas Health and Human Services to address COVID-19 activities. TMHP-TPL will review and identify any payments that a third party should have paid but denied prior to changes during COVID-19, that will need to be recovered.

OIGs Policy Coordination team is working with the Data and Technology Team to identify and evaluate emerging trends in healthcare service delivery and administration related to COVID-19. The team is reviewing published reports and identifying focal points for data analysis related to program integrity during the pandemic.

Throughout the course of the pandemic, the OIG has and will continue to adapt to events, anticipate their results and take action to support health care delivery in Texas.

Division Performance

Investigations

Investigations includes commissioned peace officers and non-commissioned personnel. It has three units:

- State Centers Investigations Team conducts criminal investigations of allegations of abuse, neglect and exploitation at state supported living centers and state hospitals.
- Cooperative Disability Investigations investigates statements and activities that raise suspicion of disability fraud.
- Electronic Benefit Transfer Trafficking conducts criminal investigations related to trafficking of Supplemental Nutrition Assistance Program (SNAP) benefits.

Benefits Program Integrity investigates allegations of overpayments to health and human services program clients enrolled in WIC; SNAP; the Temporary Assistance for Needy Families program; Medicaid; and the Children's Health Insurance Program.

Peace Officers performance

Cost avoidance	$123,384

Benefits Program Integrity performance

Overpayments recovered	$19,904,335
Cases completed	4,674
Cases opened	3,934
Cases referred for prosecution	35
Cases referred for Administrative Disqualification Hearings	239

EBT Trafficking Unit performance

Overpayments recovered	$113,592
Cases opened	36
Cases completed	116

State Centers Team performance

Cases opened	152
Cases completed	187

Chief Counsel

The Office of Chief Counsel Division provides legal counsel and is comprised of the following:

- General Law provides legal support for audits, investigations, inspections and reviews. Furthermore, General Law supports OIG operations, including researching termination/exclusion issues, reviewing federal share obligations, analyzing extrapolation processes, contracting and assisting with rule and statute changes affecting the agency.
- Litigation handles the appeal of investigations and audits that determined providers received Medicaid funds to which they were not entitled.
- Internal Affairs investigates employee misconduct in the provision of health and human services, including contract fraud within the HHS system.

Internal Affairs performance

Investigations completed	37
Cases with sustained allegations	6

Medicaid Program Integrity

Medicaid Program Integrity Division includes four units:

- The Provider Investigations unit investigates and reviews allegations of fraud, waste and abuse by Medicaid providers who may be subject to a range of administrative enforcement actions including education, prepayment review of claims, penalties, required repayment of Medicaid overpayments, and/or exclusion from the Medicaid program. Some referrals come through the OIG Fraud Hotline or complaints from the OIG's online Waste, Abuse and Fraud Electronic Referral System. Referrals are also received from managed care organizations throughout the state. When criminal Medicaid fraud is detected, MPI refers the matter to the Attorney General's Medicaid Fraud Control Unit. The two work together on joint investigations by sharing resources and information that will lead to successful administrative disposition or criminal prosecution.
- The Medical Services unit conducts claims and medical record reviews on a variety of health and human services, including acute care utilization, hospital utilization, nursing facility utilization, research and detection, and pharmacy lock-in. Medical Services also provides clinical consultation to the Benefits Program Integrity and Audit units, and the Inspections and Investigations Division on dental, medical, nursing and pharmacy services.
- The Program Integrity Development and Support unit provides support and process improvements to other MPI units. Responsibilities include developing projects to improve MPI investigative outcomes, reporting MPI statistics, acting as the Managed Care Organization Special Investigative Unit liaison, planning and conducting Investigative Initiatives and Fraud Detection Operations, and acting as the lead on open records requests.
- The Provider Enrollment Integrity Screenings (PEIS) unit is responsible for conducting certain federal- and state-required screening activities for providers seeking to enroll in Medicaid, CHIP and other state health care programs. The screenings and reviews conducted by PEIS promote compliance with federal provider enrollment program integrity requirements; increase accountability for the appropriate use of taxpayer resources by helping to prevent fraud, waste and abuse; and protect the health and safety of Texans.

Medicaid Program Integrity performance

Preliminary investigations opened	449
Preliminary investigations completed	502
Full-scale investigations completed	63
Cases transferred to full-scale investigation	38
Cases referred to AG's Medicaid Fraud Control Unit	106
Open/active full-scale cases at end of quarter	130

Medical Services performance

Acute care provider recoveries	$2,050,485
ACS identified overpayments	$2,334,688
Hospital and nursing home UR recoveries	$4,520,800
Hospital UR claims reviewed	5,929
Nursing facility reviews completed	45
Average number of Lock-in Program clients	2,189

PEIS performance

Provider enrollment inventory (applications and informal desk reviews) processed	7,258
Individual screenings processed	22,763

Audit and Inspections

Audit conducts risk-based audits related to the accuracy of medical provider payments; the performance of HHS agency contractors; and programs, functions, processes and systems within the HHS system. Protocols of provider audits are periodically published on the Resources page on the OIG's website. Audit also coordinates all federal government audits of the HHS system.

Inspections conducts inspections of HHS programs, systems and functions. Inspections also oversees the state's Women, Infants and Children (WIC) Vendor Monitoring Unit. This unit conducts in-store evaluations, compliance buys, and invoice audits to monitor vendors participating in the WIC program.

Inspections performance

Overpayments recovered	$18,956
Overpayments identified	$21

Inspections in progress

- Member Complaints Received by Texas Medicaid Managed Care Organizations - Series III: Inspection of Member Complaint Appeals
- Molina Quality Living Program
- Child and Adolescent Needs and Strengths Assessment in Community-Based Care
- Local Mental Health Authorities
- Overlapping Long-Term Care Claims During Hospital Stays
- Mental Health Targeted Case Management and Rehabilitative Services in Managed Care
- State Supported Living Centers' Background Checks and Training Processes

Audit performance

Overpayments recovered	$646,633
Overpayments identified	$47,381
Audit reports issued by contractors	0

Audit reports issued

- Medicaid STAR+PLUS Nursing Facility Risk Groups: Reporting Errors Affected Risk Group Assignments (3/30/2020)
- Security Controls over Confidential HHS System Information and Business Continuity and Disaster Recovery Plans – El Paso Health (4/24/2020)
- Tarrytown Expocare—A Texas Vendor Drug Program Provider (5/11/2020)
- Medicaid and CHIP MCO Special Investigative Units: Molina Healthcare of Texas (5/22/2020)

Audits in progress

The Audit Division had 23 audits in progress this quarter on the topics listed below. A list of audits in progress and audit topics the OIG plans to initiate can be found in the rolling audit plan located on the OIG's website (https://oig.hhsc.texas.gov/audit).

- IT Security and Business Continuity and Disaster Recovery Plans
- Pharmacy Providers
- Managed Care Pharmacy Benefit Managers' Compliance
- Durable Medical Equipment Claims
- Selected Local Intellectual and Developmental Disability Authority (LIDDA) Contractors
- Pharmacy Providers
- MCO Clean Claims for Nursing Facility Providers
- Substance Use Disorder Contracts
- Performance of Selected Contractors Supporting the Texas Integrated Eligibility Redesign System (TIERS)
- Cost Allocation of MCO Shared Services
- Selected HHS Grant Recipients
- Third Party Administrator

Strategy and Data and Technology

The Strategy Division includes the Data and Technology (DAT) and the Policy Coordination units.

- DAT implements tools and innovative data analytic techniques that streamline OIG operations and increase the identification of fraud, waste, and abuse. DAT assesses trends and patterns regarding behavior of providers, clients and retailers participating in Texas Health and Human Services (HHS) programs. DAT consists of four units: Fraud Analytics, Data Research & Analysis, Statistical Analysis, and Data Operations.
- Policy Coordination serves as the health care policy subject matter expert and liaison between HHS and the OIG. The unit conducts analysis of program policies, leads cross-functional OIG projects and initiatives and coordinates and ensures timely and effective communication with a variety of stakeholders.

Data and Technology performance

Data requests received	318
Data requests completed	300
Algorithms executed	97
New algorithms developed	19

Operations

The Operations Division is comprised of five core functions:

- Operations Support includes OIG purchasing, OIG contract management and the OIG Fraud Hotline. The Fraud Hotline receives allegations of fraud, waste and abuse and refers them for further investigation or action as appropriate.
- Finance and Budget oversees the OIG budget, tracks recoveries, reports Legislative Budget Board performance measures and works closely with HHSC Central Budget on the agency's LAR/ Exceptional Items.
- Workforce Operations and Professional Development promotes OIG training services and internal policy development.
- Third Party Recoveries works to ensure that Medicaid is the payor of last resort, oversees the Recovery Audit Contract and operates the Medicaid Estate Recovery Program.
- The Ombudsman provides an independent and neutral process for OIG employees to address concerns and work towards resolution.

Operations performance

Fraud hotline calls answered	5,491

Third Party Recoveries performance

Dollars recovered	$169,446,354
Cost avoidance	$20,341,416

External Relations

The External Relations Division focuses on engaging and ensuring a timely response to OIG critical stakeholders:

- Communications manages press relations, maintains the OIG website and social media platforms, publishes the agency's external facing reports and work products, and facilitates communication between the Inspector General and various stakeholders.
- Government Relations serves as the primary point of contact for the executive and legislative branches of government and state policy makers. Government Relations also analyzes legislation to understand the impact to OIG operations.
- Strategic Initiatives leads OIG-wide initiatives and special projects.

External Relations performance

Website page views	164,852
Communications materials produced	93

Texas Health and Human Services Office of Inspector General

Sylvia Hernandez Kauffman, Inspector General

Mailing address: P.O. Box 85200, Austin, TX 78708
Main phone number: 512-491-2000
Email: OIGCommunications@hhsc.state.tx.us

To report fraud, waste or abuse

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

Website: ReportTexasFraud.com
OIG on LinkedIn: hhsc-office-of-inspector-general
OIG on Twitter: @TexasOIG
OIG on Facebook: TxOIG

Produced by OIG Communications: Andres Araiza, manager; Emily Hummel and Art Moore, staff
Content contributors: Analee Alderete, Collette Antoine, Mo Brantley, Jim Day, Merrie Duflot, Jim Harrison, Jill Heath, Belinda Heffelfinger, Derek Johnson, Dirk Johnson, Steve Johnson, Jen Kauffman, Nikki Kline, Andreana Ledesma, Emily McCoy, Tiesha Miller, Jonathan O'Reilley, Diane Salisbury, Jill Townsend, Chelsea Wallace, Katrina West, Stephanie Wilson

This report meets the requirements for information related to the expansion of managed care as required by House Bill 1, 86th Legislature, Rider 112, Office of Inspector General Report and Government Code §531.102 (t)