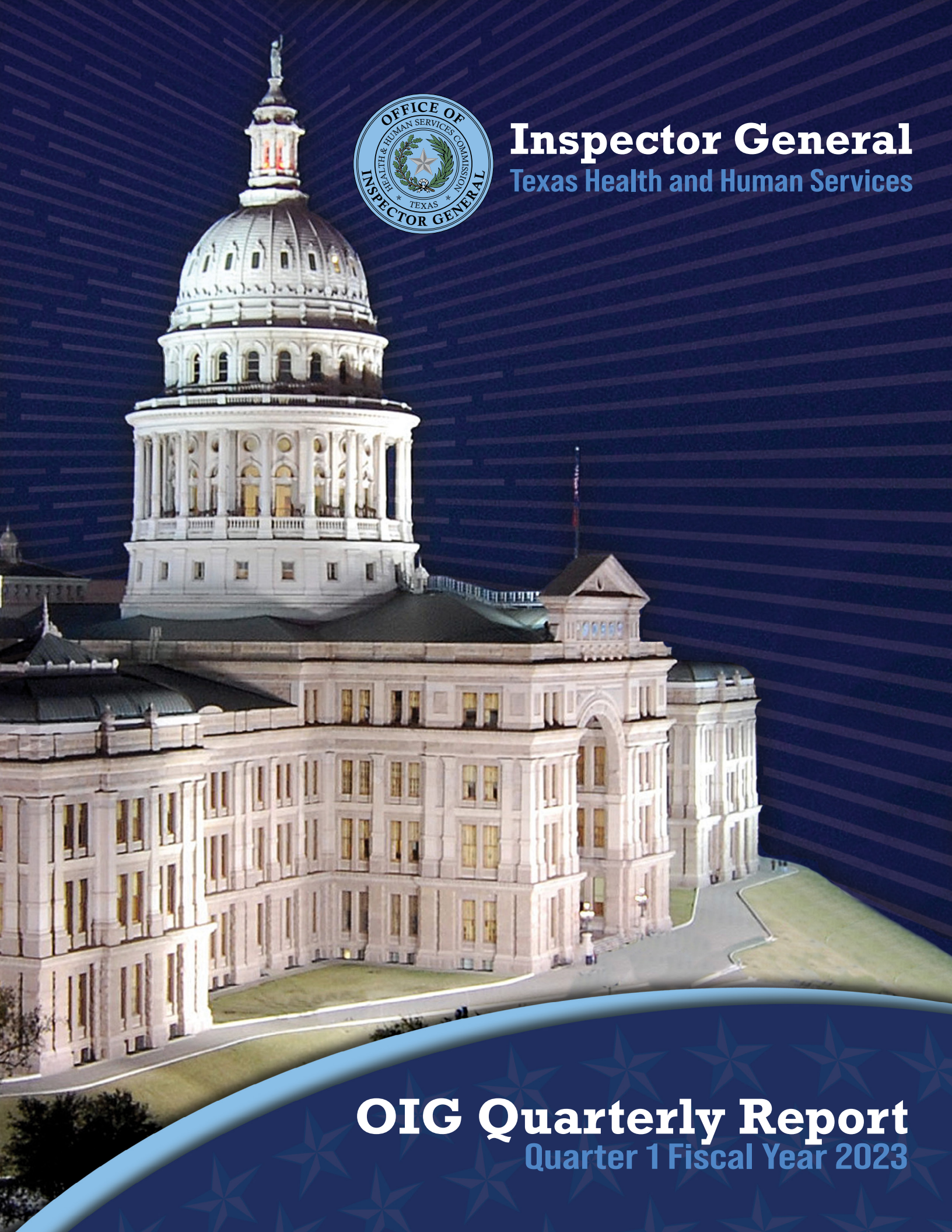


Inspector General

Texas Health and Human Services

OIG Quarterly Report

Quarter 1 Fiscal Year 2023

Table of Contents

I. Executive Summary

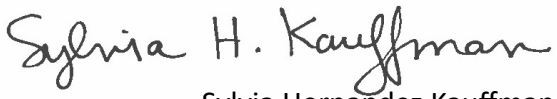
I am pleased to present to Governor Greg Abbott, Executive Commissioner Cecile Young, the Texas Legislature and the citizens of Texas the first quarterly report for fiscal year 2023, summarizing the excellent work this office performed during this period.

From September 1 to November 30, 2022, the Office of Inspector General (OIG) recovered more than $103 million. In addition, we identified more than $188 million in potential future recoveries and achieved more than $44 million in cost avoidance.

These results reflect the OIG team's dedication to our core values — accountability, integrity, collaboration and excellence. Delivering excellence in today's environment requires both the latest in technology and a high-performing team. Staying competitive is always a challenge, especially for government agencies, but one that we intend to meet head on. To continue providing the best possible return on investment to the State of Texas, the OIG has proposed exceptional item requests to the Texas Legislature for technological and staffing enhancements. The technology requests focus on the need to replace outdated systems that have exhausted their potential and expanded data processing capabilities that have proven to increase recoveries. In the staffing arena, the focus is on improving team member recruitment and retention, along with additional staff to increase our capacity in targeted areas. Combined, these requests will improve the OIG's efficiency and increase recoveries to the State of Texas.

I invite you to explore this report to better understand how this agency safeguards tax dollars and upholds standards for Texas Health and Human Services programs. The OIG in Focus on page 23 highlights the teams who accomplish our mission in nursing facilities by conducting hundreds of inspections, audits, investigations and reviews each year. You can read about OIG efforts to ensure patient safety and minimize fraud through audits, inspections, utilization reviews and provider education.

As we enter a new calendar year, I anticipate continued outstanding performance from our entire team. I am honored to work alongside them in service to the people of Texas.



Sylvia Hernandez Kauffman
Inspector General

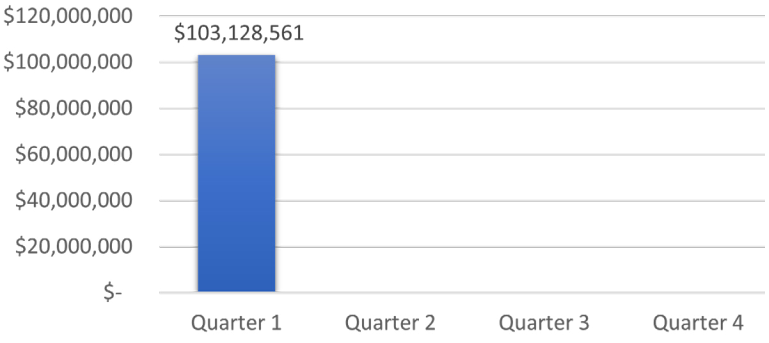
II. Quarterly Metrics

Dollars recovered

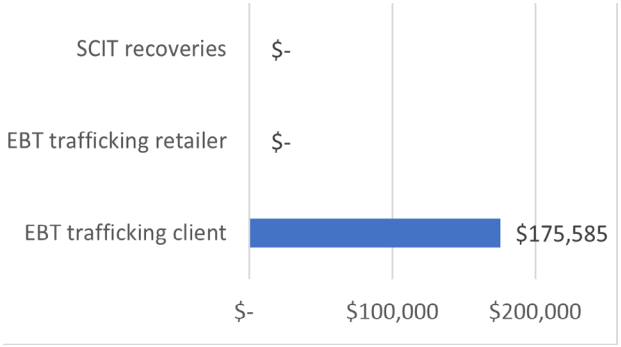
Dollars recovered are overpayments that have been collected based on the results of an investigation, audit, inspection or review.

Total dollars recovered	$103,128,561
Providers and Managed Care Organizations	**$96,667,296**
Provider overpayments from audits and inspections	$113,642
Provider overpayments from investigations	$6,656,305
Provider overpayments from automated scenarios	$963,331
Acute care provider overpayments	$1,119,069
Hospital utilization review overpayments	$3,130,305
Hospital utilization review underpayments	($4,134)
Nursing facility utilization review overpayments	$156,053
Nursing facility utilization review underpayments	($3,461)
FFS Recovery Audit Contractor recoveries	$19,419,507
Third Party Recoveries	$65,116,679
Clients	**$6,460,944**
Beneficiaries overpayments (SNAP, TANF, Medicaid, CHIP, WIC)	$6,255,879
Voluntary repayments by beneficiaries	$29,480
Electronic Benefits Transfer trafficking beneficiary overpayments	$ 175,585
Retailers	**$320**
Electronic Benefits Transfer trafficking retailer recoveries	$-
WIC collections	$320
HHS Employees and Contractors	**$-**
State Centers Investigations Team recoveries	$-

Total Dollars Recovered By Quarter



Peace Officer Recoveries



Dollars identified for recovery

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

Total dollars identified for recovery	$188,131,703
Providers and Managed Care Organizations	**$169,849,117**
Provider overpayments from audits and inspections	$-
Provider overpayments from investigations and MCO's	$3,971,343
Provider overpayments from automated scenarios	$777,987
Acute care provider overpayments	$349,118
Hospital utilization review overpayments	$3,801,828
Hospital utilization review underpayments	$-
Nursing facility utilization review overpayments	$1,727,245
Nursing facility utilization review underpayments	$-
FFS Recovery Audit Contractor recoveries	$12,604,678
Third Party Recoveries	$146,616,918
Clients	**$18,282,586**
Beneficiaries overpayments (SNAP, TANF, Medicaid, CHIP, WIC)	$18,007,188
Voluntary repayments by beneficiaries	$-
Electronic Benefits Transfer trafficking beneficiary overpayments	$ 275,398
Retailers	**$-**
Electronic Benefits Transfer trafficking retailer recoveries	$-
WIC collections	$-
HHS Employees and Contractors	**$-**
State Centers Investigations Team recoveries	$-

Cost avoidance

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

Total cost avoidance	$44,423,540
Providers and Managed Care Organizations	**$39,110,562**
Medicaid provider exclusions	$-
Fee-for-service front-end claims denial	$39,110,562
Clients	**$5,312,978**
Client disqualifications	$2,522,947
WIC vendor monitoring	$-
Pharmacy Lock-In	$2,458,267
Disqualification of Electronic Benefits Transfer recipients	$331,764

III. Provider Integrity

Trends

Medicaid Provider Field Investigations (PFI) continues to look at opportunities to utilize data analytics in the detection of fraud, waste, and abuse. This includes focusing on spikes in providers' utilization of certain billing codes related to telemedicine, changes in billing patterns related to genetic testing, and billing home health services in excess of permissible time limits (commonly referred to as impossible hours). Another example is when Medicaid policy indicates that an initial service code must be billed prior to a subsequent service code. These types of investigations rely on clear-cut Medicaid policy and billing directives from contracted MCO/DMO entities. From an analytics standpoint, data trends and patterns suggest potential policy violations. These types of investigations provide opportunities for efficient identification and recovery of inappropriately paid dollars, and for strengthening ambiguous policies.

Provider Investigations Performance

- **498 Preliminary investigations opened**
- **497 Preliminary investigations completed**
- **42 Full-scale investigations completed**
- **86 Cases transferred to full-scale investigation**
- **225 Cases referred to OAG's Medicaid Fraud Control Unit**
- **112 Open/active full-scale cases at end of quarter**

Case Highlights

Hospital settlement tops $3 million

On November 3, 2022, the OIG entered into a settlement agreement with seven North Texas outpatient hospital facilities in Grapevine, Dallas, Waxahachie, Carrollton, Irving, Garland, and McKinney for a collective settlement amount of $3,373,790.

Claims data indicated that between January 2012 through March 2022, each of the seven hospitals double-billed and were reimbursed for injections or infusions administered to clients in the emergency department. They were also reimbursed for emergency department services rendered to the same clients on the same dates of service. However, Medicaid policy states an injection or infusion administered by a nurse is included in the emergency department charge and not separately reimbursable.

Additionally, Medicaid policy states the administration of an injection is not reimbursable to outpatient hospital providers, regardless of the department in which the injection was administered. Therefore, reimbursements

Surveillance Utilization Review Team

Acute care provider recoveries	$1,119,069
Acute care services identified overpayments	$349,118
Hospital and nursing home (UR) recoveries	$3,278,764
Hospital (UR) claims reviewed	6,606
Nursing facility reviews completed	100
Average number of Lock-in Program clients	3,897

Provider Enrollment and Exclusions

Provider enrollment inventory (applications and informal desk reviews) processed	7,832
Individual screenings processed	16,482
Medicaid providers excluded	61

to the outpatient hospital providers for the administration of injections that did not have corresponding Emergency Department E/M service charges were also identified as being in error.

OIG settles case with an Irving pediatrician

On November 3, 2022, the OIG entered into a settlement agreement totaling $1,342,371 with an Irving pediatric office. Investigators requested a report from the OIG's data team for the top 20 providers who billed both molecular culture and rapid culture strep tests on the same dates of service or within three dates of service for the same recipient between October 1, 2016, and September 30, 2020. The provider in question was flagged as the top biller of these services. According to Medicaid policy, the tests are mutually exclusive procedures not to be reimbursed on the same day of service. Paid claims data and client interviews confirmed the provider improperly submitted claims, which subsequently agreed to the settlement, remitting the excess reimbursements to the State of Texas.

Preliminary Provider Investigations Opened

Attendants	35%
Physicians (individual/group/clinic)	15%
Hospitals	14%
Home health agencies	8%
Dentists	6%
Nursing facilities	3%
Therapists (counseling)	3%
Managed care organizations	3%
Pharmacies	3%
Durable medical equipment	3%
Case management	2%
Assisted living	2%
Adult day cares	1%
Seven other categories at less than 1%	2%

Rounded to nearest whole number

Types of Full-Scale Provider Investigations

Hospitals	65%
Home health agencies	9%
Dentists	8%
Pharmacies	5%
Nursing facilities	3%
Physicians (individual/group/clinic)	3%
Five other categories at less than 2%	7%

Rounded to nearest whole number

OIG reaches settlement with skilled nursing facility

The OIG reached settlements with two Texas nursing and rehabilitation facilities over their use of third-party contractors to provide vitamin and hydration infusions to patients between October 2018 and February 2020. In each case, the facility lacked documentation establishing sufficient medical necessity for the infusions. Moreover, the investigation suggested that the provider may have used the infusions as a basis to increase the complexity of the recipients' care, resulting in higher daily payment rates. Following the OIG investigations, each provider agreed to pay an administrative penalty of $500 per infusion. This resulted in a total payment of $53,000 for the Central Texas facility and $135,000 for the facility in Northwest Texas.

OIG settles case with McAllen clinic

On September 15, 2022, the OIG entered into a settlement agreement totaling $148,000 with a clinic providing family psychotherapy services in South Texas. Claims reviewed for the period between February 2015 and January 2019 indicated the provider submitted multiple claims and was reimbursed for hours exceeding the amount of time the provider was open for business, also known as billing for "impossible hours."

The provider also billed for individual services when family sessions were provided. According to Medicaid procedures, family psychotherapy is reimbursable for only one Medicaid-eligible client per session, regardless of the number of family members present per session.

North Texas dentist excluded following probated license suspension

In September, the OIG negotiated an agreed exclusion with a North Texas dentist.

The Texas State Board of Dental Examiners imposed a three-year probated suspension of the provider's license for various standard of care and overtreatment violations. The dental board alleged the provider overtreated three patients by performing restorations when adequate existing occlusal sealants were already in place, failed to properly document the use of nitrous oxide for two patients, up-coded sealant restorations as composite restorations, and did not document the use of local anesthesia when accessing the live dentin layer on one patient.

Based on OIG rules, a probated suspension of a professional license is a program violation. Given the nature of the violations and dental board's action, the OIG pursued an exclusion. The provider appealed, but prior to hearing, the parties reached an agreement that resulted in the provider being excluded for one year.

OIG settles with home health provider

In September, the OIG settled a case with a Houston-area home health provider whose medical records did not support the use of the UA modifier for some clients when billing for private duty nursing services. Depending upon a patient's underlying medical diagnosis, Texas Medicaid allows providers to use a billing modifier to increase payments to account for enhanced complexity of care.

In this case, the provider submitted claims utilizing the UA modifier—which provides additional reimbursement for patients who are ventilator-dependent or have a tracheostomy—from October 1, 2017, through September 20, 2021. A review of medical records in collaboration with the provider determined that they had improperly utilized the UA modifier for some patients without the required medical diagnosis. The provider worked with the OIG to resolve the issues, and the OIG agreed to a settlement of $20,847.

OIG settles with laboratory that lacked required certifications

In August, the OIG settled a case with a New Jersey-based laboratory that conducted lab tests for Texas Medicaid clients. Texas Medicaid rules require laboratories to have an appropriate Clinical Laboratory Improvement Amendments, or CLIA, Certification to be reimbursed for certain laboratory services. The CLIA Certification is linked to the billing codes for those services.

Investigators found that the provider received reimbursement for certain laboratory services performed between February 2015 and January 2019, but lacked the requisite CLIA certification. As a result of the program violation, the provider was subject to recoupment of the unwarranted reimbursements. The provider worked with the OIG to resolve the case and agreed to a settlement of $38,551.

Houston dentist excluded from Medicaid

A Harris County dentist settled with the OIG, resulting in an agreed five-year exclusion from Texas Medicaid. The OIG's investigation determined that from December 2015 through February 2021, while employed at

multiple dental offices, the dentist billed Texas Medicaid for restorations that were never performed, maintained inadequate or incomplete records to document required services (including sedation), billed for services without the required pre-operative x-rays or without diagnostic quality x-rays, and performed services using sedation without the required sedation permit.

As a result of these program violations, the OIG issued a Notice of Intent to Exclude. The provider requested an Informal Review Meeting (IRM), as permitted by OIG rules. At the IRM, the OIG presented its allegations to the provider in the presence of counsel, and the dentist subsequently accepted a five-year exclusion.

Southeast Texas home health care provider settles case

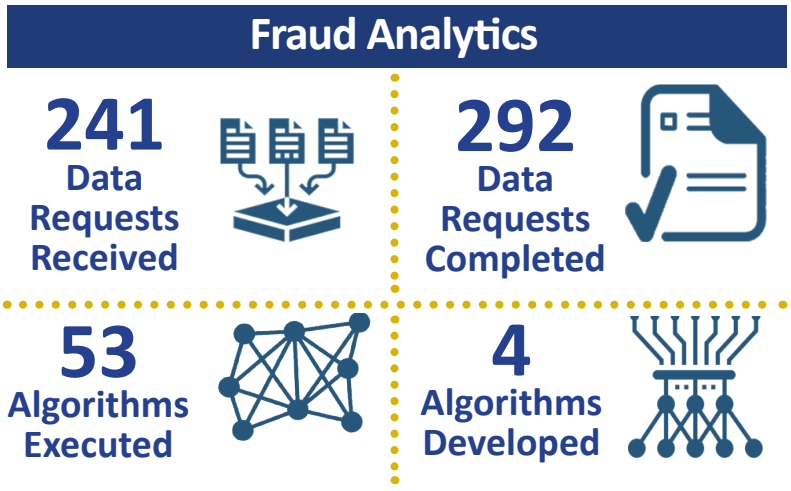
The OIG settled a case in September against a provider who self-reported that one of their nurses was working without a valid permanent Texas nursing license from October 1, 2021, through June 14, 2022. The employee had obtained a temporary nursing license in the State of Texas based upon having a valid Pennsylvania nursing license, which was current during the reported time frame. However, the employee did not take the final steps necessary to obtain a permanent Texas nursing license before the temporary license expired.

Upon discovery of the lapse, the provider utilized the OIG's self-report protocol to notify the agency. The self-report stated the provider billed Texas Medicaid for private duty nursing services for the nurse in question while the nurse did not have a valid temporary or permanent Texas nursing license. As such, the services reimbursed were not properly billed and subject to recoupment. The provider correctly reported that it owed the Medicaid program $61,994.

The OIG's self-report protocol is available at oig.hhs.texas.gov/resources/information-providers, under "Other Links."

Agency highlights

Increasing analytical functions and operational efficiencies



Through a competitive procurement, the OIG contracted with a vendor that works in both public and private sectors to develop advanced analytical tools to increase operational efficiencies and identify potential indicators of fraud, waste and abuse throughout state health and human services. The vendor delivered a tool that has enabled the OIG's data team to automate processes for requesting and reconciling claims and encounter data from managed care organizations (MCOs). This tool has reduced the processing times for data requests from approximately 60 days to 30 days or less. In addition, the vendor developed a billing pattern review methodology that enhances the OIG's ability to identify improper billing behavior when comparing billing patterns between providers.

Fraud detection operation examines home health agency providers

The OIG Fraud Detection Operation (FDO) team identified four home health agency providers with claims for skilled nursing, personal assistance services, private duty nursing, personal care services and respite care. The FDO team selected the providers for further review based on the results of algorithms generated by OIG's data team, which flagged the following:

- Outpatient overlap - billing for home health services while the client was in an inpatient facility.
- Exceeding unit limitations - a single claim line that exceeded 24 hours.
- Impossible hours - services exceeding 24 hours on a single date of service.

An FDO is the result of multiple OIG units' review and analysis of large volumes of data to identify providers who appear as statistical outliers among their peers. Investigators, through coordinated field work and research, evaluate additional evidence and information to determine if an outlier's status is attributable to possible fraud, waste, abuse or program violation.

Providers are required to provide records requested by OIG investigators, make staff available for interview, and generally cooperate with the investigation.

The record review for the four FDO-identified providers is still in progress. Based on the review findings, the cases may be referred to full investigation. Referral to investigations allows for a closer review of the provider's billing and documentation patterns and other evidence.

Provider Enrollment Integrity Screenings processes reviews

The OIG's Provider Enrollment Integrity Screenings (PEIS) team reviews disclosures, database matches and criminal records of certain providers seeking to enroll, re-enroll or revalidate their enrollment in Texas Medicaid to help prevent fraud, waste and abuse and promote the safety of Medicaid recipients. By statute, PEIS has 10 business days to complete screenings. In the first quarter of FY 2023, the team screened 81.2 percent of all applications within that time frame. In addition to safeguarding against fraud, waste and abuse by preventing ineligible providers from entering the Texas Medicaid system, PEIS is dedicated to supporting network adequacy by conducting their portion of the enrollment process as quickly as possible.

Working efficiently with physician consultants in utilization reviews

Surveillance Utilization Review (SUR) engages a team of physician consultants who work closely with OIG nursing and coder staff to review records and services for Medicaid recipients in hospitals and nursing facilities. Seeking a physician consultant opinion has historically been a lengthy, paper-driven process.

To streamline OIG work with physicians, SUR identified opportunities to reduce the timeline for completing physician consultant reviews. This included eliminating the paper process and moving to a fully electronic record platform. The transition involved nurses, physicians, finance, technology and other peripheral staff. The collaboration reduced the review time frame from several weeks or months to days, improved communication between staff and physician consultant, streamlined the physician consultant billing and payment process, improved utilization of all physician consultants, reduced the number of staff involved in the paper-driven process, eliminated courier fees, and maximized technology and tools to improve customer service.

Overall, the improved workflow with OIG physician consultants has proven beneficial. The increased engagement of all parties strengthens the collaboration between physician consultants and OIG staff and supports the delivery of timely quality service to those who serve Medicaid clients.

Audits examine telemedicine

Given the rise and sustained use of telemedicine and telecommunication technologies since the COVID-19 pandemic began, the OIG continues to ensure providers are billing for these remote health services appropriately and identify how best to protect Medicaid and CHIP programs against fraud, waste and abuse. Past OIG audits have identified physicians billing for more time than was spent with clients for telemedicine evaluation and management psychotherapy services. Two current OIG audits are focusing on behavioral health telemedicine services as these services are an important tool for increasing access and addressing the behavioral health needs of Medicaid and CHIP members. Behavioral

health telemedicine services provide members with mental health assessments, individual therapy, and medication management. Behavioral health telemedicine services are of particular interest as these services must be (a) significant and separately identifiable and (b) medical services that would be billable if provided in person.

Completed reports - Audit

Maximus, Inc. Member Communications: Texas Medicaid and CHIP Enrollment Broker

The OIG conducted an audit of Maximus, Inc. (Maximus), the sole Medicaid and CHIP enrollment broker for the state of Texas. The audit objective was to determine whether Maximus accurately, timely, and in accordance with applicable requirements:

- Communicated enrollment-related information to members who were determined eligible for Medicaid and CHIP services.
- Received and processed enrollment-related information from those members.

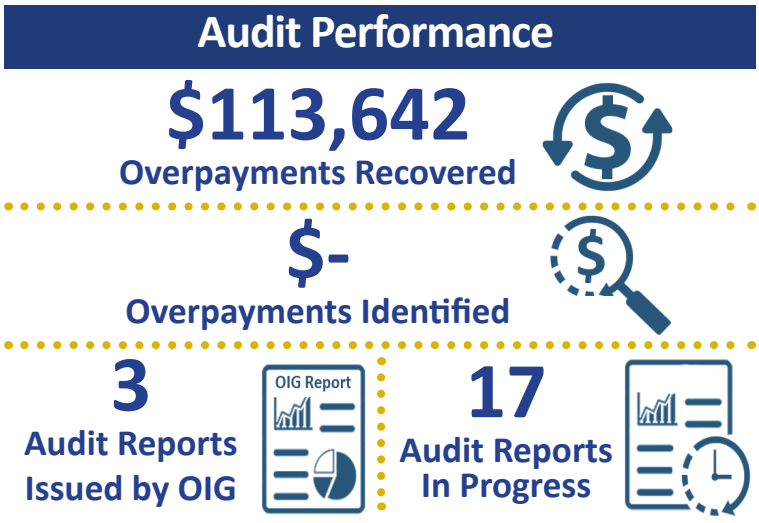
Maximus substantially complied with applicable requirements related to communicating enrollment-related information to eligible Medicaid and CHIP members and receiving and processing member enrollment-related information. However, it has opportunities to (a) ensure default managed care organization (MCO) selection complies with applicable requirements, (b) improve service to members, and (c) strengthen oversight of its mailing contractor. Additionally, while Maximus had processes and controls in place for its enrollment system, it should strengthen certain information system controls.

While Maximus communicated accurate enrollment-related information to Medicaid and CHIP members, it should improve its processes related to communicating enrollment deadlines and monitoring its print vendor, CSG. Maximus should also strengthen certain controls to help protect its data from unauthorized changes.

Maximus should:

- Work with HHSC to update its process for initiating its default algorithm to ensure that it meets applicable requirements, including Texas Administrative Code and the procedures it has submitted to HHSC.

Audit Performance



Audits Issued 3

Maximus, Inc., Member Communications: Texas Medicaid and CHIP Enrollment Broker

Oversight of the HHSC Home and Community Based Services (HCS) Program

Summary of Results: Audits of Medicaid and CHIP MCO Special Investigative Units

Audits in Progress 17

Selected DSHS Contracts

Selected Women's Protective Services Grantees

Selected Health, Developmental, and Independence Services Contract

Selected Pharmacy Benefits Managers

Selected Foster Care Providers

Durable Medical Equipment Providers Oversight

MCO Financial Reporting

MCO IT Security Controls and Business Continuity and Disaster Recovery Processes

Selected Telemedicine Providers

MCO Special Investigative Units

Selected Pharmacy Providers

- Continue to strengthen its process for resolving denied transactions.
- Work with HHSC to review prior TIERS-denied transactions that were not captured in its review process to ensure that they were appropriately resolved.
- Implement a process to ensure that its enrollment packets provide accurate response deadlines.
- Implement a process to verify the accuracy of mail date information provided by its subcontractors.
- Strengthen its controls to help protect its data from unauthorized changes.

Oversight of the HHSC Home and Community Based Services (HCS) Program

The OIG conducted an audit of the HHSC Home and Community Based Services (HCS) program oversight by the HHS Regulatory Services Division and HHS Medicaid and CHIP Services (MCS) Contract Administration and Provider Monitoring (CAPM). The HCS program enables Medicaid beneficiaries with intellectual and developmental disabilities to live in community-based settings and avoid institutionalization in intermediate care facilities. These community-based settings include homes managed by private HCS program providers. HHSC contracts with private HCS program providers to coordinate and monitor the delivery of individualized services and supports to Medicaid beneficiaries. The HCS program is available to Texans of any age not living in an institutional setting who meet HHSC's eligibility criteria.

During state fiscal year 2021, OIG Audit conducted audits of three HCS providers. Through unannounced site visits to 25 three- and four- person residential homes, these audits identified inconsistent compliance with HHSC's health and safety requirements, which indicated risks to Medicaid beneficiaries. OIG Audit conducted this audit of the oversight of HCS program providers to assess whether the residential review process effectively (a) identified and communicated conditions and needs for correction and (b) followed up with providers to ensure corrections were made.

Texas HHS Long Term Care Regulation (LTCR), part of the HHS Regulatory Services Division, (a) accurately recorded the certification and review status of three- and four- person residential homes (homes) and (b) initiated a pilot program within its quality assurance review process to improve the quality and consistency of residential reviews. However, LTCR did not consistently (a) conduct residential reviews timely, (b) calculate residential review scores correctly, (c) communicate results to HCS program providers, (d) document follow up, or (e) ensure corrective action was taken to resolve identified issues.

In addition, CAPM should update its contracts with HCS program providers to ensure those contracts reflect current terms, conditions, and contractual remedies available to enforce compliance. The OIG offered recommendations to LTCR, Regulatory Enforcement, and CAPM, which, if implemented will help ensure the health and safety of Medicaid beneficiaries and compliance with requirements.

Summary of Results: Audits of Medicaid and CHIP MCO Special Investigative Units

This report summarizes the results and conclusions of five audits performed in accordance with generally accepted government auditing standards. The five audited managed care organizations (MCOs) served 16 percent of all Texas Medicaid and CHIP members in 2021. While this summary report is not an audit report, it does provide current information about the numbers of members served, capitation payments, and special investigative unit (SIU) reporting to the OIG.

The audits were of SIU activities at five Texas Medicaid and Children's Health Insurance Program (CHIP) MCOs:

- Driscoll Health Plan, report issued April 3, 2018
- Blue Cross and Blue Shield of Texas, report issued September 28, 2018

- Molina Healthcare of Texas, Inc., report issued May 22, 2020
- Aetna Better Health of Texas, Inc., report issued August 18, 2021
- Community First Health Plans, Inc., report issued April 28, 2022

HHSC requires MCOs to establish and maintain an SIU to investigate potential fraud, waste, or abuse by Texas Medicaid and CHIP members and health care service providers. Fraud, waste, and abuse monitoring and prevention activities MCOs must conduct include:

- Maintaining an SIU
- Analyzing claims
- Hotlines
- Training

The five audited MCOs met requirements for (a) conducting recipient verifications and monitoring provider and member service patterns; (b) having specific SIU policies and procedures in place; (c) submitting fraud, waste, and abuse plans to the OIG; (d) conducting fraud, waste, and abuse training; and (e) maintaining a fraud, waste, and abuse hotline. Four of the five MCOs had dedicated SIU staff to handle Texas volume. Four of the five MCOs also accurately reported recoveries, although some MCOs did not always complete investigative activities within required time frames. However, most MCOs had findings related to reporting SIU activities to the OIG or referrals to the OIG; most MCOs had issues with some aspect of investigation timelines; and some MCOs did not adequately perform all required investigation elements. All the MCOs implemented corrective action plans to address the OIG's recommendations. The OIG intends to audit the SIU functions of all MCOs. Since the audits are conducted over a period of several years, the OIG periodically produces summary reports to provide stakeholders with an overview of performance.

Completed reports - Inspections

Clinical Laboratory Improvements Amendments Certification: 16 Managed Care Organizations

The OIG conducted inspections of all 16 managed care organizations' (MCOs') processes for ensuring laboratory service providers have the appropriate Clinical Laboratory Improvement Amendments (CLIA) certification prior to paying submitted claims. Laboratories must apply for a CLIA certificate and identify their specialty and sub-specialty areas through the U.S. Centers for Medicare and Medicaid Services. These specialty and sub-specialty certification codes, in turn, correspond to specific procedure codes that the laboratory has been certified to perform. Certificates are valid for two years. Some inspected MCOs had processes for obtaining a provider's CLIA certificate at the time of credentialing and recredentialing in the MCO's provider networks. However, the MCOs did not have consistent processes for (a) obtaining and maintaining current provider CLIA certificates, (b) denying claims from laboratories

Inspections Issued	8
Nursing Facility Emergency Preparedness: Villa Toscana at Cypress Woods	
Nursing Facility Emergency Preparedness: Oak Park Nursing & Rehabilitation Center	
Nursing Facility Emergency Preparedness: Focused Care at Westwood	
Nursing Facility Emergency Preparedness: Alamo Heights Health and Rehabilitation Center	
Nursing Facility Emergency Preparedness: Arden Place of Houston	
Nursing Facility Staffing Hours Verification: Liberty Health Care Center	
Nursing Facility Emergency Preparedness: Southeast Nursing & Rehabilitation Center	
Nursing Facility Emergency Preparedness: Paradigm at Woodwind Lakes	

with expired CLIA certificates, or (c) denying claims from providers that billed for procedures not covered by their CLIA certificate. The MCOs should:

- Ensure they obtain and maintain the current CLIA certificate for each laboratory in its provider network billing CLIA procedure codes.

Inspections in Progress 2

Durable Medical Equipment Wound Care Supplies Billing

Emergency Ambulance Claims Oversight

- Use the information provided by HHSC to develop processes to ensure the lab certification codes listed on providers' CLIA certificates correspond to procedure codes in their claims payer system.
- Ensure their claims payer system denies claims for procedure codes that do not correspond to the laboratory certificate codes listed on a provider's CLIA certificate.

Summary of nursing facility emergency preparedness inspections

The OIG completed seven inspections this quarter on nursing facility emergency preparedness. In 2020, the U.S. Department of Health and Human Services Office of Inspector General conducted a review of selected nursing facilities in Texas to evaluate compliance with life safety and emergency preparedness requirements. The report identified noncompliance with emergency preparedness requirements related to emergency preparedness plans, emergency supplies, emergency power, communication plans, and emergency preparedness plan training. The OIG initiated these inspections because of potential health and safety concerns caused by inadequate emergency preparedness programs at nursing facilities.

The objective of the inspections was to determine whether the skilled nursing facilities followed select state and federal requirements for emergency preparedness. The scope of the inspections included the nursing facilities' (a) documentation of calendar year 2021 emergency preparedness training and testing and (b) emergency preparedness program in place as of May 2022. Key results for each inspection follow.

Alamo Heights Health and Rehabilitation Center

Alamo Heights Health and Rehabilitation Center's (Alamo Heights) emergency preparedness plans and processes complied with 22 of 23 (95.7 percent) state and federal emergency preparedness requirements for nursing facilities reviewed as part of this inspection. Alamo Heights had an updated emergency preparedness (a) plan, (b) communication plan, and (c) training and testing program. Alamo Heights also had updated procedures related to alternative power sources and subsistence needs for residents and staff. During a site visit to Alamo Heights' facility, inspectors saw multiple emergency preparedness elements, including a generator used as an alternate energy source and supplies for resident and staff subsistence. However, Alamo Heights did not maintain a printed copy of its current emergency preparedness plan at each workstation assigned to a personnel supervisor who had responsibilities under the plan.

Arden Place of Houston

Arden Place of Houston's (Arden Place) emergency preparedness plans and processes complied with 20 of 23 (87 percent) state and federal emergency preparedness requirements for nursing facilities reviewed as part of this inspection. Arden Place had an updated emergency preparedness (a) plan and (b) training and testing program. Arden Place also had updated procedures related to alternative power sources and subsistence needs for residents and staff. During a site visit to Arden Place's facility, inspectors saw multiple emergency preparedness elements, including a generator used as an alternate energy source and supplies for resident and staff subsistence. However, Arden Place did not:

- Document a risk assessment.

- Document exercises or drills to test the emergency preparedness plan.
- Document required contact information for the Texas Health and Human Services (HHS) Office of the Long-Term Care Ombudsman in its communication plan.

Focused Care at Westwood

Focused Care at Westwood's (Focused Care) emergency preparedness plans and processes complied with 22 of 23 (95.7 percent) state and federal emergency preparedness requirements for nursing facilities reviewed as part of this inspection. Focused Care had an updated emergency preparedness (a) plan and (b) training and testing program. Focused Care also had updated procedures related to alternative power sources and subsistence needs for residents and staff. During a site visit to Focused Care's facility, inspectors saw multiple emergency preparedness elements, including a generator used as an alternate energy source and supplies for resident and staff subsistence. However, Focused Care did not document required contact information in its communication plan for (a) the state licensing and certification agency, Texas HHS, and (b) the Texas HHS Office of the Long-Term Care Ombudsman.

Oak Park Nursing & Rehabilitation Center

Oak Park Nursing & Rehabilitation Center (Oak Park) had an updated emergency preparedness (a) plan, (b) communication plan, and (c) training and testing program. Oak Park also had updated procedures related to alternative power sources, subsistence needs for residents and staff, and documentation for past trainings and tests. Additionally, during the OIG's on-site visit to Oak Park's facility, inspectors saw multiple emergency preparedness elements, including a generator used as an alternate energy source and supplies for resident and staff subsistence. Oak Park's emergency preparedness plans and processes complied with the state and federal emergency preparedness requirements for nursing facilities reviewed as part of this inspection. The OIG did not identify any issues or opportunities for improvement.

Paradigm at Woodwind Lakes

Paradigm at Woodwind Lakes' (Paradigm) emergency preparedness plans and processes complied with 20 of 23 (87 percent) state and federal emergency preparedness requirements for nursing facilities reviewed as part of this inspection. Paradigm had an updated emergency preparedness plan and a communication plan. Paradigm also had updated procedures related to alternative power sources and subsistence needs for residents and staff. During a site visit to Paradigm's facility, inspectors saw multiple emergency preparedness elements, including a generator used as an alternate energy source and supplies for resident and staff subsistence. However, Paradigm did not:

- Document initial employee training on emergency preparedness.
- Document all exercises or drills to test the emergency preparedness plan.
- Confirm review and update of the emergency preparedness training and testing program.

Southeast Nursing & Rehabilitation Center

Southeast Nursing & Rehabilitation Center's (Southeast Nursing) emergency preparedness plans and processes complied with 19 of 23 (82.6 percent) state and federal emergency preparedness requirements for nursing facilities reviewed as part of this inspection. Southeast Nursing had an updated emergency preparedness (a) plan and (b) training and testing program. Southeast Nursing also had updated procedures related to alternative power sources and subsistence needs for residents and staff. During a site visit to Southeast Nursing's facility, inspectors saw multiple emergency preparedness elements, including a generator used as an alternate energy source and supplies for resident and staff subsistence. However, Southeast Nursing did not:

- Document initial employee training on emergency preparedness.
- Document required annual staff training on emergency preparedness.
- Maintain a printed copy of its current emergency preparedness plan at each workstation assigned to a personnel supervisor who had responsibilities under the plan.
- Document the required contact information for the Texas HHS Office of the Long-Term Care Ombudsman in its communication plan.

Villa Toscana at Cypress Woods

Villa Toscana had both printed and online versions of an updated emergency preparedness (a) plan, (b) communication plan, and (c) training and testing program. The availability of emergency preparedness documents in both printed and online forms should improve access to the information in an emergency and offers an electronic platform for reviewing and updating all elements within the plan. Villa Toscana also had updated procedures related to alternative power sources; subsistence needs for residents and staff; and documentation for past trainings and tests. Additionally, during the OIG's on-site visit to Villa Toscana's facility, inspectors saw multiple emergency preparedness elements, including a generator used as an alternate energy source and supplies for resident and staff subsistence. Villa Toscana's emergency preparedness plans and processes complied with the state and federal emergency preparedness requirements for nursing facilities reviewed as part of this inspection. The OIG did not identify any issues or opportunities for improvement.

Nursing Facility Staffing Hours Verification: Liberty Health Care Center

The OIG conducted an inspection of Liberty Health Care Center (Liberty Health), a skilled nursing facility. The OIG initiated this inspection because of potential health and safety concerns caused by staffing shortages at nursing facilities. The inspection objective was to determine whether the direct care licensed nursing hours recorded at Liberty Health supported the hours reported to the U.S. Centers for Medicare and Medicaid Services (CMS) in compliance with federal requirements. The inspection scope covered the period from January 1, 2021, through June 30, 2021.

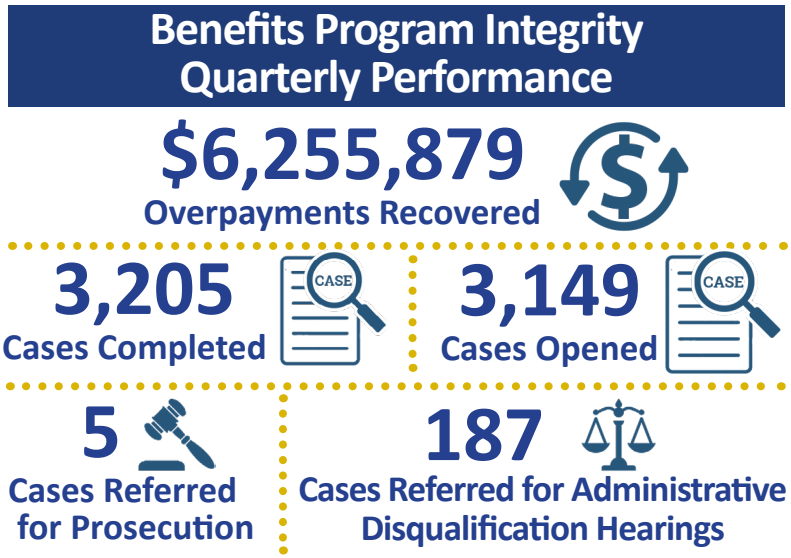
Liberty Health accurately reported direct care licensed nursing hours worked to CMS for 298 (61.8 percent) of the 482 payroll records reviewed as part of this inspection. However, Liberty Health (a) overreported some direct care licensed nursing hours worked due to not accounting for all required meal break deductions and (b) did not have processes to consistently report correct direct care licensed nursing hours worked by contract staff to CMS.

The OIG offered recommendations to Liberty, which, if implemented, will help ensure that Liberty reports accurate and complete direct care licensed nursing hours to CMS.

IV. Client Accountability

Trends

The Benefits Program Integrity (BPI) division completed 3,205 investigations involving benefit recipient overpayments or fraud allegations. Concerns involving a clients household composition made up 75 percent of all completed BPI investigations, with an additional 16 percent involving unreported income. Household composition cases usually involve an unreported household member who has reportable income or a reported household member who does not actually live in the same residence. Both instances cause the household to receive more benefits than they are eligible for. For this quarter, BPI referred 5 investigations for prosecution and 187 investigations for administrative disqualification hearing.



Case highlights

Dallas SNAP client pleads guilty to fraud

In September, a Dallas woman pleaded guilty in Texas District Court on charges of illegal possession of Supplemental Nutritional Assistance Program (SNAP) benefits. The charges stemmed from an investigation by the OIG.

The 1996 Federal Welfare Reform Act requires states to permanently disqualify individuals from the SNAP program if they have a felony drug conviction for conduct occurring after August 22, 1996. Applicants must provide truthful information to the state and notify the State of any past felony drug convictions during the application process.

The individual in question applied for SNAP benefits on January 31, 2011, and claimed under penalty of perjury that she had no such felony drug convictions. However, OIG investigators uncovered evidence that she was convicted of Unlawful Possession of a Controlled Substance, a state jail felony, on April 15, 2004.

The investigation showed that from January 2011 through November 2012, the defendant failed to disclose the conviction on five separate applications for SNAP benefits, receiving $9,252 in excess benefits. As a result, she was sentenced to three days in county jail and permanently disqualified from the SNAP program.

Olney woman convicted for SNAP fraud

A woman in Olney was found guilty in an administrative hearing of committing an Intentional Program Violation. The verdict is the result of an investigation by the OIG.

The individual applied to receive SNAP benefits on October 20, 2017. Because eligibility is tied to household resources, applicants must provide truthful information to the state and notify the state if their household's composition or income changes.

In her application, the defendant claimed under penalty of perjury that the household consisted of only herself and two children. However, OIG investigators uncovered evidence that the children's father was, in fact, living in the home and receiving income from a full-time job.

The investigation revealed that over more than four years, the perpetrator received $21,148 in excess benefits because of the fraudulent, unreported information. As a result, she was disqualified from the SNAP program for 12 months and ordered to pay full restitution.

Hidalgo County SNAP and Medicaid client pleads guilty to theft

A Hidalgo County resident pleaded guilty to felony theft after an investigation by the OIG.

The individual applied to receive SNAP benefits on August 19, 2015. In her application, the defendant claimed that the household's income was from her employment. However, OIG investigators found that the defendant had consistent U.S. currency deposits into her and her husband's joint bank account that she did not report during the application process. Had she truthfully disclosed the household income, her benefits would have been drastically reduced since household resources determine eligibility.

The defendant continued to falsely report the household income for almost four years, from August 2015 through May 2019. In total, the defendant obtained $20,397 in SNAP benefits and $11,514 in Medicaid benefits she was not entitled to receive.

In September 2022, she was sentenced to 10 years of probation and ordered to pay $31,911 in restitution to Texas Health and Human Services.

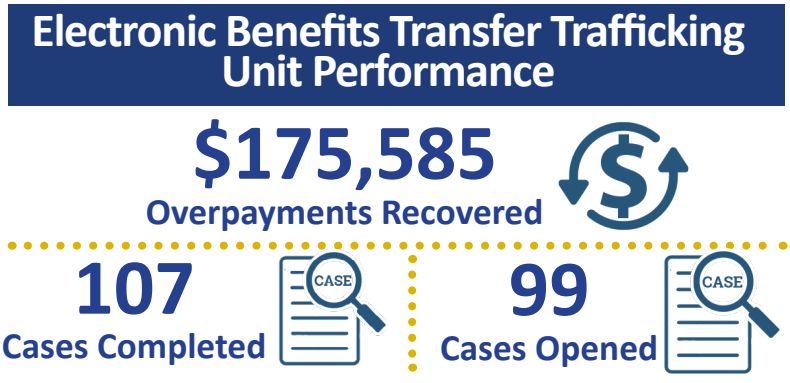
Agency highlights

In September, BPI completed the SNAP Fraud Framework grant project by creating a risk model that will help identify fraud, waste and abuse in benefit programs by using data analytics. BPI was able to use the federal grant process through the United States Department of Agriculture (USDA) Food and Nutrition Services (FNS) to obtain funding to develop the data analytics risk model. The risk model was piloted for the first time during this quarter and has already produced five investigations that are currently assigned to field investigators as potential fraud.

V. Retailer Monitoring

Trends

Electronic Benefits Transfer (EBT) Trafficking Unit continues to receive referrals regarding the cloning and skimming of EBT client card and personal data from the point of sales devices in retail stores. This scheme involves suspects altering the point-of-sales unit with another device that is designed to capture a client's information. Once the information is captured, it is forwarded to an unknown location and a counterfeit card is created. That card is then used



in other cities to deplete the account's benefit balance without the client's knowledge. OIG investigators are working closely with state and federal partners, including the FBI and USDA-OIG, to address this issue.

The Women, Infants and Children (WIC) Vendor Monitoring Unit (VMU) conducted 90 compliance buys across the state this quarter. A compliance buy is a covert in-store inspection in which an OIG inspector poses as a WIC client and uses a WIC Electronic Benefits Transfer (EBT) food card to make purchases to determine whether vendors are following WIC rules. Violations were cited during 15 of the 90 store visits.

The team also completed 22 inventory reviews across the state. An inventory review is a comparison of a vendor's paid claims and purchase invoices for WIC food items. The purpose of the inventory review is to determine if the vendor had a sufficient inventory of WIC food items to justify their submitted claims. Inventory reviews conducted this quarter resulted in complete compliance for all vendors.

WIC VMU also conducted 100 on-site store inspections. Fifty-seven violations were cited. The inspection is an overt in-store assessment where the OIG works with the respective WIC vendor to identify any deficiencies with the sale of authorized WIC products.

Case highlights

Texas store and SNAP client investigated for benefits trafficking

The OIG's EBT Trafficking Unit initiated an investigation of a retailer after a transaction review indicated high-dollar purchases. During the course of the investigation, they also uncovered evidence that the SNAP recipient allowed another individual, who is a United States citizen residing in Mexico, to use their address to fraudulently apply for and receive $27,600 in SNAP benefits. The client agreed to an administrative settlement for the entire amount.

SNAP trafficking case pending trial

The EBT Trafficking Unit investigated an allegation that a restaurant owner purchased SNAP benefits from several recipients. The owner is alleged to have used the benefits to purchase restaurant inventory from a large discount retailer. from August 2018 through November 2021 Investigators obtained sufficient evidence to support the allegation, and the case was referred to the district attorney. A grand jury indicted the restaurant owner on September 30, 2022, and an arrest warrant was issued. The case is pending trial.

High-risk Dallas vendor cited for WIC violations

A Dallas store, identified as a high-risk vendor, by the Texas WIC program was the subject of a recent compliance buy inspection by WIC VMU. During three separate visits to the store, the WIC inspector noted an ongoing pattern of violations for failing to display the prices of all WIC approved products. As a result of the store's non-compliance, a $320 civil monetary penalty was assessed and recovered.

VI. HHS Oversight

Trends

Internal Affairs (IA) worked 76 active investigations and closed 44 investigations in the first quarter of FY 2023. IA processed 125 referrals this quarter and investigated 38 of those referrals. The remaining were forwarded to the appropriate business areas, including the Office of the Independent Ombudsman for State Supported Living Centers (SSLC); Department of Family and Protective Services (DFPS), Office of Internal Affairs; and HHS Complaint and Incident Intake.

Approximately 50 percent of Internal Affairs' open cases continue to involve Child Protective Services (CPS) client/supervisor allegations of DFPS employees falsifying documents.

IA processed 125 referrals in the first quarter of FY 2023 and worked to diligently review and process them in a timely manner. In October, Internal Affairs saw their highest number of referrals processed in a one-month period, higher than any other month during the past three years. With a resulting increase in investigator caseloads, IA closed 21 cases in October, more than in any other month during the past three years.

Internal Affairs Performance

44 Cases Completed

76 Cases Opened

Open Internal Affairs Cases by Type

Falsifying Documents	30%
Unprofessional Conduct	20%
Tampering with Governmental Record	15%
IA Law Enforcement Assist	15%
Privacy Breach	5%
Contract Fraud	5%
Moonlighting	2%
Theft	2%
Workplace Harassment	2%
Conflict of Interest	2%
Misapplication of Fiduciary Responsibility	2%

State Centers Investigations Teams Performance

216 Cases Completed

292 Cases Opened

Many referrals to IA through the OIG online fraud reporting system are from sources other than HHS or other state agencies.

During the first quarter, the OIG's State Center Investigations Team (SCIT) opened 292 investigations and completed 216 investigations, with an average completion time of 23 days. This compares to 139 opened investigations and 135 completed investigations in the first quarter of fiscal year 2022.

Case highlights

Client injured at state facility

A recent case referred to SCIT alleged physical abuse of a client at a state supported living center in South Central Texas. Interviews conducted by the team and video evidence gathered during the investigation confirmed the allegation. The case was subsequently referred to the county district attorney for criminal prosecution.

Client injured at Mexia facility

An employee at the Mexia State Supported Living Center was accused of striking a resident at the facility. After a thorough investigation by SCIT, the case was referred to the Limestone County district attorney for prosecution. Ultimately, the former employee pleaded guilty to injury to a disabled individual, and the OIG received notice of the outcome in the first quarter of fiscal year 2023. As part of the plea agreement, the individual received five years of community supervision and was ordered to pay court costs and fines.

Agency highlights

OIG improves Third Party recovery processes

In addition to a state Third Party Liability (TPL) file provided to managed care organizations daily, MCOs provide other insurance information to the state through a referral process when it is determined that clients maintain other insurance. Previously, this referral process included monthly medical benefit information. To improve benefits coordination and third-party recoveries for the state and MCOs, the OIG implemented an additional weekly referral file for the MCOs to provide pharmacy and medical other insurance information.

Additionally, a new file was developed to provide responses to the MCOs for MCO-submitted medical and pharmacy referrals. The response file includes the disposition/outcome for each medical and pharmacy other insurance referral submitted by the MCO for reconciliation purposes, which will help the MCOs improve submission of other insurance data.

The Texas Medicaid and Healthcare Partnership (TMHP) worked with each MCO during September 2022 to test and implement the new pharmacy referral and response files.

Policy recommendations

The OIG provides program integrity feedback on policy changes

House Bill 4 (87th Legislative Session, 2021) requires HHS to allow more services to be delivered using telemedicine, telehealth and audio-only methods on a permanent basis after the public health emergency ends, if clinically appropriate and cost-effective. As part of their policy development to implement the bill, HHS requested program integrity feedback from the OIG on allowing audio-only (e.g., telephonic) delivery of certain physician services beyond the COVID-19 public health emergency. The OIG noted that adding these services as a permanent Medicaid benefit without further refining service code usage parameters would present some program integrity vulnerabilities.

Differential pay policy

Following an Internal Affairs investigation of staff who allegedly received differential pay (i.e., an increase in salary when an employee works an evening, night or weekend shift), Internal Affairs recommended that HHS HR Policy E3-Employee Compensation-Shift Differentials be revised to clarify the requirements for an employee to receive a shift salary differential (e.g., whether employees must actually work an entire off shift to qualify for a shift salary differential), and that certain management staff receive training on the policy. During Q1 FY 2023, OIG staff submitted a summary of the issues and recommendations Internal Affairs staff identified to the HHSC Human Resources and Chief Counsel divisions.

Rules

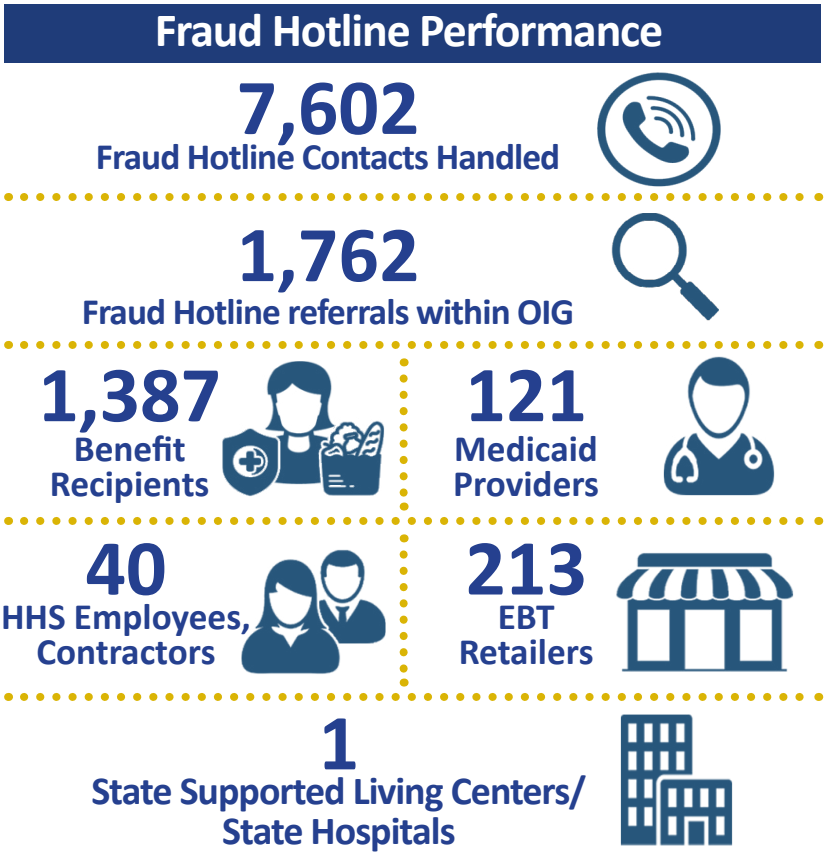
Nursing Facility Utilization Review Rules

The proposed repeal of existing rules and new rules for 1 TAC §371 related to Nursing Facility Utilization Reviews (NFUR) were published in the Texas Register in October. The proposed rules update and re-organize NFUR procedures and provider requirements, delete redundant language, provide procedures for desk reviews, and allow for a new federal case mix classification system that will eventually replace the current resource utilization group basis for nursing facility payments. The proposed NFUR rules were on the agenda for the HHSC Executive Council meeting held in November. No public comments were received at that time, but comments from one association were received prior to the closing of the formal public comment period. OIG will review these comments and provide rule revisions/responses as appropriate.

VII. Stakeholder Engagement

Texas Fraud Prevention Partnership update

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



In September, the OIG held a TFPP MCO Leadership meeting that included OIG and MCO leadership. These meetings offer the opportunity to discuss current initiatives and prevention efforts. The meeting included discussion of fraud, waste and abuse trends; the OIG's hospital emergency department data initiative; and updates on OIG audits and surveillance utilization reviews. The next TFPP MCO Leadership meeting is scheduled for January 2023.

A TFPP Special Investigative Unit (SIU) meeting held in October included SIU staff from MCOs and dental maintenance organizations, along with the Texas Office of Attorney General Medicaid Fraud Control Unit. The OIG's SIU coordinator trained MCOs on best practices for referring provider investigations, and United Healthcare presented a case study on a psychiatrist billing for services not rendered.

The OIG held TFPP Special Investigative Unit one-on-one meetings with Amerigroup, Community Health Choice, United Healthcare, DentaQuest, MCNA, and United Dental to discuss their pending investigations, referrals and current fraud, waste and abuse schemes. The Attorney General Medicaid Fraud Control Unit staff also participated.

Planned improvements for OIG's public fraud reporting form

The OIG is working on a project to update the fraud reporting form on the OIG website. The planned updates will improve the ease of reporting and the quality of fraud, waste and abuse reports received from the public. Additionally, these changes will enable investigators to conduct preliminary investigations more quickly. To support this project, the OIG is seeking funding for the improvements through a legislative appropriations request.

Training Summary

50
Trainings Conducted This Quarter

External Relations Performance

75
Communication Products

65,060
Website Page Views

Educating providers on fraud prevention

OIG Chief Dental Officer Janice Reardon, DDS collaborated with the communications team to produce an article for the Texas Dental Association's TDA Today. The article focused on requirements for an informed consent for treatment signed by the patient or guardian. Checking for signed informed consent is part of a provider record review performed by the OIG. The record review is one way the OIG detects fraud, waste and abuse in Medicaid-supported dental services and ensures providers are upholding the Texas State Board of Dental Examiner's standard of care.

An article produced for the Texas Association of Home Care and Hospice detailed the OIG's investigation of UA modifiers in private duty nursing. Claims data analysis revealed providers billing for services to patients with a tracheostomy or dependent on a ventilator when the patient's medical condition or diagnosis did not meet the level of care to substantiate the additional amount billed. OIG Litigation continues to educate providers and their compliance departments about the issue.

Also in the first quarter, the communications team produced an article for the Texas Medical Association about the OIG Fraud Hotline. Readers learned what kind of behavior to report to the OIG and what to expect when making a call.

Conferences, Presentations and Trainings

- Inspector General Kauffman gave the keynote address at the Texas Tech University Health Sciences Center Compliance Symposium in September. She spoke about the OIG's focus on data analytics to identify fraud, waste and abuse in health care delivery. She also toured the medical school and spoke with physicians, professors and administrators about the challenges facing providers in rural Texas. OIG Chief Medical Officer Dr. Ted Spears also gave a presentation about the state of telemedicine.

- In September, BPI staff attended the United Council on Welfare Fraud Conference in West Virginia. Welfare fraud investigators came together from across the nation to attend trainings, conduct case studies, analyze trends and discuss how to combat welfare fraud going forward. Both state and federal partners attended the conference to learn and provide guidance. Federal partners in attendance included USDA FNS, USDA OIG and US Health and Human Services Center for Medicaid Services.

- The OIG Forensics, Research and Analysis Team's team lead completed the GIAC Certified Forensic Examiner (GCFE) course. The GCFE validates a practitioner's knowledge of computer forensic analysis, with an emphasis

on core skills required to collect and analyze data from Windows computer systems. Digital forensics analysis is of paramount importance in today's computer-centric world. The GCFE provides a way for professionals to demonstrate that they have the necessary skills, knowledge and ability to conduct typical incident investigations, including e-discovery, forensics analysis and reporting, evidence acquisition, web browser forensics, and tracing application and user activities on computer systems.

- OIG Program Support and Training is strengthening employee training academies developed by the Provider Field Investigations (PFI), Benefits Program Integrity (BPI) and Audit divisions. These academies build on the OIG University plan of strong, structured skills training during an employee's first year, then more in-depth skills development through cross-training in subsequent years. Priority is given to helping staff develop quick proficiency in fraud, waste and abuse prevention, detection, investigation and auditing through access to experienced staff leading the training, practical on-the-job experience, systems understanding and strong mentorship and guidance. Topics include case tracking, specific investigation case studies, evidence gathering, administrative disqualification hearings, and audit report writing.

- OIG University focuses on broadening leadership skills. In October, Program Support and Training delivered Covey: Speed of Trust workshops focused on strengthening team cohesion, improving communication across levels, and the root causes of mistrust. These have a direct impact on a unit's ability to work effectively in their FWA efforts, employee engagement and retention, and conflict resolution. When leaders create a high-trust team, they can provide staff with more focused feedback and direction, concentrate on skill-building and cross-training, and be more effective in strategic planning. Each of these positively impacts productivity in investigations, audits, inspections and reviews.

- The OIG recently collaborated with HHS IT through a shadowing initiative that enabled HHS IT to learn more about the day-to-day operations of OIG program areas. HHS IT was also able to observe how technology is leveraged to support the identification of fraud, waste and abuse and obtain OIG staff feedback to inform future strategic planning initiatives. The initiative has resulted in beneficial feedback and valuable solutions for OIG program areas to enhance the automation of tasks.

- The OIG continues to deploy FWA prevention strategies through public outreach, education and training. In October 2022, OIG staff presented a training to Texas Health Steps staff and providers. The presentation included information about the OIG's mission and vision, an overview of provider responsibilities and the latest trends in waste and wrongdoing.

- In October, the State Centers Investigative Team (SCIT) conducted its bi-annual peace officer training. The training consisted of courtroom testimony, safety driving, firearms training and tactics.

- OIG staff attended the National Health Care Anti-Fraud Association Annual Training Conference in November. The gathering of investigators, analysts and law enforcement spotlighted trends and emerging schemes in health care fraud.

VIII. OIG in Focus

Upholding patient care, preventing fraud in nursing homes

The goal of the OIG's work in nursing facilities is to support patient care and ensure the proper spend of Medicaid dollars. Medicaid covers 62 percent of nursing home residents, each requiring regular nursing care that can include medical and psychological services. The OIG's oversight is carried out each year through hundreds of inspections, audits, investigations and reviews.

Ensuring patient safety

OIG inspections focus on systemic issues and risk assessment and help detect fraud, waste and abuse. The OIG completed eight inspections in the first quarter of FY 2023 to improve the safety of residents in Texas skilled nursing facilities.

Seven published inspection reports examined whether the selected skilled nursing facilities followed specific state and federal requirements for emergency preparedness. The scope of the inspections included the facilities' a) documentation of emergency preparedness training and testing and b) the plans they had in place.

The inspections identified noncompliance related to emergency preparedness plans and training, emergency supplies and power, and communication plans. The OIG made recommendations to the facilities with compliance issues. Key results for each inspection can be found in the HHS Oversight section of this report.

An additional inspection in the first quarter was dedicated to potential staffing issues at a selected nursing facility. Four other inspections in 2022 also examined whether the direct care licensed nursing hours recorded at selected skilled nursing facilities supported the hours reported to CMS. The inspections determined the accuracy of the hours reported at the five facilities ranged from 77 to 100 percent. The inspections also noted instances of facilities a) overreporting some hours worked due to not accounting for meal breaks and b) not having processes to consistently report correct nursing hours worked by contract staff. The OIG made recommendations to ensure accurate reporting

OIG inspection topics for FY 2023 include nursing facility procedures to transfer patients to emergency rooms and well as facility controls to report abuse, neglect and exploitation.

Audits

Recent OIG audits assessed risks related to assisted living facilities advertising as providing memory care services without disclosing certification status for serving residents with Alzheimer's disease. The audits also examined whether facilities conducted required background checks prior to employment, completed resident assessment and service plan documentation, and provided the required number and type of resident activities. The audits discovered opportunities and made recommendations to various facilities to improve processes related to (a) annual employability checks of facility employees via the Employee Misconduct Registry, (b) ensure staff-to-resident ratios comply with requirements, and (c) provide prospective residents and their guardians with written notice disclosing whether the facility is certified to provide specialized care for residents with Alzheimer's disease and related disorders.

Nursing Facility Utilization Review

In addition to patient safety, OIG oversight of nursing facilities ensures the proper spend of taxpayer resources. The OIG's nursing facility utilization (NFUR) team completed claim and medical record reviews at 388 nursing facilities in FY 2022. NFUR's nursing and coder staff review records and services for Medicaid recipients in nursing facilities, comparing billed services to those documented as delivered. Nurse reviewers use the clinical record to evaluate the quality of care, medical necessity and efficiency of health care provided to residents.

Nurse reviewers discovered a trend involving long-term care facilities administering medically unnecessary vitamin

infusions. The patient care issues seen by the OIG included:

- Administering the infusion too quickly, which could cause adverse effects on the client.
- Administering the infusion when the medical record indicated the client should not receive the infusion due to a medical condition or other medications.
- Lack of medical records indicating the medical need for the vitamin infusion.
- Incomplete medical record documentation (i.e., no detailed orders, progress notes, supporting labs or appropriate diagnosis).
- Orders for the infusions made by a physician who had not seen the client.

Medicaid Recoveries for Nursing Homes in Fiscal Year 2022

$1,031,093
Overpayments Recovered

$6,040,293
Overpayments Identified For Future Recovery

In the first quarter, the OIG reached settlements with two nursing and rehabilitation facilities over their billing for third-party providers of vitamin and hydration injections. Both cases were highlighted under the Provider Integrity case examples. Because of the ongoing trend, the OIG published an issue brief to educate facilities about the billing and patient health problems surrounding vitamin infusions and the OIG's resulting investigation.

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: hhsc-office-of-inspector-general

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