OFFICE OF INSPECTOR GENERAL
HEALTH AND HUMAN SERVICES
TEXAS

QUARTERLY REPORT








Quarter 1, Fiscal Year 2024

OIG
2004 - 2024
20 YEARS

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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 (FY) 2024, summarizing the excellent work the office performed during this period.

From September 1, 2023, to November 30, 2023, the Texas Health and Human Services Office of Inspector General (OIG) recovered more than $101.5 million. In addition, we identified more than $238.5 million in potential future recoveries and achieved more than $55.6 million in cost avoidance.

I am deeply honored that Governor Abbott entrusted me with the responsibility of being Inspector General for Texas Health and Human Services. I feel privileged to take on this role alongside the conscientious public servants at the OIG as we continue our vital work for the people of Texas. As we look to the future, our priority will be the mission first, and our people always.

That mission — fighting fraud, waste and abuse in Texas health and human services — has never been more important than it is today. The National Health Care Anti-Fraud Association estimates that anywhere from 3 to 10% of total health care expenditures are lost to fraud every year. In Texas, which spends approximately $46 billion annually on health and human services, that means as much as $4.6 billion are siphoned away from their intended purpose each year.

Combating this trend will require perseverance and innovation, but I am confident our team is up to the task, as they have demonstrated continually over the agency's history. In fact, 2024 will mark the 20th anniversary of the OIG, which was established by the 78th Texas Legislature in 2003 and began operations in 2004.

As we approach this milestone, I would like to thank all those who helped shape the OIG into what it is today. Your hard work and dedication have been instrumental to our past success and set the stage for our future accomplishment. I look forward to honoring this past as we take on new challenges in safeguarding Texas tax dollars and HHS programs for the next 20 years.

Raymond Charles Winter
Inspector General

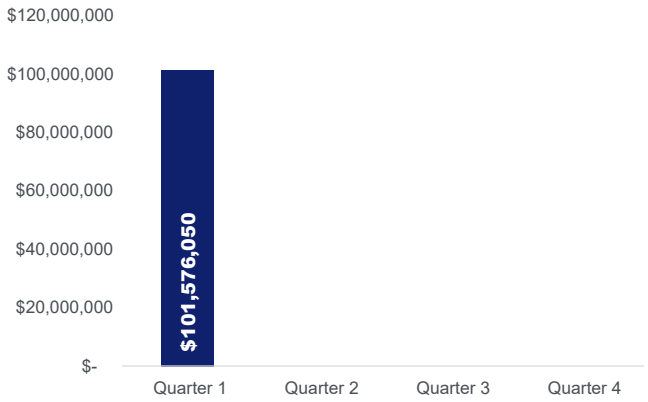
QUARTERLY METRICS

DOLLARS RECOVERED

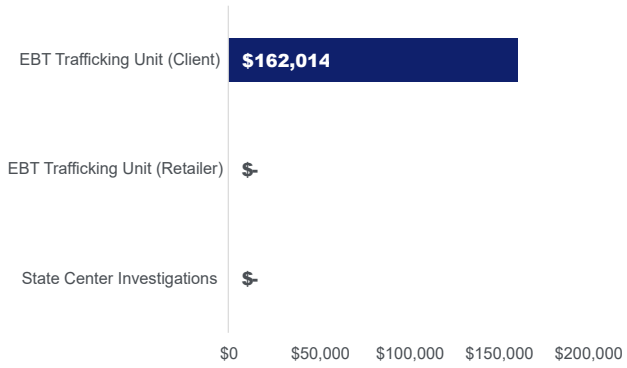
Dollars recovered are overpayments collected based on the results of an investigation, audit, inspection or review.

TOTAL DOLLARS RECOVERED	$101,576,050
PROVIDERS AND MANAGED CARE ORGANIZATIONS	**$95,258,759**
Audit and inspection overpayments	$90,677
OIG and MCO investigation overpayments	$3,040,856
Targeted queries overpayments	$429,518
Acute care review overpayments	$478,965
Hospital utilization review overpayments	$5,482,442
Nursing facility utilization review overpayments	$1,270,630
FFS Recovery Audit Contractor recoveries	$22,784,517
Third Party Recoveries	$61,681,153
CLIENTS	**$6,317,291**
Beneficiary overpayments (SNAP, TANF, Medicaid, CHIP, WIC)	$6,120,737
Voluntary repayments by beneficiaries	$34,540
Electronic Benefits Transfer trafficking beneficiary overpayments ★	$162,014
RETAILERS	**$0**
Electronic Benefits Transfer trafficking retailer recoveries ★	$0
WIC collections	$0
HHS EMPLOYEES AND CONTRACTORS	**$0**
State Centers Investigations Team recoveries ★	$0

TOTAL RECOVERIES BY QUARTER



★PEACE OFFICER RECOVERIES



DOLLARS IDENTIFIED FOR RECOVERY

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

TOTAL DOLLARS IDENTIFIED FOR RECOVERY	$238,515,773
PROVIDERS AND MANAGED CARE ORGANIZATIONS	**$217,475,281**
Audit and inspection overpayments	$64,070
OIG and MCO investigation overpayments	$5,672,198
Targeted queries overpayments	$705,917
Acute care review overpayments	$297,970
Hospital utilization review overpayments	$5,016,465
Nursing facility utilization review overpayments	$521,291
FFS Recovery Audit Contractor recoveries	$22,345,180
Third Party Recoveries	$182,852,189
CLIENTS	**$21,040,492**
Beneficiary overpayments (SNAP, TANF, Medicaid, CHIP, WIC)	$20,549,339
Voluntary repayments by beneficiaries	$0
Electronic Benefits Transfer trafficking beneficiary overpayments ★	$491,153
RETAILERS	**$0**
Electronic Benefits Transfer trafficking retailer recoveries ★	$0
WIC collections	$0
HHS EMPLOYEES AND CONTRACTORS	**$0**
State Centers Investigations Team recoveries ★	$0

COST AVOIDANCE

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

TOTAL COST AVOIDANCE	$55,623,698
PROVIDERS AND MANAGED CARE ORGANIZATIONS	**$50,552,198**
Medicaid provider exclusions	$2,919,172
Fee-for-service front-end claims denial	$47,633,026
CLIENTS	**$5,071,500**
Client disqualifications	$2,844,731
Pharmacy Lock-In	$1,997,101
Disqualification of Electronic Benefits Transfer recipients ★	$229,668
RETAILERS	**$0**
WIC vendor monitoring	$0

PROVIDER INTEGRITY

TRENDS

Provider Investigations continues to receive complaints related to dentists and endodontists for inadequate and potentially dangerous patient care services. The OIG continues to conduct preliminary and full investigations involving these providers and recommend administrative action based on the findings.

Provider Investigations Performance	
388	Preliminary investigations opened
418	Preliminary investigations completed
38	Cases transferred to full-scale investigation
65	Full-scale investigations completed
79	Cases referred to OAG Medicaid Fraud Control Unit
88	Open/active full-scale cases at end of quarter

CASE HIGHLIGHTS

OIG issues $3.4 million notice of overpayment to two Houston pharmacies

The OIG issued notices of overpayment exceeding $3.4 million to two affiliated pharmacies in Houston, both with the same pharmacist-in-charge. An OIG initiative examining inventory reconciliation discovered both pharmacies billed Medicaid for filling prescriptions in excess of purchased inventory. One pharmacy had an error rate that exceeded 90% for their top 20 prescribed pharmaceuticals, including having purchased no inventory for seven of the top 20 medications billed to Medicaid.

Upon learning of this pattern of behavior, the OIG implemented a payment hold on both pharmacies based on a credible allegation of fraud. In the face of the OIG investigation and payment hold, one of the pharmacies surrendered its pharmacy license and ceased operation, and the other stopped billing Medicaid altogether. Both pharmacies defaulted on the overpayment notices, resulting in a debt to the State of Texas for the full overpayment amounts: $2,284,092 and $1,125,242, respectively.

Gulf Coast pediatric clinic settles improper billing case

In September, the OIG entered into a settlement agreement with a pediatric medical clinic in Portland, Texas for $331,866.

Claims data indicated that from November 2017 through October 2021, the provider billed Strep A molecular panels on the same date or within three days of a Strep A rapid test. According to the Center for Medicare & Medicaid Services (CMS) National Correct Coding Initiative, these two services are considered mutually exclusive and should not be reimbursed on the same day for the same client. Additionally, according to CMS Laboratory Date of Service Policy, the date of service must be the date the specimen was collected. The OIG verified all MCOs define the date of service in accordance with CMS policy.

A provider analysis was performed, highlighting any instance in which the two Strep A tests were billed on the same date of service. The data showed instances where one test was billed within three days of another without a subsequent Evaluation and Management service code, eliminating any instance where another specimen could have been collected for testing. The results showed the provider inappropriately billed these Strep A codes 48,849 times during the four-year timeframe.

OIG settles pediatric formula case

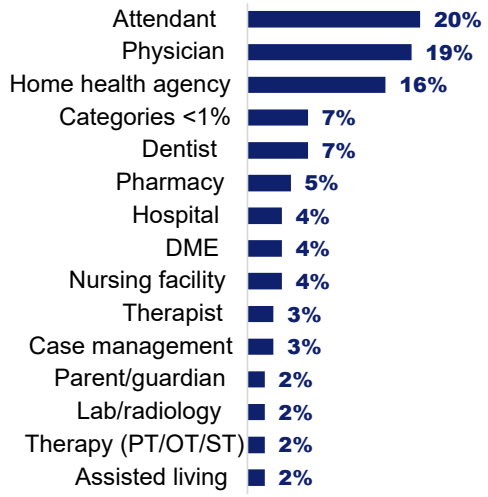
In November, the OIG executed a settlement agreement with a medical supply provider that failed to maintain adequate records on the delivery of enteral formula for pediatric patients. A review of patient records revealed deliveries that were not supported by required documents. The review also noted instances where proof of delivery was not properly maintained by the provider. A lump sum settlement of $14,199 was reached for the billing errors.

Case settled with South Texas home health provider that employed a prohibited person
The OIG settled a case in October with a Weslaco home health provider. The provider employed a personal care attendant who was on the Employee Misconduct Registry after an arrest for an offense that prohibits employment in such positions. The provider also improperly submitted claims for billing personal care attendant services that the attendant never rendered. The provider worked collaboratively with OIG Litigation to resolve these issues, and the OIG agreed to a settlement of $35,136. Medicaid providers are reminded to check the Exclusions Database and Employee Misconduct Registry before making new hires.

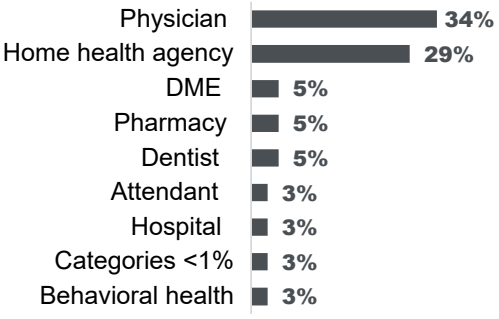
OIG settles case with New Jersey laboratory
In September, the OIG settled a case with a New Jersey-based laboratory company that billed for a specific infectious disease detection code in excess of daily limits. For some procedure codes, the Texas Medicaid Provider Procedures Manual restricts the number of times they may be billed per day, per client. The provider's use of modifiers circumvented systems designed to enforce the daily limits of restricted codes. The provider worked with the OIG to resolve the issues, agreed to no longer add inappropriate modifiers to the lab codes, and agreed to a settlement of $799,226.

OIG settles case with South Texas adult day care facility
In September, the OIG entered into a settlement agreement for $38,500 with an adult day care facility in Brownsville. The case was initiated as part of an OIG fraud detection operation, which identified the provider as an outlier for billing day care services during the weekend, billing overlapping services for the same recipient, and billing for more units than allowed. The investigation found that from November 2018 through July 2021, the provider received payment for Day Activity and Health Services when the facility was either closed or delivering meals to the clients' homes, and it was reimbursed for the same meals through two separate federally funded programs (Medicaid and the Child and Adult Care Food Program). Additionally, the provider failed to perform the necessary background checks on employees and failed to maintain records to support the services billed.

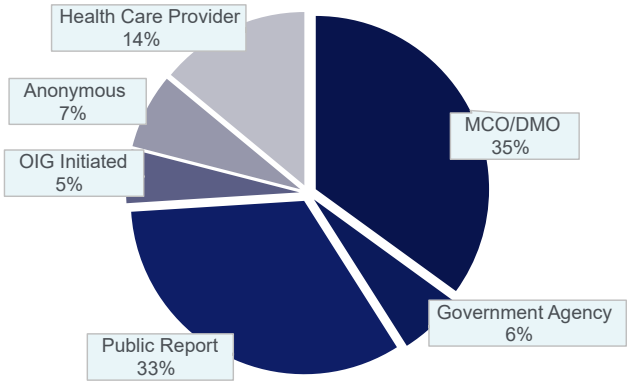
Preliminary Provider Investigations
(by type)



Full-Scale Provider Investigations
(by type)



Investigation Referral Sources



OIG settles cases with Houston hospital and New York laboratory billing unallowable codes
This quarter the OIG settled cases with a Houston hospital and a New York-based laboratory company that billed codes for services not available to Texas Medicaid clients. All of the codes at issue were genetics codes that were identified and disallowed in annual Healthcare Common Procedure Coding System Special Bulletins. The hospital and laboratory both worked with the OIG to resolve their cases and agreed to settlements of $720,723 and $231,084, respectively.

Surveillance Utilization Review

$478,965	Acute care provider recoveries
$297,970	Acute care services identified overpayments
62	Acute care services cases closed
$5,485,758	Hospital and nursing home (UR) recoveries
8,882	Hospital (UR) claims reviewed
26	Nursing facility reviews completed
3,089	Average number of Lock-in Program clients

Provider Enrollment and Exclusions

7,871	Provider enrollment applications processed
21,654	Individual screenings processed
59	Medicaid providers excluded

OIG settles cases with multiple pediatricians double billing for hearing tests
This quarter, the OIG settled several cases totaling $445,542 with pediatric practices that billed audiometry codes on the same day as a Texas Health Steps check-up. Periodic hearing tests are included as part of the Texas Health Steps check-up and may not be billed separately. Providers should refer to the current periodicity schedule for Texas Health Steps visits that can be found at the Texas HHS website, along with other resources. The providers — one in Dallas, one in Arlington and two in Houston — agreed to settlements of $51,947, $70,558, $249,022 and $74,015, respectively.

OIG settles with East Texas hospice provider
The OIG settled a case in September with a Longview hospice provider. The OIG received a referral after an investigation by a Centers for Medicare and Medicaid Services contractor. The contractor's investigation suggested that the provider was billing hospice services for ineligible patients. A review of medical records showed that several patients did not meet initial requirements for admission or continued participation in hospice. The OIG's litigation team pursued the resulting overpayment, reaching a settlement of $337,730.

OIG settles case with South Texas pharmacy billing for drugs not purchased
The OIG settled a case in November with a Mission pharmacy that billed Medicaid for medications that were not supported by their purchase records. During the investigative period, the pharmacy was reimbursed for at least 10 different medications that they could not prove they ever purchased. The pharmacy agreed to a settlement of $192,905 to resolve the case.

OIG settles case with East Texas cardiovascular specialist
The OIG settled a case in October with a Cleveland, Texas cardiovascular provider. The investigation suggested that the practice was reimbursed for more expensive monitored, attended video EEGs when they actually performed less expensive portable, unattended EEGs. The OIG worked with the provider to resolve the issues and agreed to a settlement of $12,000.

OIG settles case with out-of-state independent laboratory provider
In September, the OIG entered into a settlement agreement for $799,226 with an out-of-state independent laboratory provider. The OIG investigation found that from September 2015 through May 2023, the provider billed for both low-risk and high-risk Human Papillomavirus (HPV) infectious agent detection on the same date of service for a single client. Billing for both on the same day is a violation of the National Correct Coding Initiative (NCCI) Code Pair Edits policy. Further, from February 2016 through April 2020, the provider appended

modifiers 59 (to indicate a distinct procedure, service or session) or 91 (to identify a repeat laboratory test on the same date of service as the initial laboratory test) to claims for infectious agent antigen detection even though the documentation did not support that a different site was tested or that tests were repeats of the initial test. By adding the modifiers, the claims bypassed the NCCI edits that prevent improper payment, enabling the provider to bill and receive payment for more than three antigen tests for a single client on a single date of service, in violation of Texas Medicaid policy.

OIG settles case with Houston home health agency
The OIG settled a case in November with a Houston home health agency that was the subject of an OIG billing review. The review showed that the home health agency billed for 24-hour nursing care for a client with ventilator dependency and tracheostomy — which is reimbursed by Medicaid at a higher rate — even though the client's care plan did not indicate either condition. A review of medical records submitted by the provider showed insufficient evidence to support that the client had the tracheostomy or ventilator dependency required for the more expensive 24-hour nursing care being billed. The provider worked with the OIG to resolve these issues and agreed to a settlement of $162,183.

OIG settles case with West Texas health care provider
The OIG settled a case in October with an El Paso health care provider. The provider improperly submitted claims and received reimbursement, primarily for billing CPT codes for office and outpatient visits and behavioral health day treatment without maintaining and producing required documentation to support medical necessity. The provider worked collaboratively with OIG Litigation to resolve these issues, and the OIG agreed to a settlement of $3,876 to resolve the case.

AGENCY HIGHLIGHTS

Fraud detection operation examines pharmacy providers
The OIG's Medicaid Program Integrity (MPI) team conducts fraud detection operations (FDOs), which use data to identify fraud, waste and abuse. The focus of the November FDO was prescription services billed to Texas Medicaid at a level above and beyond that of the providers' peers. The OIG Fraud Analytics team enhanced three existing algorithms, developed five new algorithms, and developed a new risk-based method for identifying specific claims for further review based on member claims history related to pharmacies. MPI selected providers to examine based on this analysis, which flagged:

Fraud Analytics and Data Operations

144	Data requests received
142	Data requests completed
46	Algorithms executed
5	Algorithms developed

- Specific drugs that had a significant spike in claims.
- Prescription brokering, to include member to prescriber, member to pharmacy, and prescriber to pharmacy distances.
- Filled prescriptions where the prescriber has no Medicaid billing or rendering history.

The FDO operations were concentrated in one metropolitan area of the state November 6-10. Records were requested from prescribing providers as well as the outlier pharmacies and will be reviewed once received. If a referral to Provider Investigations is made, this will allow for a closer look at the pharmacy's billing and documentation patterns and other evidence.

Fraud Analytics introduces artificial intelligence into the fraud detection toolkit
The OIG's Fraud Analytics team developed a predictive model to identify potential fraud, waste and abuse using neural networks, a type of artificial intelligence. The team trained the supervised machine learning model to identify risky providers using examples of providers that are currently excluded from participating in the Texas Medicaid program. The model will support the OIG's identification of questionable provider behavior and respective claims for closer review.

Data Operations helps inform the appropriate federal match rate for clinical services provided by the Surveillance Utilization Review team

Data Operations completed the design, development and implementation of a new timekeeping system for the Surveillance Utilization Review (SUR) team. SUR is comprised of several units, including Hospital Utilization Review, Nursing Facility Utilization Review, Acute Care Surveillance and the Lock-In Program. Staff across all SUR teams can now record the time spent on specific clinical tasks through the new timekeeping system, which streamlines time entry and ensures proper budgetary tracking and cost allocation methodologies are applied in accordance with differing federal-state match rates.

Data Initiatives Project Team trains peers

The Data Initiatives Project Team's (DIPT's) outpatient hospital facility emergency department (ED) initiative reviews outpatient hospital provider claims for ED services to identify patterns of inappropriate or incorrect coding or billing that have resulted in overpayments. Through this initiative, the OIG is able to recover misspent Texas Medicaid funds from outpatient hospital providers, as appropriate. This quarter, DIPT provided training to the OIG Litigation Team on how to read and interpret outpatient hospital facility ED initiative data files. The training ensures OIG attorneys can clearly demonstrate to providers how the OIG determined the overpayments for cases within the initiative, which also helps educate providers on preventing these errors in the future.

Audit team prepares for local behavioral and mental health authority audits

In May 2023, the passage of Senate Bill 26 amended Texas Health and Safety Code Section 531.1025 to require the OIG to audit each of the 39 local behavioral health authorities (LBHAs) and local mental health authorities (LMHAs) at least once every five years. To meet this requirement, the OIG has already initiated the first two audits of Bluebonnet Trails Community Services and MHMR Concho Valley. The OIG looks forward to completing several audits in this series and reporting the results in the current fiscal year.

Senate Bill 1342 strengthens third-party liability requirements

Senate Bill 1342, 88th Texas Legislature, 2023, which took effect September 1, 2023, amended Texas Human Resources Code, Section 32.0424 to include federal rule changes that clarify and strengthen existing third-party liability (TPL) requirements for health insurers liable for payment of Medicaid claims. These amendments will help the OIG Third Party Recoveries team ensure that Medicaid is the payer of last resort by strengthening OIG's authority to collect from liable third parties, such as commercial insurance carriers.

Provider Enrollment Integrity Screenings team tackles workload increase

The Provider Enrollment Integrity Screenings (PEIS) team screens certain Medicaid provider applications to proactively safeguard client well-being and Medicaid program integrity. Since National Provider Identifier (NPI) based enrollment was deployed in Texas in 2021, the volume of provider enrollment applications routed to the OIG's PEIS team for review increased substantially. The end of the COVID-19 public health emergency (PHE) in May 2023 also added to PEIS' workload as providers whose Texas Medicaid enrollment was extended during the PHE are now required to revalidate their enrollment. Thanks to the efforts of PEIS personnel, the addition of three temporary staff members, and three new full-time positions granted by the 88th Texas Legislature, the team is completing more than 99% of screenings within the required 10 business day period.

AUDIT REPORTS COMPLETED

Managed Care Pharmacy Encounters Paid to Bemaj Pharmacy, Inc.: A Managed Care Network Provider Contracted Under Amerigroup Texas, Inc., Amerigroup Insurance Company and Superior HealthPlan, Inc.

The OIG conducted an audit of managed care encounters paid to Bemaj Pharmacy, Inc., (Bemaj) to determine whether it (a) properly billed for selected paid encounters associated with Texas Medicaid clients enrolled with Amerigroup Texas, Inc., and Amerigroup Insurance Company (Amerigroup) and Superior HealthPlan, Inc. (Superior) and (b) complied with applicable contractual, state and federal requirements.

Bemaj filled and dispensed prescriptions for Texas Medicaid clients; however, Bemaj did not consistently comply with certain requirements for dosage directions, medication strength, maintaining support and signing or dating written prescriptions. Additionally, Bemaj dispensed opioid and Schedule II prescriptions received via fax, which is not allowed. Specifically, Bemaj:

- Received an overpayment of $356 for six pharmacy encounters tested.
- Filled two invalid opioid prescriptions and 40 invalid Schedule II prescriptions that it received through fax, resulting in an overpayment of $7,234.
- Submitted six opioid claims and 73 Schedule II claims for written prescriptions that were not signed or dated by a pharmacist on the date the prescription was filled, resulting in an overpayment of $11,085.

As a result, Bemaj was overpaid and should repay $18,676 to the state of Texas.

Audit Performance

$90,677 Overpayments recovered

$64,070 Overpayments identified

Audits Issued (2)

Managed Care Pharmacy Encounters Paid to Bemaj Pharmacy, Inc.: A Managed Care Network Provider Contracted Under Amerigroup Texas, Inc., Amerigroup Insurance Company and Superior HealthPlan, Inc. (9/1/2023)

Baylor Scott & White Health: A Texas Medicaid Provider (11/30/2023)

Audits In Progress (19)

Managed Care Pharmacy Benefits Management Services

DMO and MCO Financial Reporting

Selected Local Mental Health Authorities

Selected Pharmacy Providers

Selected Prescribed Pediatric Extended Care Centers

Selected Electroencephalogram (EEG) Providers

MCO IT Security Controls and Business Continuity

Selected Long-Term Care Discharges

Selected Day Care Providers

Baylor Scott & White Health: A Texas Medicaid Provider

The OIG initiated this audit of Baylor Scott & White Health (BSW) due to the increased risk associated with teleservices claims for evaluation and management, psychiatry and psychotherapy services caused by the increase in teleservices provided during the COVID-19 public health emergency. BSW provided behavioral health services to its patients via teleservices; however, it:

- Double billed for 470 behavioral health teleservices, totaling $30,239.
- Billed 183 unallowed facility fees for services totaling $13,629.
- Incorrectly billed $1,544 for psychotherapy services with the wrong therapy code.

As a result, BSW was overpaid and should repay a total of $45,413 to the state of Texas. In addition, BSW was unable to demonstrate it provided the required privacy practice notification to three of 88 patients included in audit testing.

INSPECTION REPORTS COMPLETED

Managed Care Claims Submitted by Texas Medicaid Durable Medical Equipment and Supplies Providers: Byram Healthcare Centers, Medical Plus Supplies, and Respiratory & Medical Homecare Unlimited

Recent litigation involving durable medical equipment (DME) and supplies providers who submitted false Medicare wound care supply claims prompted an interest in reviewing the potential risk for wound care supplies in Texas Medicaid. The OIG initiated these inspections to determine whether claims for wound care supplies were supported. The objective was to determine whether the providers supported their wound care supply claims according to guidelines. The three inspections were of Byram Healthcare Centers (Byram), Medical Plus Supplies, and Respiratory & Medical Homecare Unlimited.

Inspections Issued (3)

- Managed Care Claims Submitted by Byram Healthcare Centers (10/6/2023)
- Managed Care Claims Submitted by Medical Plus Supplies (10/10/2023)
- Managed Care Claims Submitted by Respiratory & Medical Homecare Unlimited (10/31/2023)

Inspections In Progress (3)

- Ambulance Claims Oversight: Non-Medically Necessary Ambulance Claims
- Mental Health Private Psychiatric Bed Funds
- Follow-Ups of Nursing Facility Staffing Hours Verification Inspections

Byram's records did not always contain all required information. Two (7%) of the 30 managed care claims tested did not have complete order form information. The OIG made a recommendation to Byram that, if implemented, will help improve its recordkeeping.

For Respiratory & Medical Homecare Unlimited and Medical Plus Supplies, the tested invoices and proof of delivery documents matched the prescribed item types and quantities for the claims tested. As a result, these inspections identified no issues or opportunities for improvement.

CLIENT ACCOUNTABILITY

TRENDS

The Benefits Program Integrity (BPI) Unit investigates allegations of overpayments to health and human services program clients. This quarter the unit completed 3,993 investigations involving benefit recipient overpayments or fraud allegations.

Concerns involving a client's household composition made up 54% of all completed BPI investigations, with an additional 20% involving unreported income. Household composition cases usually involve an unreported household member who has reportable income or a reported household member who does not live in the same residence. Both instances cause the household to receive more benefits than they are eligible for. For this quarter, BPI referred 21 investigations for prosecution and 266 investigations for administrative disqualification.

Benefits Program Integrity Performance

$6,120,737
Overpayments recovered

4,092
Cases opened

3,992
Cases completed

21
Cases referred for prosecution

266
Cases referred for administrative disqualification

CASE HIGHLIGHTS

Rio Grande Valley SNAP beneficiary disqualified and ordered to repay stolen benefits
A Webb County woman was found guilty in an administrative hearing following an OIG investigation. The individual applied to receive SNAP benefits but failed to report a required household member. OIG investigators found evidence the unreported required household member was employed and receiving regular income. Eligibility for SNAP is tied to household resources. Therefore, applicants are legally required to provide truthful information regarding income, financial resources and household composition. In total, the subject received $46,081 in SNAP benefits she was not entitled to. The subject was ordered to repay all $46,081 in restitution to Texas Health and Human Services and disqualified from SNAP participation for 12 months.

Former San Antonio-area woman found guilty in administrative hearing
A woman who previously lived in Bexar County was also found guilty in an administrative hearing following an OIG investigation. The individual applied to receive SNAP benefits in Texas but failed to report that she and her five children were now living in another state. OIG investigators found evidence that substantiated the subject and her children resided in California. Eligibility for SNAP is tied directly to the state where the individual resides. In total, the subject received $41,248 in SNAP benefits to which she was not entitled. The subject was ordered to pay $41,248 in restitution and disqualified from SNAP for 12 months.

AGENCY HIGHLIGHTS

BPI recoveries up in Q1
Over the first quarter of FY 2024, BPI has seen an 11% increase in both dollars identified and dollars recovered. In addition, BPI has seen an 18% increase in case completions compared to the same period in FY 2023.

BPI forms out-of-state shopping task force
In the first quarter of FY 2024, BPI noticed an increase in referrals related to out-of-state shopping, which can indicate that a client no longer lives in Texas. BPI is working closely with our eligibility determination partners as well as Integrity Support Services to combat this trend. As a result, an out-of-state shopping task force was formed to identify fraud associated with out-of-state shopping and seek recovery of overpayments through the civil and criminal process.

RETAILER MONITORING

TRENDS

Electronic Benefits Trafficking Unit

The Electronic Benefits Transfer (EBT) Trafficking Unit is comprised of commissioned law enforcement officers and non-commissioned investigators who conduct criminal investigations into EBT misuse by retailers. This quarter, the EBT Trafficking Unit completed 108 investigations and presented another 62 investigations for either administrative disqualification hearings (52) or prosecution (10).

Electronic Benefits Transfer Trafficking Unit Performance	
$162,014	Overpayments recovered
93	Cases opened
108	Cases completed

The most common occurrence across cases involves clients selling their SNAP benefits to a small store or food truck in exchange for cash. The retailers typically give cash to the EBT cardholders, at a discounted rate, and the retailers use the full amounts of the benefits to buy inventory for their businesses.

WIC Vendor Monitoring Unit

The Women, Infants, and Children (WIC) Vendor Monitoring Unit (VMU) uses a variety of tools to monitor and ensure the compliance of retailers participating in the WIC program. This quarter, WIC VMU conducted 59 compliance buys across the state. A compliance buy is a covert in-store inspection. An OIG inspector poses as a WIC client and uses a WIC (EBT) food card to make purchases to ensure vendors are following WIC rules. No violations were cited.

WIC Vendor Monitoring Unit Performance	
59	Compliance buys
11	Inventory reviews
70	On-site store inspections

The team also completed 11 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 inventory review determines if the vendor had a sufficient inventory of WIC food items to justify submitted claims. All vendors reviewed this quarter were in compliance.

The WIC VMU also conducted 70 on-site store inspections. The inspection is an overt in-store assessment during which the OIG works with the respective WIC vendor to identify any deficiencies which may or may not exist in association with the sale of authorized WIC products.

CASE HIGHLIGHTS

BBQ restaurant owner admits to trafficking benefits

The EBT Trafficking Unit received an anonymous complaint alleging that the owner of an East Texas barbecue restaurant was purchasing SNAP benefits from various recipients and using the cards to buy items for his restaurant. Investigators examined the records from a local warehouse retail store and identified $12,694 in fraudulent charges using 16 different EBT cards. An additional $2,654 in fraudulent charges were identified at another area retailer involving one card. OIG investigators interviewed the benefit recipients who admitted to letting the restaurant owner use the SNAP benefits. In a later interview the restaurant owner confessed to using the SNAP benefits. The case was referred to the district attorney's office and is scheduled to be presented to a grand jury in July 2024.

Transaction history analysis IDs Fort Worth retailer for SNAP fraud
The EBT Trafficking Unit, through analysis of transaction history, discovered that a Fort Worth retailer had monthly SNAP redemptions that were greater than the store's inventory and eligible stock. Interviews and transaction reviews of recipients with high dollar transactions at the suspect retailer showed that the same recipients had high-dollar transactions at a warehouse retail store, where membership accounts for the recipients and the store owner revealed the store owner's account contained multiple EBT cards. Investigators conducted surveillance, undercover operations, and interviews with suspects to confirm the allegations. In total, $17,231 in SNAP benefits are alleged to have been used illegally in the scheme. The criminal case was filed with the Tarrant County District Attorney's Office.

Food truck owner caught using SNAP benefits for supplies
EBT Trafficking Unit investigators received allegations that a food truck owner was illegally purchasing SNAP benefits to buy inventory for his business. The investigators interviewed a benefit recipient who admitted he let the owner use his benefits to purchase inventory for the food truck. Membership information and transaction history data from a local warehouse retail store revealed that five EBT cards not belonging to the food truck owner were used on his account. An interview with the food truck owner was arranged, but he did not appear. The investigation alleges the owner fraudulently used $10,265 in SNAP benefits that did not belong to him. The case was submitted to the district attorney's office for prosecution.

AGENCY HIGHLIGHTS

EBT Trafficking Unit expands West Texas operations
Thanks to increased funding received from the Texas Legislature, the OIG's EBT Trafficking Unit received three additional investigative staff positions. The positions will be used to create an El Paso field office.

Collaboration furthers WIC VMU goals while offering flexibility for vendors
The WIC VMU management team held a meeting with a large vendor's compliance team regarding inventory reviews for the upcoming year. After discussion of the vendor's challenges preparing inventory data, a coordinated plan was formulated that will expedite the completion of inventory reviews for this vendor.

HHS OVERSIGHT

Internal Affairs Performance

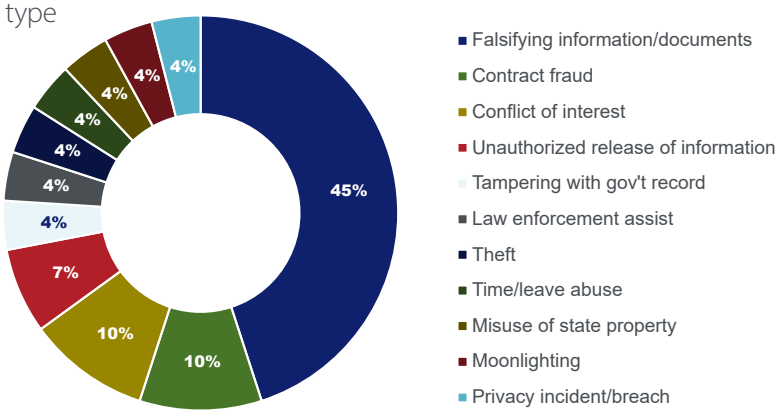
63	Cases opened
53	Cases completed

State Center Investigations Team Performance

176	Cases opened
232	Cases completed

Internal Affairs Cases

by type



TRENDS

Major Case Unit

The Major Case Unit (MCU) is a team of multidisciplinary forensic accounting and investigative experts who conduct or assist with the OIG's highest-profile, highest-dollar cases. In the first quarter of FY 2024, the MCU opened one case, closed two cases, and is currently investigating nine active cases. They are also assisting several law enforcement agencies with cases that originated at the OIG. MCU investigations this quarter have involved high-dollar contract fraud, inappropriate billing by providers, and complex employee misconduct.

Internal Affairs

Internal Affairs (IA) processed 98 referrals this quarter. IA worked on 63 active investigations and closed 53 investigations in the first quarter. The remaining referrals were forwarded to the appropriate business areas, including the Office of the Independent Ombudsman for State Supported Living Centers; the Department of Family and Protective Services (DFPS) Office of Internal Affairs; and HHS Complaint and Incident Intake.

Approximately 43% of Internal Affairs' open cases involve Child Protective Services client or supervisor allegations of DFPS employees falsifying documents. Many referrals are also coming from outside entities not involved with a state agency or HHS. In the first quarter of FY 2024, only 45% of referrals were opened as IA investigations due to this increase in non-agency-related referrals. Although workloads have increased, IA maintains an average open case time of 82 days, well below the 180-day deadline.

State Center Investigations Team

The OIG State Center Investigations Team (SCIT) is comprised of commissioned peace officers who investigate allegations of abuse and other wrongdoing at state hospitals and state supported living centers. In the first quarter of FY 2024, SCIT opened 176 investigations and completed 232 investigations with an average completion time of 27 days. This compares to 271 opened investigations and 242 completed investigations in the prior quarter. In the first quarter of 2023, SCIT opened 292 investigations and completed 216 investigations.

CASE HIGHLIGHTS

Texas Works Advisor improperly posted a client's information on social media

IA investigated a case involving a Texas Works Advisor who posted a photograph of themselves in front of their work computer. The computer displayed client information, which was also posted on the employee's personal social media account. The employee denied using their state-issued computer to access social media but admitted the privacy violation. The employee was terminated for violating work rules.

Former HHS employee found to have a conflict of interest
IA investigated a now former employee for allegedly soliciting HHSC-contracted vendors for donations for a sports team. The vendors were interviewed and stated they wanted to help the employee and did not feel pressure to provide their support. The employee admitted to the conduct and offered to pay back the vendors. The employee resigned from HHS for reasons unrelated to the investigation.

Investigation finds employee committed benefits fraud
IA investigated a case involving a Texas Works Advisor who allegedly committed an intentional program violation by submitting several fictitious benefits applications for herself and her children. The employee omitted the father's income information to qualify her family for benefits they were not legally entitled to receive. As a result, the employee received over $3,000 in excess benefits. The employee admitted to the conduct but has not responded to the repayment agreement.

SCIT investigations confirm physical abuse at two state facilities
Two recent SCIT cases involved allegations of physical abuse at separate state facilities, one at the Big Spring State Hospital and the other at the San Antonio Supported Living Center. In both cases, OIG investigators reviewed video evidence and conducted interviews that confirmed the allegations. Both cases were referred to the respective district attorney for criminal prosecution.

AGENCY HIGHLIGHTS

Internal Affairs investigators complete advanced training in forensics software
Two Internal Affairs investigators recently received advanced training in EnCase computer forensic software. This training qualified them to take an exam and practical that will earn an internationally recognized certification for EnCase software, which is a forensics program used to extract information from computers while maintaining the integrity of the information.

POLICY RECOMMENDATIONS

Differential pay policy updated
Following an Internal Affairs investigation into staff who allegedly received an inappropriate shift salary differential, the OIG recommended that HHS update its differential pay policy. A shift salary differential allows employees to receive increased pay for working evening, night and weekend shifts. OIG recommendations included training for certain management staff and suggested that HHS clarify requirements for an employee to receive a shift salary differential, such as specifying whether employees must work an entire off-shift to qualify for a shift salary differential. HHS updated its guidance in October to address the OIG's feedback.

OIG provides program integrity feedback on policy changes
In September, HHS requested program integrity feedback from the OIG on reimbursement for certain clinician-administered, high-cost drugs and biologics delivered in an inpatient setting. The OIG recommended that HHS consider a policy for determining when it is medically appropriate for a member to receive the drug in an inpatient, instead of outpatient, setting. This ensures the most cost-effective and medically appropriate place of service and protects members from unnecessary hospitalizations. The OIG also recommended that HHS continue to monitor the total cost of care after implementation to understand how using high-cost drugs and biologics reduces other costs for traditional treatment that impact MCO capitation rates.

RULES

Proposed
The OIG is processing a proposed Texas Administrative Code (TAC) rule project. Several sections in 1 TAC, Part 15, Chapter 354, Subchapter J, concerning Third-Party Recoveries (TPR), are proposed for amendment as a result of changes to federal rules and legislation passed during the Texas legislative session. These rules were posted for 31 days of public comment in the Texas Register on November 17, 2023.

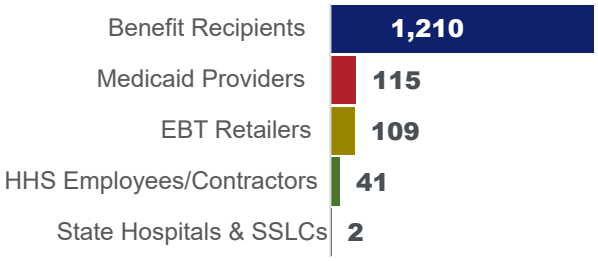
STAKEHOLDER ENGAGEMENT

Fraud Hotline Performance

9,111 Fraud Hotline contacts handled

1,477 Fraud Hotline referrals to OIG units

Fraud Hotline Referrals by Type



STAKEHOLDER MEETINGS

Texas Fraud Prevention Partnership CEO meeting

On September 21, the OIG held the Texas Fraud Prevention Partnership (TFPP) meeting with OIG leadership and executive leadership from the managed care organizations (MCOs) to discuss current initiatives and combined efforts to prevent, detect and investigate fraud, waste and abuse. The OIG is planning two more meetings in FY 2024.

Texas Fraud Prevention Partnership special investigative unit meeting

A TFPP special investigative unit (SIU) online meeting was held October 26 and attended by all MCOs and the Texas Office of Attorney General Medicaid Fraud Control Unit. At the meeting, Community Health Choice presented information on their review of therapy billing codes, Amerigroup presented on enteral supply fraud, and the OIG's Program Integrity Development and Support unit shared information about their ongoing pharmacy fraud detection operation. The OIG also emphasized the requirement for MCOs to consistently ensure that providers are submitting accurate performing (also called rendering) provider data on all institutional and group claims.

The OIG also held TFPP SIU one-on-one meetings with Amerigroup, Community Health Choice, Cook Children's, Superior, Texas Children's, and United Health plans along with Dental Maintenance Organizations MCNA, DentaQuest, and United Dental to discuss their pending investigations, referrals and current fraud, waste and abuse schemes. Medicaid Fraud Control Unit staff also participated in the meetings.

External Relations Performance

89 Communications products

101,677 OIG web page views

Parkland Hospital

On November 6, Inspector General Winter was honored to tour the historic Parkland Memorial Hospital in Dallas. He and other OIG staff met with leadership from both the hospital system and Parkland Health Community Health Plan to learn how they serve Texans in the Dallas area.

Children's Medical Center Dallas

On November 7, Inspector General Winter toured Children's Medical Center in Dallas. He and other OIG staff learned about how this hospital serves children and families from around the world who are facing complex medical conditions.

Stakeholder association meetings
Throughout the first quarter of FY 2024, Inspector General Winter met with numerous stakeholder associations to learn more about their organizations, members and priorities. The meetings also allowed Winter to share his vision and goals for the OIG and explore opportunities for future collaboration. Additional meetings with other stakeholder organizations are being planned for future quarters in FY 2024. This quarter's meetings included:

- Texas Association of Community Health Plans, October 25.
- Texas Hospital Association, October 30.
- Texas Association of Health Plans, November 1.
- Teaching Hospitals of Texas, November 9.
- Texas Medical Association, November 16.

CONFERENCES, PRESENTATIONS AND TRAININGS

Texas Tech Health Science Center Compliance Symposium
On October 5, Chief of Staff Susan Biles presented at the Texas Tech Health Science Center Compliance Symposium. In addition to informing attendees of OIG's recent work, Biles unveiled a new guide designed to help resident physicians navigate their role in maintaining Texas Medicaid program integrity.

National Health Care Anti-Fraud Association
On November 7, Chief of Investigations and Utilization Reviews Steve Johnson and other division staff attended the National Health Care Anti-Fraud Association Conference in Dallas. Johnson participated in a three-member panel discussing best practices and areas of improvement for collaboration between MCO SIUs and state program integrity units.

San Antonio State Supported Living Center
On November 15, Inspector General Winter and OIG leaders toured the San Antonio State Supported Living Center where they met with the center's leaders and local OIG State Center investigators to learn more about their work.

On-demand training expanded
The OIG's Program Support and Training Unit expanded its staff outreach by making recorded "Explore OIG" training sessions available on demand. These recordings allow staff to download transcripts or hear entire presentations, including questions and answers from participants. The addition of the "Explore OIG" training series adds depth to the online training available in the OIG existing on-demand library.

Training Overview

47 Trainings conducted this quarter

OIG IN FOCUS

LOOKING AHEAD WITH INSPECTOR GENERAL WINTER

Raymond Charles Winter was appointed by Governor Greg Abbott to serve as Inspector General for Texas Health and Human Services. He took office on October 2, 2023.

Winter joined the Office of Inspector General in June 2023 as Assistant Deputy Inspector General for Complex Litigation. He previously served at the Office of the Attorney General of Texas for more than 24 years, including 15 as Chief of the Civil Medicaid Fraud Division.

Prior to joining the Office of Attorney General, Winter was a staff attorney at the Texas Natural Resource Conservation Commission, now the Texas Commission on Environmental Quality, and a U.S. Army infantry officer. He holds a bachelor's degree from Texas A&M University and a law degree from the University of Houston.

This OIG in Focus took the opportunity to check in with Inspector Winter as he steps into this new role.

What are your priorities for the OIG?

Our mission is, always has been and will remain, our top priority. Collectively, the dollars spent on the programs we protect comprise around 30% of the overall Texas budget. It is a huge amount of money, and the taxpayers of Texas deserve our full attention to our mission of protecting HHS programs against fraud, waste and abuse. Although we're protecting taxpayer dollars, we're talking not just about money. We're talking about real people. The services that we protect are services desperately needed by millions of people across the state of Texas.

One of my priorities is to increase our effectiveness in deterring unlawful or inappropriate conduct, recovering dollars, and helping to ensure that funds the legislature has dedicated for these purposes are used for those intended purposes — helping Texans.

At the same time that the OIG has single-minded focus on our mission to protect vulnerable Texas and safeguard taxpayer dollars, we must also take care of our employees here at the OIG. We have some of the finest, most dedicated staff that I have seen in over 30 years of state service. The success of our mission depends on the performance of our staff, and our responsibility as leaders of this agency and my duty as Inspector General is to ensure that our staff has the tools and support it needs to accomplish the mission.

Why is compliance so important?

The system in place is a public-private partnership, and it depends upon all the participants and the players coming to the table in good faith and transparency. There is an obligation on the part of those who wish to participate in the program to know what the rules are and to comply with them. No one is forced to be a Medicaid provider; the people who participate – clinicians, service providers, drug manufacturers, pharmacies, etc. – are all volunteers. It's very clear under our system of law and rules that when somebody volunteers to engage in a regulated enterprise or regulated undertaking such as this, they have an obligation to know and follow the rules. The reason we have rules is to ensure that dollars are spent properly and people who need services get the services they are entitled to.

At the end of the day, our job at the OIG is to make sure people obey the rules and taxpayer dollars are spent properly so that clients get the services they need. We must be transparent and operate in good faith, and the rules shouldn't change in the middle of the game; there shouldn't be a shifting playing field. The rules need to be objectively discernible and attainable, and people need to understand what the rules are.

Do you have any final thoughts for the OIG's partners?

Any time anybody needs any information from us, we are going to be happy to provide that information. It is my goal that all interested stakeholders and constituents find our office to be transparent, open and responsive. As I travel around the state and I get to know more people in this agency, I'm finding them to be dedicated professionals who believe in our mission and who are passionate about their work. We stand ready to collaborate with all those involved — clients, providers, MCOs, HHS program staff and other governmental entities — to ensure the public-private partnership works and the people of Texas receive the services they need.

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(800) 436-6184

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)