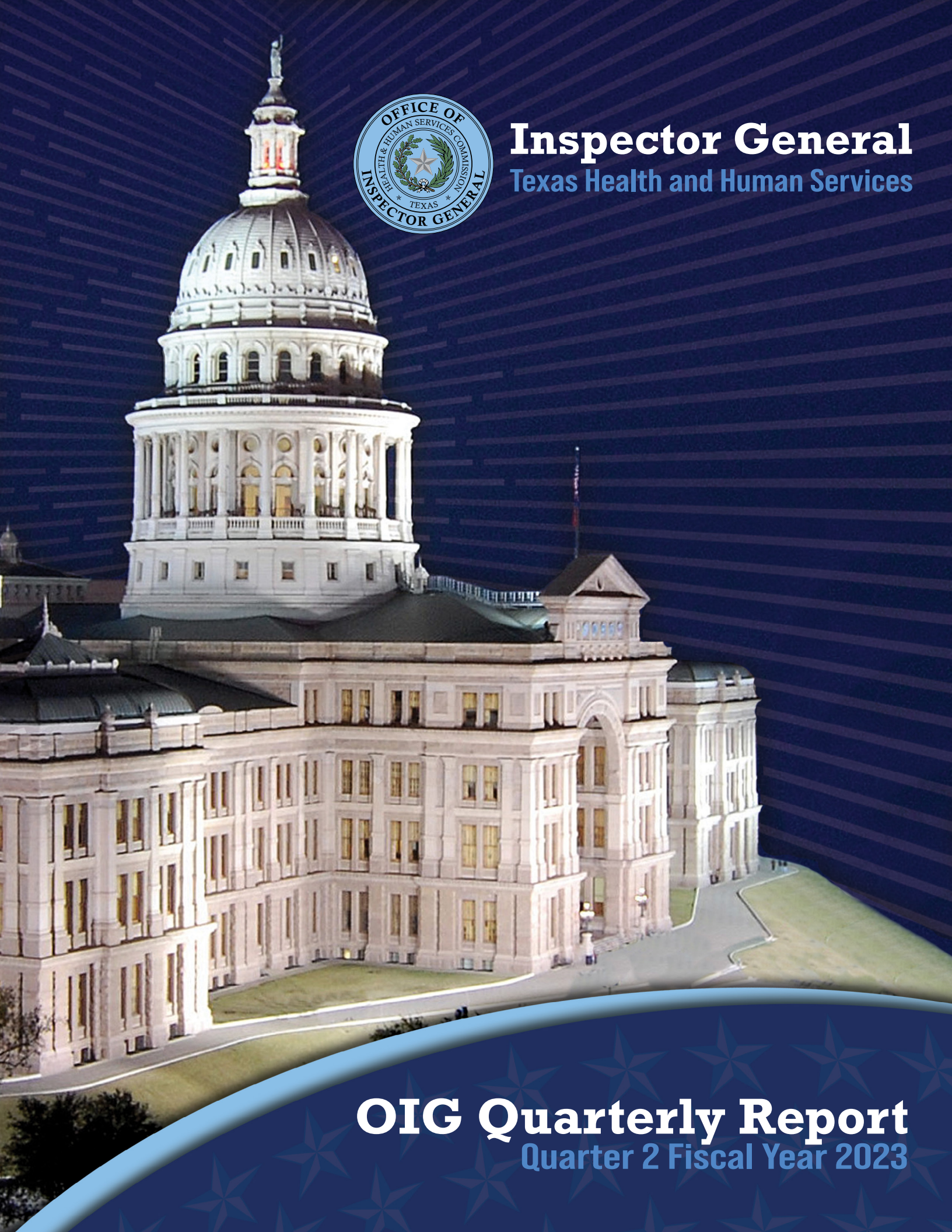

Inspector General

Texas Health and Human Services

OIG Quarterly Report

Quarter 2 Fiscal Year 2023

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I. Executive Summary

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

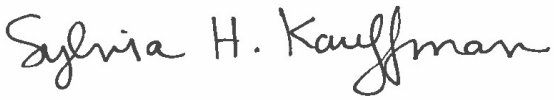
From December 1, 2022, to February 28, 2023, the Office of Inspector General (OIG) recovered more than $112 million. In addition, we identified more than $376 million in potential future recoveries and achieved more than $45 million in cost avoidance.

As the OIG pursues our mission of preventing fraud, waste and abuse in Texas' health and human services, a key component of our success is tied to our ability to educate stakeholders. The OIG has a unique vantage point in the overall health and human service landscape. As our teams conduct audits, inspections, investigations and reviews, they gain valuable insights that can be tapped to improve outcomes system-wide.

In this edition of the OIG Quarterly Report, you will see numerous instances of educational outreach through our partnerships with stakeholders. For example, in the OIG in Focus, you can learn about our observations in contract monitoring from our audits of HHS contracts across a variety of programs and agencies. In our retailer monitoring section, you will see information about recent crimes involving SNAP card skimming and a link to our Ad Hoc Report on SNAP Skimming and outreach materials for SNAP retailers and clients.

Whether it be with providers, managed care organizations, clients, retailers, community leaders or other governmental entities, I am proud of the partnerships our office has developed. I'm even more proud that we successfully leverage those partnerships to protect Texas tax dollars and the individuals relying on HHS programs.

Preventing fraud, waste and abuse before it can happen will always be a priority for the OIG. You can be assured we will continue cultivating every opportunity to create partnerships and educate our stakeholders as we work to fulfill our mission.



Inspector General

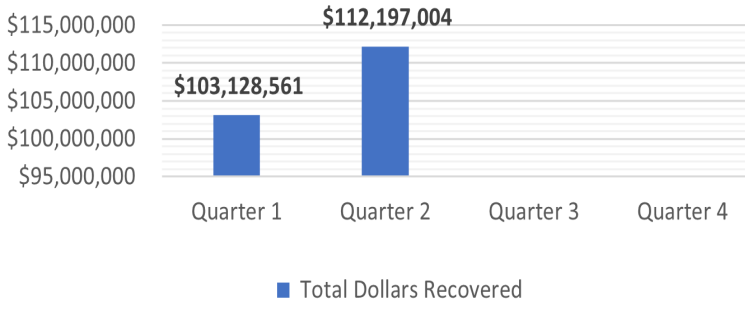
II. Quarterly Metrics

Dollars recovered

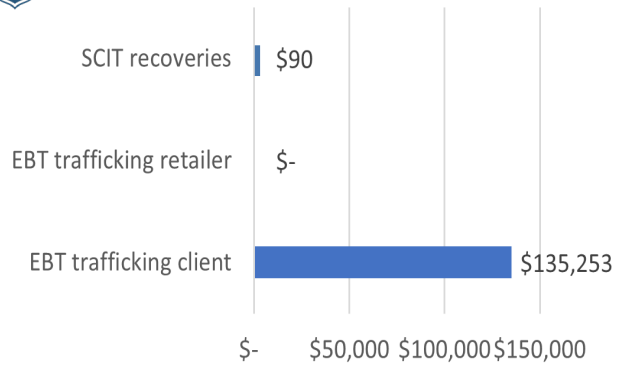
Dollars recovered are overpayments that have been collected based on the results of an investigation, audit, inspection or review.

Total dollars recovered	$112,197,004
Providers and Managed Care Organizations	**$106,746,827**
Provider overpayments from audits and inspections	$93,912
Provider overpayments from investigations and MCOs	$3,873,926
Provider overpayments from automated review scenarios	$2,364,456
Acute care provider overpayments	$228,857
Hospital utilization review overpayments	$3,192,267
Hospital utilization review underpayments	($11,180)
Nursing facility utilization review overpayments	$186,385
Nursing facility utilization review underpayments	($3,103)
FFS Recovery Audit Contractor provider recoveries	$27,697,710
Third Party Recoveries	$69,123,597
Clients	**$5,450,088**
Beneficiaries overpayments (SNAP, TANF, Medicaid, CHIP, WIC)	$5,287,281
Voluntary repayments by beneficiaries	$27,554
Electronic Benefits Transfer trafficking beneficiary overpayments	$135,253
Retailers	**$0**
Electronic Benefits Transfer trafficking retailer recoveries	$0
WIC collections	$0
HHS Employees and Contractors	**$90**
State Centers Investigations Team recoveries	$90

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 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 — $376,497,836

Providers and Managed Care Organizations	**$360,193,496**
Provider overpayments from audits and inspections	$0
Provider overpayments from investigations and MCOs	$4,352,534
Provider overpayments from automated scenarios	$2,818,224
Acute care provider overpayments	$934,932
Hospital utilization review overpayments	$4,337,739
Hospital utilization review underpayments	$0
Nursing facility utilization review overpayments	$7,390,523
Nursing facility utilization review underpayments	$0
FFS Recovery Audit Contractor provider recoveries	$37,622,050
Third Party Recoveries	$302,737,494
Clients	**$16,304,334**
Beneficiaries overpayments (SNAP, TANF, Medicaid, CHIP, WIC)	$16,034,841
Voluntary repayments by beneficiaries	$0
Electronic Benefits Transfer trafficking beneficiary overpayments	$269,492
Retailers	**$6**
Electronic Benefits Transfer trafficking retailer recoveries	$6
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; 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 — $45,560,596

Providers and Managed Care Organizations	**$38,183,555**
Medicaid provider exclusions	$0
Fee-for-service front-end claims denial	$38,183,555
Clients	**$7,377,041**
Client disqualifications	$2,668,598
WIC vendor monitoring	$0
Pharmacy Lock-In	$2,472,565
Disqualification of Electronic Benefits Transfer recipients	$2,235,878

III. Provider Integrity

Trends

Medicaid Provider Field Investigations (PFI) continues to examine dental providers whose billing patterns suggest possible fraud, waste or abuse. Issues include billing for a high number of restorations (fillings) in children coupled with lower billing for preventive procedures such as sealants and preventive resin restorations. In many cases, a records review indicates upcoding by the dentist to receive a higher reimbursement for a restoration when post-treatment x-rays reveal that only a sealant was placed.

Investigators also found instances of x-rays not supporting medical necessity for placement of stainless steel crowns (caps), unnecessary removal (extraction) of primary (baby) teeth and upcoding simple extractions by using a more expensive reimbursement code reserved for more difficult extractions.

Additionally, investigations address dental providers billing for an equal number of pulpotomies (root canals) and stainless steel crowns on primary teeth. Often the dental x-rays do not show that a pulpotomy is medically necessary.

Provider Investigations Performance

- **513 Preliminary investigations opened**
- **469 Preliminary investigations completed**
- **68 Full-scale investigations completed**
- **49 Cases transferred to full-scale investigation**
- **198 Cases referred to OAG's Medicaid Fraud Control Unit**
- **93 Open/active full-scale cases at end of quarter**

Another concern within the Medicaid dental program arises when providers bill for services different than the ones they provided or services they did not provide. Examples include billing for x-rays not taken and performing a composite (white) restoration while billing for a stainless steel crown.

PFI is also examining the high utilization of Advanced Life Support (ALS) emergency transport compared to Basic Life Support non-emergency or emergency transport. In these situations, the medical records did not support billing for ALS or were not provided.

Further, based on an algorithm developed by OIG fraud data analysts, the Data Reviews team has begun notifying providers of potential overpayments associated with reimbursements for services provided to clients after their date of death. The review spans approximately 900 providers of all types, including physicians, hospitals, pharmacies, therapists, home health agencies and other specialty services.

Case highlights

OIG reaches settlement with 17 Central Texas hospitals

The OIG settled cases in early December with 17 outpatient hospital facilities. The providers were improperly reimbursed for the administration of injections and infusions in the outpatient emergency department; injections and infusions are included in an emergency room service charge and are not reimbursed separately. The providers worked collaboratively with OIG Litigation to resolve these issues, and the OIG agreed to a settlement for all 17 facilities totaling $2,179,158.

South Texas pediatrician settles after improper billing for strep tests

In December 2022, the OIG entered into a settlement agreement with a South Texas pediatric medical clinic for $522,901.

Claims data indicated that between February 1, 2017, through January 31, 2021, the provider billed for a Strep A-Molecular Panel 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 (NCCI), these two services are considered mutually exclusive and should not be reimbursed on the same day for the same recipient. Additionally, according to the CMS Laboratory Date of Service Policy, the date of service must be the date the specimen was collected. The OIG verified that all managed care organizations (MCOs) define the date of service in accordance with CMS policy.

An analysis of this provider's claims data identified instances in which the provider billed the two Strep A tests on the same date of service or within three days of each other, without a subsequent visit, precluding the possibility that another specimen could have been collected for testing. The OIG identified , through data analytics, 23,500 instances in which the molecular panel was improperly billed and reimbursed.

Surveillance Utilization Review Team

Acute care provider recoveries	$228,857
Acute care services identified overpayments	$934,932
Hospital and nursing home (UR) recoveries	$3,192,267
Hospital (UR) claims reviewed	5,059
Nursing facility reviews completed	104
Average number of Lock-in Program clients	3,920

Provider Enrollment and Exclusions

Provider enrollment inventory (applications and informal desk reviews) processed	8,392
Individual screenings processed	18,625
Medicaid providers excluded	52

Preliminary Provider Investigations Opened

Home health attendants	37%
Physicians (individual/group/clinic)	21%
Home health agencies	10%
Dentists	7%
Nursing facilities	4%
Hospital	4%
Pharmacies	3%
Durable medical equipment	2%
Case management	2%
Therapists (counseling)	2%
Adult day cares	1%
Managed care organizations	1%
Ambulance	1%
Eight other categories at less than 1%	5%

Rounded to nearest whole number

Investigation finds pharmacy billing for medication in quantities it did not purchase

On December 20, 2022, the OIG agreed to a $56,302 settlement with a McAllen pharmacy. The OIG's investigation found that from September 1, 2015, through August 31, 2019, the pharmacy's inventory and purchase records did not support the quantities of medications it billed to Medicaid. The pharmacy's contracts and vendor drug

program policy require a pharmacy to maintain records of all National Drug Code purchases. The OIG identified 14,160 instances in which the pharmacy billed for quantities of medications not accounted for in the pharmacy's purchase records.

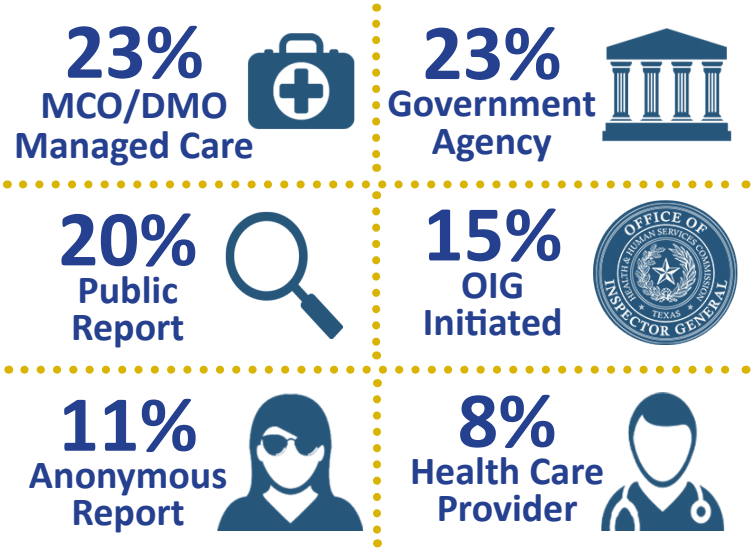
OIG reaches settlement with a North Texas therapy provider

The OIG settled another case in December with a therapy provider who self-reported to the OIG that a certified occupational therapist assistant was falsifying time records from May 28 through June 25, 2022. The falsified records claimed services were provided that had not been performed. As a result, the provider received $1,410 in Medicaid payments for the employee's fabricated services; the provider agreed to repay Medicaid.

OIG issues letter to Abilene mental health professional

The OIG issued an educational letter in December to a qualified mental health professional located in Abilene, who was new to the profession. The provider improperly submitted time for services never rendered from January 13, through February 15, 2022. The provider worked collaboratively with OIG Litigation to resolve the issues and took responsibility for his billing.

Investigation Referral Sources



Types of Full-Scale Provider Investigations

Physicians (individual/group/clinic)	22%
Hospitals	20%
Home health agencies	18%
Pharmacies	8%
Ambulance	6%
Dentists	6%
Durable medical equipment	6%
Six other categories at less than 3%	14%

Rounded to nearest whole number

OIG reaches settlement with a North Texas pediatrician

The OIG settled a case in January with a pediatric home care provider who self-reported that a licensed vocational nurse was providing pediatric home care services at locations other than the patient's home, in violation of the provider's policy and agreement with HHS. The violations, which occurred from July 12 through August 5, 2022, resulted in overpayments of $5,305. The OIG settled with the provider, who reimbursed the full amount.

Attendant excluded for 10 years

The OIG settled a case with a Starr County home health provider wherein a personal care attendant submitted service hours that were not rendered. The attendant was excluded from Medicaid for 10 years, beginning in November 2022. The home health provider worked with the OIG to resolve this issue and the OIG agreed to a settlement of $23,308 in December.

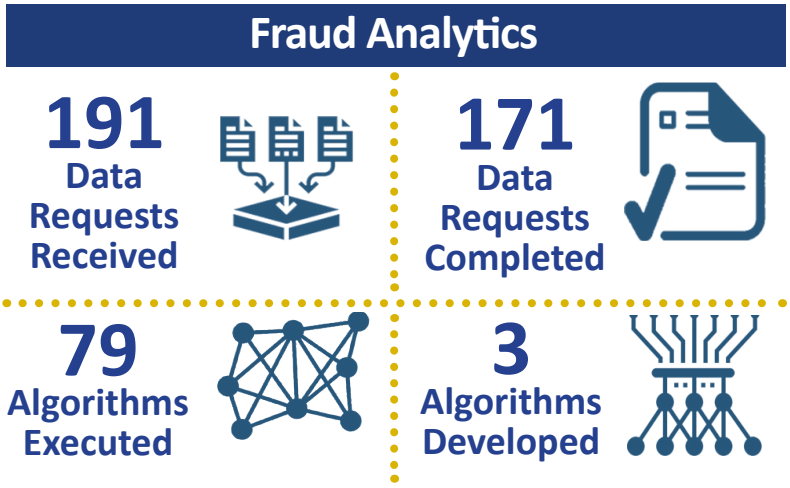
OIG excludes unlicensed home health operator for 20 years

In December, the OIG excluded the owner of an unlicensed home health care agency in the Beaumont area. The owner entered into a home health contract with an elderly individual but failed to provide services. The owner also checked the individual into a motel where he subsequently suffered hypertensive episodes that were not timely or appropriately addressed or referred to medical personnel. As a result of the OIG investigation, the owner was excluded from Texas Medicaid for 20 years.

Agency highlights

Advanced algorithms developed for durable medical equipment payments

The OIG's Fraud Analytics team developed a set of complex algorithms to identify potentially improper payments for durable medical equipment. The algorithms flagged payments that do not meet NCCI or CMS payment rules. NCCI payment rules (edits) include procedure-to-procedure edits (pairs of services that should not be billed together on the same day) and medically unlikely edits, which represent the maximum quantity of a service for a client on the same day under most circumstances.



Data Reviews division established

To realize the OIG's strategic priority to serve as a data-driven organization, several teams from across the OIG were reorganized into a new Data Reviews division in February 2023. The Data Reviews division includes the Data Initiatives Project Team, Targeted Queries team, Recovery Audit Contractor team, Third Party Recoveries team and the Provider Enrollment Integrity Screenings team. By combining similar functions that leverage data to detect, deter and prevent fraud, waste and abuse in Texas' public health care systems, the OIG expects to enhance knowledge-sharing across the teams, promote process efficiencies and create opportunities to further enhance its work using data-informed insights.

Home health agency fraud detection operation

The OIG opened full-scale investigations of two providers identified for the home health agency (HHA) fraud detection operation (FDO) originally reported in the first quarter of fiscal year 2023. The HHA services reviewed in this FDO included personal care services, out-of-facility respite care, private duty nursing for clients aged 20 and under and personal assistance services and out-of-facility respite care for clients aged 21 and older. Each Medicaid program and service requires that the provider keep thorough medical records to show that the service was necessary and administered correctly. Records reviews and interviews determine if these and other requirements have been met.

A review of records from the two providers revealed that key required items were missing from the clients' medical record, including physician orders, progress notes, assessments, reassessments and plans of care. This support is integral to ensuring that clients receive the appropriate amount, duration and scope of Medicaid-funded services.

Referral of the two referenced providers for full-scale investigation will allow a closer look at patterns within the providers' billing and medical records. Full-scale investigations could include additional interviews and review of a larger set of client medical records to gain a broader understanding of the provider's operations. The next FDO is scheduled for FY 2023 Q3 and will focus on chemical dependency treatment facilities and substance use disorders.

NFUR adopts more efficient and collaborative review process

The OIG Nursing Facility Utilization Review (NFUR) team performs retrospective utilization reviews of nursing facility records to evaluate whether facilities correctly assessed and documented Medicaid residents' needs. The reviews also determine if the appropriate level of care was provided and medically necessary. New NFUR rules enacted in February allow reviews to be conducted onsite in an unannounced or announced format or through an off-site desk review. Previously, all reviews were conducted onsite. The changes streamline the review process and allow greater flexibility in records request timelines.

Based on a request that came from the OIG's community of facilities, NFUR onsite nurse reviews will now be completed the same business day the nurse arrives. Previous onsite reviews ranged from three to five days. The enhancements began in December. The OIG also sent letters to long-term care associations announcing the new record request timelines. The OIG is also operating a helpline and developing a user guide to assist providers submitting the requested electronic documents for review. Bi-annual education sessions about facility preparedness during a review will be offered to assist facility staff members who have never experienced a NFUR review. Stakeholder meetings will provide updates, reminders, feedback and information shared during reviews.

Completed reports

Thompson Emergency Shelter, Operated by Boysville, Inc.: A Texas Department of Family and Protective Services Contractor

The OIG initiated this audit of Thompson Emergency Shelter, operated by Boysville, Inc. (Boysville), as part of an ongoing risk assessment of Texas Department of Family and Protective Services (DFPS) contracts for the provision of essential services to children in the state's conservatorship. The audit objective was to determine whether Boysville had processes and controls in place to ensure it provided foster care services at Thompson Emergency Shelter in accordance with selected statutes, contract terms and minimum standards. Boysville is a not-for-profit children's home and shelter. This audit focused on operations at the Thompson Emergency Shelter, near San Antonio, which provides emergency care for boys and girls, ages 0 through 17, for up to 90 days. During that time, Boysville identifies more permanent placement options for those children. Thompson Emergency Shelter served 142 children during fiscal year 2022.

Audit Performance

$93,912
Overpayments Recovered

$0
Overpayments Identified

1
Audit Report Issued by OIG

29
Audit Reports In Progress

Audit Issued 1

Thompson Emergency Shelter, Operated by Boysville, Inc.: A Texas Department of Family and Protective Services Contractor

Boysville had processes and controls in place to ensure that the Thompson Emergency Shelter met selected requirements designed to ensure the health and safety of children in its care. For the sample of staff records tested, Boysville obtained background checks, performed required drug testing, and ensured that staff completed required training. Additionally, for the applicable children's records tested, Boysville completed preliminary and initial service plans that included all selected elements. These plans are important because they help providers identify and address children's needs.

However, Boysville should strengthen its processes and controls over cost reporting and payments and some caregiver services. Specifically, Boysville did not always:

- Maintain documentation to support the allowability of expenses on its 2021 cost report.
- Identify all discrepancies in payments received from DFPS.

- Provide evidence that it met child-to-caregiver ratio requirements.
- Ensure that children underwent initial health screenings within 72 hours of admission, as required.

The OIG recommended that Boysville:

- Develop and implement processes to ensure it supports the allowability and accuracy of expenses included on its cost report.
- Strengthen its processes and controls to identify, report and resolve payment discrepancies to DFPS and work with DFPS to determine if there is an overall underpayment or overpayment for 2022 and resolve that discrepancy, if applicable.
- Develop and implement processes and controls to (a) document the time all staff are on duty by cottage and (b) monitor cottages to ensure minimum child-to-caregiver ratios are met.
- Strengthen its processes and controls to ensure health screenings and service plans are performed within required timelines and documented.

Audits in Progress	29
Selected DSHS Contracts	
Selected Women's Protective Services Grantees	
Selected Health, Developmental, and Independence Services Contracts	
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	
Selected Prescribed Pediatric Extended Care Centers	
Selected Family Violence Prevention Program Providers	

Inspections in Progress	3
Durable Medical Equipment Wound Care Supplies Billing	
Mental Health Private Psychiatric Funds	
Emergency Ambulance Claims Oversight	

IV. Client Accountability

Trends

The OIG contracts with a third-party vendor for the Tort Motor Vehicle Program (MVP). The vendor performs data matching with a national data warehouse in which multi-state casualty claims (car accidents, slip-and-fall accidents and other accidents) are recorded. This data match identifies claims involving Texas Medicaid clients with injuries that are the subject of a settlement with, or judgment against, a liable third party that may be subject to recovery by the state. All matches are reported to the state which investigates to determine if the claim may be subject to recovery. If appropriate, the state then pursues the recovery from the liable third party. The MVP vendor has continued to expand their program through outreach and partnership with additional insurance carriers. This has resulted in a significant increase in tort recoveries.

Benefits Program Integrity Quarterly Performance

$5,287,281
Overpayments Recovered

3,018
Cases Completed

3,700
Cases Opened

15
Cases Referred for Prosecution

185
Cases Referred for Administrative Disqualification Hearings

In the second quarter of the 2023 fiscal year, the OIG recovered $1,809,015 directly from data matches made by the vendor. This is a 79% increase from the $1,012,267 recovered during the same period in fiscal year 2022.

Case highlights

Jefferson County client guilty of SNAP fraud

A woman in Beaumont pleaded guilty to fraud in the 252nd District Court, Jefferson County, Texas. The verdict is the result of an OIG investigation. The client applied to receive SNAP benefits seven times, beginning in December 2018. On each application, she falsely claimed the household either had no income or the only income was from her self-employment. However, OIG investigators determined the client had legal access to a joint bank account with her children's father. The joint bank account had monthly deposits not reported as income accessible to the individual. Based on the unreported unearned income, the household received $17,953 in excessive SNAP benefits from February 2019 through June 2022. In January 2023, the client pleaded guilty and was sentenced to five years' deferred probation. The client also signed a disqualification agreement resulting in a 12-month SNAP disqualification and was ordered to pay $17,481 in restitution to Texas Health and Human Services.

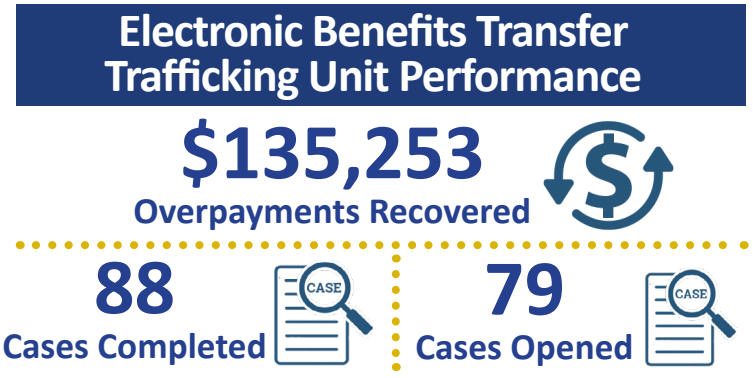
Edinburg client pays full restitution

A woman in Edinburg paid full restitution as the result of a pre-trial diversion by Hidalgo County prosecutors. The restitution follows an investigation by the OIG. The client applied to receive SNAP benefits on October 6, 2015, claiming under penalty of perjury that the household's income was from Social Security benefits. However, OIG investigators found a joint bank account with consistent deposits not reported during the application process. If the client had truthfully disclosed the household's income, the benefits would have been reduced. The client continued to falsely report the household's income from October 2015 through December 2019. In total, she obtained $26,436 in Medicaid and CHIP benefits she was not entitled to receive. In December 2022, the client paid full restitution and state prosecutors filed a motion to dismiss. Subsequently, a Hidalgo County district judge formally dismissed the case.

V. Retailer Monitoring

Trends

Electronic Benefits Transfer (EBT) Trafficking Unit continues to receive referrals regarding the skimming and cloning of EBT cards from point of sales devices in retail stores. The scheme involves suspects altering the point-of-sales unit with a skimming device designed to capture the 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 to purchase items from a different retailer and deplete the account's benefit balance without the client's knowledge. OIG investigators are working closely with state and federal partners to address this issue. OIG Communications added SNAP skimming prevention resources to its website, including a report on SNAP skimming.



The Women, Infants and Children (WIC) Vendor Monitoring Unit (VMU) conducted 69 compliance buys across the state for this quarter. A compliance buy is a covert in-store inspection. An OIG inspector poses as a WIC client and uses a WIC EBT card to make purchases to ensure vendors are following WIC rules. Violations were cited during 42 of the 69 store visits; common violations include not prominently displaying prices for WIC-approved items and improperly labeling a food as WIC-approved when it is not authorized on the WIC program.

The team completed 103 inventory reviews across the state. An inventory review is a comparison of a vendor's paid claims and their purchase invoices for WIC food items. The purpose of the inventory review is to determine if the vendor had a sufficient inventory of WIC food items to justify their submitted claims. Inventory reviews conducted this quarter resulted in complete compliance for all vendors.

WIC VMU also conducted 144 onsite store inspections, with 14 violations cited. The inspection is an overt in-store assessment in which the OIG works with the respective WIC vendor to identify any deficiencies with the sale of authorized WIC products.

Texas WIC also discontinued the ability for participants to redeem alternative formulas on February 28, 2023. The WIC VMU will resume monitoring formula by mid-year, after a grace period for vendor transition.

Case highlights

Hidalgo County retailer disqualified for SNAP fraud

EBT investigated a Hidalgo County retailer who allegedly exchanged cash for SNAP benefits and allowed the purchase of ineligible items with SNAP benefits. In an interview with OIG investigators, the store's owner confessed to both allegations. Nine recipients were identified as participants in the trafficking scheme; they were referred to the Administrative Disqualification Hearing process for potential disqualification or payment recovery. This case was referred to USDA Food Nutrition Services for review, and the retailer was permanently disqualified from the SNAP program in January.

SNAP recipient and food truck owner investigated for benefits trafficking

The EBT Trafficking Unit received a complaint from the OIG Benefits Program Integrity Unit (BPI) alleging a recipient sold her SNAP benefits to a food truck owner who purportedly used the SNAP benefits to purchase food truck inventory. The client confessed to selling the SNAP benefits to the food truck owner in exchange for lodging. The investigation also uncovered evidence that the food truck owner used the SNAP benefits at a big box store and used other SNAP clients' cards on the same account. The case is being referred to the district attorney's office for criminal prosecution.

Undercover operation nabs retailer suspected of SNAP fraud

EBT Trafficking opened an investigation after analysis of a retailer's transaction history revealed suspicious purchases based on the fraud indicators contained in the OIG's algorithms. EBT Trafficking investigators conducted an undercover operation where they successfully exchanged SNAP benefits for cash and purchased ineligible items with SNAP benefits. The investigation also revealed that the store owner is a SNAP recipient who failed to disclose ownership or income from the store when applying for those benefits. The case is being filed with the district attorney's office for criminal prosecution.

VI. HHS Oversight

Trends

Internal Affairs (IA) worked on 61 active investigations and closed 42 investigations in the second quarter. IA processed 129 referrals and investigated 44 of those referrals. The remainder were forwarded to the appropriate business areas, including the Office of the Independent Ombudsman for State Supported Living Centers; 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 client or supervisor allegations against DFPS employees. This may be the result of increased DFPS scrutiny, DFPS management establishing quality assurance processes to identify misconduct, as well as a greater number of clients alleging caseworker misconduct.

IA is now regularly surpassing 100 referrals received per quarter; many referrals come from entities unaffiliated with a state agency or HHS.

Internal Affairs Performance

42 Cases Completed

44 Cases Opened

Open Internal Affairs Cases by Type

Falsifying information/documents	31%
Benefits fraud for personal gain	16%
Unprofessional conduct	12%
Tampering with a government record	8%
Privacy incident/breach	8%
Time/leave abuse	5%
Theft	3%
Moonlighting	3%
Law enforcement assist	3%
Contract fraud	3%
Travel fraud	2%
Misuse of state property	2%
Conflict of interest	2%
Bribery	2%

State Centers Investigations Team Performance

293 Cases Completed

302 Cases Opened

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 second quarter of fiscal year 2023 they opened 302 investigations and completed 263 investigations with an average completion time of 26.5 days. This compares to 164 opened investigations and 148 completed investigations in the first quarter of fiscal year 2023. In the second quarter of 2022, SCIT opened 165 investigations and completed 125 investigations.

Case highlights

Privacy breach investigated

IA recently investigated a case involving a terminated HHS Texas Works Advisor who allegedly accessed client information to create a fictitious SNAP approval letter. The investigation, begun after the employee's termination for other issues, established that the advisor accessed two clients' information without a legitimate business need and altered HHS documents to create a fictitious document. There was no evidence to indicate the employee

followed through with the attempt to create a forgery or received any benefits. There was not sufficient evidence to support a criminal violation of Texas Penal Code Section 37.10, Tampering with Governmental Records, or Section 23.21, Forgery. As a result, the criminal allegations were not sustained. However, the allegation the employee violated HHS Work Rules and Information Security Standards and Guidelines was sustained.

Unprofessional conduct found in violation of SSLC policy

IA investigated a case involving a State Supported Living Center (SSLC) employee who allegedly recorded a client with their cellphone. SSLC policies limit the use of cellphones to emergency communications and prohibit unapproved photos or videos of SSLC clients. Policies such as these are crucial to protecting the privacy of state facility residents. Investigators examined video surveillance of the incident, which was insufficient to support the allegation the employee photographed the client. However, the video evidence established the employee violated policy when they were observed with their phone out, held up, and running an app. The employee was terminated during the course of the investigation.

Abuse case referred for prosecution

A recent SCIT case involved accusations of physical abuse to a client at a state supported living center. The SCIT investigator conducted interviews and reviewed surveillance video, finding ample evidence to corroborate the allegation. The case was subsequently referred to the county district attorney for criminal prosecution.

Policy recommendations

The OIG provides program integrity feedback on policy changes

HHS requested program integrity feedback from the OIG on advance care planning, a new medical benefit for Medicaid clients that includes face-to-face or audio/video communication between a health care provider and patient (or the patient's designee) to discuss future health care wishes should the patient become unable to make decisions about their care. The OIG recommended that the advance care planning policy specify the age range, diagnosis codes and limitations for which the benefit applies; clarify whether a modifier is to be used by a nurse practitioner or certified nurse specialist; distinguish, where applicable, audio-only or audio/video-specific requirements; and specify whether requirements apply to other providers billing under the same group or entity.

HHS also requested program integrity feedback from the OIG on a private duty nursing policy related to use of the UA modifier for specialized services. The OIG recommended that the private duty nursing policy specify that the UA modifier is for clients with an invasive ventilator dependency or tracheostomy, and remove diagnosis codes relating to other enabling devices and supplemental oxygen codes approved for payment of the UA modifier. All other approved diagnosis codes should be retained. OIG staff also identified approximately $4.2 million per quarter in paid claims for the UA modifier where no diagnosis code was listed. As such, the policy should require inclusion of an approved diagnosis code on claims where the UA modifier is billed.

The OIG provides Medicaid with policy recommendations related to program integrity

With only a few exceptions, Medicaid providers are required to first be enrolled in Medicare. During a recent investigation, OIG staff identified an apparent policy discrepancy relating to Medicare enrollment requirements for durable medical equipment (DME) providers. Current policy exempts Comprehensive Care Program (CCP) providers from Medicare participation requirements but requires CCP DME providers to be enrolled in Medicare. No exemption exists for DME providers that do not serve Medicare-eligible individuals and would not meet Medicare certification requirements. The OIG recommended that this policy be updated to clarify whether DME providers, including CCP DME providers, must be enrolled in Medicare or can be exempt from Medicare participation requirements.

Rules

Nursing Facility Utilization Review rules enacted

The proposed repeal of existing rules and new rules under Title 1, Chapter 371 of the Texas Administrative Code related to NFUR were adopted and published in the February 3 issue of the Texas Register. The adopted rules update and re-organize NFUR procedures and provider requirements, remove 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. These rules became effective on February 9, 2023. The OIG also provided a letter to nursing facility advocates on February 10, 2023, with additional guidance on document submission timelines under the updated rules.

VII. Stakeholder Engagement

Surveillance Utilization Review meets with stakeholders

Surveillance Utilization Review (SUR) continues to educate and inform stakeholders of utilization review activities and updates. The unit held quarterly meetings in December 2022 for NFUR and in October 2022 for Hospital Utilization Review (HUR).

The December 2022 HUR meeting focused on clarifying inconsistencies in documentation for various diagnoses and procedure codes. NFUR discussions included updates on NFUR process improvements, common errors found during onsite reviews and changes to the onsite review process.

Texas Fraud Prevention Partnership update

A February 2023 Texas Fraud Prevention Partnership (TFPP) Special Investigative Unit (SIU) meeting included SIU staff from managed care organizations and dental maintenance organizations, along with the Texas Office of Attorney General Medicaid Fraud Control Unit (MFCU). The OIG Data Initiatives Project Team provided an overview of their investigative work, and Amerigroup provided information on a scheme involving the misuse of a specific code for durable medical equipment. Additionally, Texas Children's shared photos and information about their 2022 compliance week, wherein staff participated in games and activities to promote fraud, waste and abuse awareness.

Fraud Hotline Performance

8,296 Fraud Hotline Contacts Handled

1,857 Fraud Hotline Referrals Within OIG

1,311 Benefit Recipients

115 Medicaid Providers

40 HHS Employees, Contractors

389 EBT Retailers

2 State Supported Living Centers/ State Hospitals

External Relations Performance

75 Communication Products

96,891 Website Page Views

The OIG also held TFPP SIU one-on-one meetings with Cook Children's, Texas Children's and Superior to discuss their pending investigations, referrals and current fraud, waste and abuse schemes. MFCU staff also participated in the meetings.

Texas Fraud Prevention Partnership leadership meeting

The TFPP is an ongoing collaboration between the OIG and Texas Medicaid and CHIP MCOs who share a common goal in preventing fraud, waste and abuse in the delivery of health and human services.

In January, the OIG held a TFPP MCO Leadership meeting for OIG and MCO leaders to discuss current initiatives and their combined efforts to prevent, detect and investigate fraud, waste and abuse. Topics included the latest trends; MCO referrals; and updates on OIG data operations, audits and surveillance utilization reviews. The next TFPP MCO Leadership meeting is in July 2023.

Conferences, presentations and trainings

Specialized trainings on improper Medicaid payments in outpatient emergency hospitals

Training Summary

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Trainings Conducted This Quarter

In February, the Data Initiatives Project Team (DIPT) completed a series of specialized training sessions provided to OIG investigators and attorneys on improper Medicaid payments in outpatient emergency hospital settings. The training leveraged DIPT's multi-disciplinary approach to detecting and deterring Medicaid fraud, waste and abuse by educating OIG staff about the duplicative and improper payment scenarios involved in the initiative, detailing the Medicaid policy and medical coding research supporting the violations, and demonstrating how to use the associated claims data to clearly explain the violations to providers and payers.

Investigators contribute to criminal justice class

In January, Benefits Program Integrity staff provided a presentation to a Vanguard Academy criminal justice class. This is the second year OIG staff were invited to provide presentations to the class. OIG investigators discussed the types of investigations the OIG performs, how investigations are conducted and how evidence is gathered. The students were engaged and asked many questions pertaining to criminal charges, evidence and interviewing subjects.

Audit participates in annual training

OIG Audit took part in two weeks of division-wide training. The OIG's internal experts presented a varied slate of classes, which were followed by several days of performing a mock audit. The OIG strives to provide abundant internal and external opportunities for auditors to meet their required training hours every year.

Annual civil rights and ethics training completed

Professionalism is the foundation of all OIG values. Our integrity is the most important asset we have in preventing fraud, waste and abuse. OIG Program Support and Training collaborated with the HHS Civil Rights Office and Office of Ethics to provide the annual in-depth training for OIG staff. The Civil Rights Office presented on the wide range of responsibilities and services including employment discrimination, harassment, accessibility and reasonable accommodation requests. The Office of Ethics presented on making ethical decisions, avoiding conflicts of interest and reporting moonlighting and volunteer activities.

VIII. OIG in Focus - Contract Monitoring

The Office of Inspector General's commitment to preventing fraud, waste and abuse includes conducting investigations and risk-based audits related to HHS contracts. Investigations and audits can reveal weaknesses in internal controls and in contract monitoring and oversight. Contract monitoring is the process of ensuring that a vendor adequately performs the service the state pays it to perform.

To assist programs in strengthening their contract monitoring and oversight, the OIG team has compiled lessons learned, based on findings from our work. The following observations by OIG auditors, inspectors and investigators provide opportunities for the agency to continue to strengthen its contract oversight activities:

Ensure the ratio of contract managers to contracts is reasonable
Contract monitoring is labor intensive. Having an adequate number of resources assigned to oversee a contract helps ensure a successful contract life cycle. An adequate ratio of contracts to contract managers that considers the complexity and type of contract facilitates effective oversight.

Strengthen policies and procedures
Written policies and procedures, including the HHS Procurement and Contract Management Handbook, help ensure a consistent, high-quality contract monitoring process. Specific procedures should include guidance on conducting quality assurance of contracts to verify compliance with federal and state laws.

Enhance training for contract managers and staff
Staff training in contract monitoring policies and procedures increases the likelihood that individuals will monitor contracts reliably. Findings in OIG investigations, audits and inspections can often be traced back to lack of training and lack of clear contract monitoring policies and procedures.

Communicate clear expectations to vendors
Planning is integral to contract monitoring. When developing a procurement, the agency should define the clear outcomes, including deliverables and expectations, that will determine success throughout the contract life cycle.

Develop specific contract monitoring plans for high-risk contracts
A specific contract monitoring plan listing expected and completed activities can be used throughout the contract period to mitigate risk for higher risk contracts. A tailored plan helps ensure that monitoring occurs, even in the event of staffing changes.

Maintain contract files in SCOR as required
Contract files should be maintained in the System of Contract Operations and Reporting (SCOR) as required by the Procurement and Contract Management Handbook, and any supplemental files should be organized so that someone could reconstruct and understand the history of the contract.

Consistently link payments to satisfactory performance
Educating first-time and veteran contract holders helps ensure that invoices received and payments made are only for goods or services supported by the contract. OIG auditors and investigators have observed invoice approval without proper review or lacking evidence that work was completed as required.

Conduct on-site monitoring
For certain contracts, as directed by an agency's risk-based monitoring plan, agency officials should conduct random

vendor record reviews to ensure key contract terms are being fulfilled. On-site monitoring visits are most effective when based on a specific methodology or a checklist of review tasks.

Include access to records and right-to-audit clauses in all contracts

Agencies have a responsibility to verify that information from vendors is accurately reported and ensure that funds are appropriately expended. The contract must stipulate that the agency, the OIG, and other oversight entities have authority to access and audit contractor records at any point during or after the contract term. Contracts should also require subcontractors to provide access to records.

An effective contract monitoring system can mitigate risk and prevent errors. For the OIG, auditing contracts is part of its statutory duties related to prevention and detection of fraud, waste and abuse.

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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)