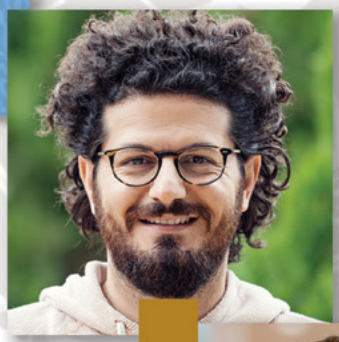


21D0634

Inspector General

Texas Health and Human Services

OIG

Quarterly Report

Quarter 4 Fiscal Year 2022

Table of Contents

I. Executive Summary

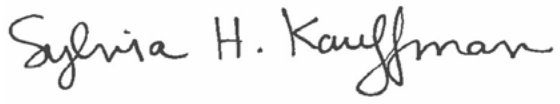
I am pleased to present to Governor Greg Abbott, Executive Commissioner Cecile Young, the Texas Legislature and the citizens of Texas the fourth quarterly report for fiscal year 2022, summarizing the excellent work this office has performed during this period.

From June 1 to August 31, 2022, the Office of Inspector General (OIG) recovered nearly $130 million. For the fiscal year, net recoveries were more than $490 million. In addition, we identified nearly $877 million in potential future recoveries and achieved more than $166 million in cost avoidance.

With a mission to prevent, detect and deter fraud, waste and abuse (FWA) in Texas health and human services delivery, the OIG continues to evolve as the health care landscape changes. This agency has found using data analytics to be the most effective use of state resources and is growing its capabilities to deploy sophisticated technology to detect FWA. Being data-driven allows the OIG to focus its work and build solid, evidence-based cases. This fiscal year, we formalized the Data Initiatives Project Team, which is a multi-disciplinary collective comprised of investigators, data analysts, clinicians, policy specialists, and attorneys who work collaboratively to increase FWA prevention and detection while streamlining operations. Our successes in data analytics this past fiscal year is summarized in the OIG in Focus on page 33.

Collaboration is one of the agency's core values. That's why we are working with law enforcement agencies across Texas to hold individuals accountable who seek to defraud public health and human services. Our commitment to collaboration extends to working with Medicaid providers to prevent FWA from happening in the first place. The OIG Fraud, Waste and Abuse Prevention Strategy emphasizes stakeholder partnerships and opportunities for training, education and raising awareness while developing recommendations to improve HHS programs and inform future OIG work. We also continue to proactively engage providers by encouraging them to voluntary disclose errors.

The outstanding work performed by the OIG team reflects our commitment to our core values — Accountability, Integrity, Collaboration and Excellence. This team remains dedicated to our mission: ensuring that funds dedicated to providing services to those who need them are spent only for their intended purpose. I am honored to work alongside this outstanding team.



Sylvia Hernandez Kauffman
Inspector General

II. Fiscal Year 2022 Results

Dollars recovered

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

Total dollars recovered	$490,750,025
Audit and Inspections	
Audit collections	$2,223,191
Investigations and Reviews	
Provider overpayments	$49,804,555
Data review overpayments	$7,529,162
Acute Care provider overpayments	$901,607
Hospital overpayments	$13,644,907
Hospital underpayment	($49,069)
Nursing facility overpayment	$1,031,093
Nursing facility underpayments	($13,949)
Recovery Audit Contractor recoveries	$51,936,519
Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC)	$52,310,162
Voluntary repayments by beneficiaries	$163,874
WIC collections	$5,055
Total Investigation and Reviews Recoveries	**$177,264,856**
Third Party Recoveries	**$310,429,095**
Peace Officers	
Electronic Benefits Transfer trafficking retailer and beneficiary overpayments	$832,884
State Centers Investigations Team recoveries	$940
Total Peace Officers Recoveries	$833,824

Dollars identified for recovery

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

Total dollars identified for recovery	$877,869,298
Audit and Inspections	
Provider overpayments	**$5,618,010**
Investigations and Reviews	
MCO identified overpayments	$28,216,217
Acute Care provider overpayments	$1,831,980
Hospital overpayments	$17,617,925
Hospital underpayments	($34,411)
Nursing facility overpayments	$6,040,293
Nursing facility underpayments	($4,072)
Data review overpayments	$7,388,230
Recovery Audit Contractor recoveries	$65,225,285
Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, CHIP, WIC)	$64,715,455
WIC collections	$27,050
Total Investigation and Reviews Identified Recoveries	**$191,023,952**
Third Party Identified Recoveries	**$679,752,888**
Peace Officers	
Electronic Benefits Transfer trafficking retailer and beneficiary overpayments	$1,472,888
State Centers Investigations Team recoveries	$1,560
Total Peace Officers Identified Recoveries	**$1,474,448**

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	$166,960,738
Investigations and Reviews	
Medicaid provider exclusions	$16,910,119
Client disqualifications	$6,793,187
WIC vendor monitoring	$0
Pharmacy Lock-In	$8,080,089
Third Party Recoveries	
Fee-for-service front-end claims denials	**$134,432,731**
Peace Officers	
Disqualification of Electronic Benefits Transfer recipients	**$744,612**

III. Fiscal Year Review

DIPT expands OIG data capabilities

The OIG continues to broaden its use of data analytics to help uncover fraud, waste and abuse (FWA) trends in the health care system by assessing potentially problematic behavior patterns.

The OIG Data Initiatives Project Team (DIPT) is a multi-disciplinary collective comprised of investigators, data analysts, policy specialists, clinicians and attorneys who work collaboratively to increase FWA prevention and detection while streamlining operations. DIPT uses data to identify billing trends that indicate potential violations of Medicaid policy across providers. Whenever DIPT identifies a behavior with one provider that may indicate FWA, it partners with the OIG's data team to initiate a sophisticated data analysis across the Texas health care system to determine whether similar issues are occurring with other Medicaid providers. Depending on the results of this analysis, DIPT may initiate a process that can lead to provider education and/or the recovery of overpayments, as appropriate. Much of DIPT's work in FY 2022 focused on erroneous billing for injections and infusions in hospital emergency rooms.

Fiscal year 2022 performance	
Audit reports issued	36
Audits in progress	13
Inspections reports issued	10
Inspections in progress	8
Total investigations opened	16,423
Total investigations completed	18,656
BPI client investigations completed	15,463
EBT retailer investigations completed	365
Internal Affairs investigations completed	143
State center investigations completed	573
Medicaid provider investigations completed	
Preliminary	1,913
Full-scale	199
PI cases transferred to full-scale investigation	220
PI cases referred to Medicaid Fraud Control Unit	724
Hospital claims reviewed	27,234
Nursing faciltiy reviews completed	388
Medicaid and CHIP provider enrollment screenings performed	62,563
Medicaid providers excluded	174
Fraud Hotline calls answered	26,064
Fraud Hotline handled points of contact	26,533

For an expanded discussion about DIPT, technology and the OIG's varied use of data to detect potential fraud, waste and abuse in Texas health and human services programs – as well as how the agency plans to expand data analytics in the future – see the OIG in Focus on page 34.

Preventing fraud, waste and abuse

Part of the OIG's mission is to prevent FWA from occurring in the first place. In FY 2022, the OIG achieved nearly $44.3 million in cost avoidance, which deterred potentially questionable spending before it could occur. This was achieved through front-end claims denials, client disqualifications, Medicaid provider exclusions, the Pharmacy Lock-In Program and WIC vendor monitoring.

The OIG Fraud, Waste and Abuse Prevention Strategy emphasizes stakeholder partnerships and opportunities for collaboration, training, education and raising awareness while developing recommendations to improve HHS programs and inform future OIG work. In FY 2022, the OIG initiated 42 targeted prevention activities directed at clients, the public, providers, HHS staff and contractors.

The OIG worked with the Texas Dental Association to produce a dental solicitation brochure and presented the information in this brochure to TxHealthSteps (THSteps) staff before distributing the brochure to all THSteps providers. After sharing this information, OIG staff were invited back to present to THSteps caseworkers and various provider groups. The OIG furthered its work with THSteps by reviewing the Preventative Care Medical Checkups Policy and providing comments related to clarifying the use of modifiers for social determinants of health screening provider codes.

Additional stakeholder engagement activities included the OIG's development of an educational video for home health providers and their staff related to personal care attendants, which was posted to an external website. This work led to further collaboration with the Texas Health and Human Services (HHS) Office of Disability Coordination and presentations to attendant care providers. The OIG Communications Team continues to proactively share prevention and education messages through the agency's digital media channels and education articles produced for four leading Texas health care associations. Articles published this year included topics on the OIG's self-report process for providers who discover their own billing errors or program violations; verifying that current or potential employees are not excluded from Medicaid program participation; reporting suspected wrongdoing to the OIG Fraud Hotline; the collaboration between the OIG and Managed Care Organization (MCO) special investigative units; documentation requirements for an OIG record review; and the outcomes of various OIG investigations and data-driven initiatives.

Benefits Program Integrity (BPI) expanded educational efforts in fraud prevention by presenting at two large conferences. In collaboration with the Texas HHS Access and Eligibility Services (AES) Integrity Support Services (ISS) department, BPI presented in September 2021 at the United Council on Welfare Fraud conference. The presentation was given to fraud investigators from across the United States. The presentation focused on ISS and BPI's collaborative fraud prevention efforts and included best practices to successfully bridge fraud prevention efforts during the eligibility process and additional measures for benefit recovery.

BPI also presented in August as one of the keynote speakers at the first annual Texas Fraud Awareness and Prevention Conference. BPI staff presented to Texas HHS AES employees, fraud investigators from across the nation and USDA Food and Nutrition Service stakeholders. BPI provided information on best practices to detect client eligibility fraud, guided eligibility staff on what constitutes an appropriate referral to BPI, defined the necessary information when creating a referral, and discussed fraud trends.

Litigation team settles a record number of cases

This fiscal year proved to be a productive year for the OIG Litigation team, which achieved settlement agreements totaling more than $16 million. The team negotiated settlements to resolve 147 matters in FY 2022 - a record amount of settlements in one fiscal year.

Chart 1 describes the number of case settlements by provider type. Home health allegations are traditionally the most common complaint based solely on the number of cases; however, these traditionally involve much smaller dollar amounts.

Chart 2 describes the amount of settlement dollars by provider type. The The largest settlements involved hospitals. The hospital settlements were

Chart 1.

Provider type	Number of cases	Percent of cases
Home health agency	59	38%
Dental	23	16%
Physician (individual/group/clinic)	20	14%
Hospitals	16	11%
Therapy (counseling)	11	7%
Personal care services	4	3%
Pharmacy	4	3%
Nurses	3	2%
Rehabilitation centers	2	2%
Durable medical equipment	2	1%
Lab/radiology/x-ray	1	1%
Laboratories	1	1%
Ambulance service	1	1%
Totals	147	100%

the result of an ongoing DIPT initiative that identified a common error across the health care system; hospitals were billing for injections and infusions in the emergency department although the charges were already covered by another code.

Chart 2.

Provider type	Amount of settlement
Hospitals	$7,836,276
Home health agency	$3,066,469
Physician (individual/group/clinic)	$1,889,167
Pharmacy	$1,550,380
Dental	$696,723
Rehabilitation centers	$320,153
Personal care services	$287,012
Durable medical equipment	$172,178
Lab/radiology/x-ray	$154,917
Therapy providers	$150,404
Ambulance services	$80,000
Laboratories	$46,287
Therapy (counseling)	$23,432
Nurse	$3,700
Other	$1,310
Total	$16,278,408

All numbers have been rounded

Texas Fraud Prevention Partnership fiscal year update

Throughout the fiscal year, the OIG continued to prioritize formal discussions and collaboration with the Texas Medicaid MCOs through the Texas Fraud Prevention Partnership (TFPP). The TFPP encourages all Texas Medicaid and CHIP MCOs to collaborate with the OIG to strengthen the Medicaid and CHIP programs in Texas.

The OIG hosted TFPP MCO Leadership Meetings three times during FY 2022 to discuss current initiatives and combined efforts to prevent, detect and investigate fraud, waste and abuse.

The OIG also held individual meetings with executive leadership from Texas Medicaid health and dental plans. These meetings covered such topics as illegal dental solicitation; attendant care issues; MCO cost avoidance; preventing COVID-19-related FWA; issues related to current and upcoming OIG audits; updates on hospital and nursing facility utilization reviews; and discussions around OIG data initiatives and the Lock-In Program.

TFPP SIU meetings are held three times each year with MCO Special Investigative Units (SIUs) and the Attorney General Medicaid Fraud Control Unit to share insights and information. The OIG also holds one-on-one meetings with SIU staff at the largest MCOs to discuss their investigations, referrals and trends.

Inspections collaborates to prevent waste in laboratory billing

In May, the OIG Inspections Team, together with HHS Medicaid and CHIP Services (MCS) Medical Benefits Policy, met with all MCOs to share a new process that will allow them to identify and deny claims for laboratory services providers that are not properly certified.

The OIG conducted inspections of all 16 MCOs' processes to ensure laboratory service providers have the appropriate Clinical Laboratory Improvement Amendments (CLIA) certification prior to paying submitted claims.

Laboratories must apply for a CLIA certificate and identify their specialty and sub-specialty areas through the U.S. Centers for Medicare and Medicaid Services (CMS). These specialty and sub-specialty certification codes correspond to specific procedure codes the laboratory has been certified to perform, and thus, bill and receive reimbursement for services associated with those procedure codes.

Through inspections, the OIG found that MCOs did not have processes in place to prevent improper payments to laboratories. None of the 16 MCOs' claims payer systems captured details of each laboratory's CLIA certification(s), and they had no mechanism to deny claims submitted by a laboratory which did not have necessary CLIA certification(s) to perform the services.

The OIG shared this result with HHS MCS Medical Benefits Policy and worked with MCS to provide MCOs with the information they need to ensure they pay only for appropriate laboratory services.

Centralized risk review update

The OIG's policy and audit divisions conduct continuous risk assessments to identify future audit topics. The reviews include research, interviews and data analysis to determine a topic's potential impact on Texas health care programs. Analysis focuses on compliance, health and safety, data integrity and unusual service usage patterns. As a result of this centralized risk review process, OIG staff identified and prioritized areas of focus for audits, inspections, investigations and reviews for FY 2023. They include day care regulation; abuse, neglect and exploitation reporting at nursing facilities; and long-term care improper discharge, among others. The FY 2023 audit and inspections work plan is available on the OIG's website.

Audit team saves taxpayer resources by improving efficiency audits of financial statistical reports

The OIG Audit Division has been refining an approach to auditing MCOs' financial statistical reports (FSRs), an important tool in setting the capitation rates Texas HHS pays to provide Medicaid services. If the expenses reported on FSRs are overstated, capitation rates may be inflated—costing taxpayers more.

The capitation rate is the rate determined each year that HHS pays MCOs per client (member), per month. The rate varies depending on the MCO, the client's risk group, and the client's service area. The "rate cell" refers to the specific rate HHS pays an MCO for serving members in that program, risk group and service area.

MCO administrative expenses, which are reported on the FSRs, also factor into capitation rate determinations. MCO contracts include limitations on administrative expenses and establish provisions to limit profits. The determined amount of profit sharing is called the experience rebate.

MCOs submit FSRs for each program and service area, which totaled 149 separate FSRs in the first quarter of FY 2022. With an abundant amount of data and limited resources, the audit team determined how to potentially contain costs by identifying inaccurate reporting. The OIG worked with independent actuaries and settled on a strategy to find a specific rate cell of a certain program, service area and risk group with high dollar amounts and potential risk of overpayment.

Under the new approach, the OIG identified future potential MCOs for audit operating in the same rate cell while in the audit planning stage. The approach means if the first MCO audit finds significant FSR reporting errors, auditors can quickly use that same audit plan to look at another MCO operating in that same cell to potentially identify systemic issues that might be translated across the entire population.

Identifying unallowed costs on the FSR reduces expenditures reported by MCOs. This reduction in MCOs' expenditures could result in MCOs returning additional experience rebate amounts and ultimately lower rates—saving taxpayer dollars.

The two FSR audits performed in FY 2022 yielded these results:

- The first audit was limited to looking at just the administrative costs of operating the MCO. Auditors reviewed expenses on selected line items reported to determine if they were allowable and found approximately $1.5 million in unallowable costs that were included in the FSRs, affecting prospective rates. The estimated experience rebate to be returned to the state is $681,000.

- The second audit included reviewing medical expenses and administrative payments made to affiliated companies. The MCO is required to prove they are paying these affiliates at or below fair market value. There is a risk that the MCO could overstate their expenses. An affiliate relationship potentially allows an MCO to shift revenue and expenses in a way that the MCO shows elevated expenses while the affiliate is paid

at an above fair market value. This audit identified approximately $8.2 million in over-reported costs, which resulted in an experience rebate of $4.4 million being returned to the state.

Not only are audits recovering excessive experience rebates, but they also ensure these unallowable costs do not affect future capitation rates—saving future taxpayer resources. The OIG plans to employ the lessons learned in FY 2022 to future FSR audits in FY 2023 and beyond.

The importance and complexity of this contract work has led to the need to augment the OIG's audit team. In the coming fiscal year, the agency hopes to secure additional resources to create a complex contracts audit team. Highly complex health and human services contracts are used across the system, including to provide services related to Medicaid, child protection and public health. These contracts are multifaceted, and vendors often have intricate ownership and reporting structures. The new team will be instrumental in auditing complex financial, statistical and performance information, which is critical as health and human services functions are increasingly provided by large vendors through complex contracts.

OIG collaborates with other agencies to stop health care fraud

The OIG continues to strengthen its collaboration with law enforcement agencies across Texas.

As a partner in the FBI's McAllen Criminal Investigations Division Task Force the OIG assisted with a durable medical equipment provider investigation. According to the indictment, the provider billed Medicaid more than $4 million between 2006 and 2013 for claims that were supported by either false or missing documentation. The case was referred to the U.S. Attorney's Office for prosecution. The provider pled guilty to conspiracy to commit health care fraud and agreed to pay $3,652,195 in restitution.

A U.S. Marshal contacted a BPI investigator regarding the shooting death of a 75-year-old man in his Weslaco home. Surveillance video captured the suspect's vehicle, and deputies contacted BPI when they identified the truck at a convenience store minutes prior to the shooting. The BPI investigator provided the suspect's name and address based on the EBT card used at the store. Authorities arrested a 35-year-old man who confessed that while driving, he shot his gun towards the victim's house with no intention of shooting the victim. The suspect was charged with manslaughter.

The EBT Trafficking Unit in Grand Prairie provided information that led to a homicide suspect's arrest. The Plano Police Department identified a suspect in the fatal shooting of a 22-year-old Dallas resident and asked EBT to locate the suspect, who was believed to be a SNAP client. OIG investigators conducted searches and provided information that directly resulted in the suspect's apprehension.

A BPI investigator determined that a man who applied for and received Medicaid and Social Security Disability Insurance benefits was a Mexican citizen. He fraudulently received more than $247,000 in government assistance payments over a six-year period. He was sentenced to 45 months in prison and was ordered to pay full restitution. The OIG worked with U.S. Homeland Security Investigations and the Office of Inspector General – Social Security Administration on the case.

Texas providers continue to self-report

Medicaid providers are increasingly using the OIG's self-report process to resolve cases. Self-reports in FY 2022 led to the resolution of 50 cases. This is compared to 45 cases resolved through self-reporting in FY 2021. The OIG closed 33 self-reports in FY 2020. Providers and managed care organizations may use the OIG Fraud Hotline or website at any time to report any compliance or overpayment matters relating

Self-report settlements by year

Fiscal year	Number of cases	Settlement amount
2017	26	$251,271
2018	12	$1,066,666
2019	14	$2,373,450
2020	33	$23,507,585
2021	45	$8,171,252
2022	50	$6,375,481

to themselves. The OIG considers self-reporting as a potential mitigating factor in determining the appropriate enforcement action.

The OIG responded to the increased use of the self-report process by publishing an easy-to-follow guide that explains the self-report process. The provider types that utilized the self-report process include clinics, hospitals, home health agencies and mental health rehabilitative services. The resolved self-reports in FY 2022 resulted in settlements totaling $6,375,481. In FY 2021, settlements totaled $8,171,252.

OIG develops Automated Fraud Data Analytics Model

The OIG continues to enhance fraud detection using funds from a U.S. Department of Agriculture (USDA) grant to build data-driven methods of identifying beneficiary fraud in SNAP. The OIG's Benefits Program Integrity (BPI) division was one of nine state agencies across the country to receive a share of the $5 million SNAP Fraud Framework Implementation Grant awarded in September 2020. Agencies received funding for two years to implement innovative concepts and best practices aimed at improving state efforts to detect, investigate and prevent SNAP misuse.

With the awarded funds, the OIG partnered with a vendor to create the Automated Fraud Data Analytics Model, a user-friendly tool that identifies potential cases of SNAP fraud, waste or abuse (FWA). The SNAP model is comprised of two different dashboards. The first displays cases with the greatest potential for FWA calculated through a series of algorithms analyzing eligibility, EBT transactions and investigation data with BPI feedback. All the data from its three main sources (eligibility, EBT transactions and investigations) are easily viewable to OIG investigators for each of the cases identified in this dashboard. BPI designated a specialized team to review identified cases with the greatest potential for FWA and determine if a full-scale investigation is warranted.

The second dashboard allows users to query the Texas Integrated Eligibility Redesign System (TIERS) for data elements and various identifiers that aid in detecting fraud. The purpose is to make the investigative process more efficient. The new search features allow investigators to search for data in a variety of ways to better identify and substantiate fraud, waste and abuse.

BPI recovers $52 million, the most ever

BPI established over $64 million in claims identified for recovery and recovered more than $52 million in the SNAP, TANF, Medicaid, CHIP and WIC programs. In addition, BPI completed more than 15,000 investigations.

Lock-In program helps fight prescription drug abuse

The Texas health care community plays a critical role in stemming the tide of prescription misuse through participation in the the Medicaid Lock-In Program (MLIP).

MLIP is a resource for medical professionals to identify patients who may need help with substance use issues. Through the MLIP, the OIG reviews referrals and data to determine if a Medicaid client meets the criteria for lock-in to a single designated pharmacy and/or prescriber.

In FY 2022, the OIG Lock-In Program resulted in $7,282,610 cost savings to Texas taxpayers. MCOs continue to play a key role in identifying and referring clients to the program. In FY 2022, the OIG received 2,071 referrals from MCOs, a 14 percent increase from FY 2021 MCO referrals (1,822).

Fraud detection operations update

The OIG is actively pursuing eight investigations originating from the agency's fraud detection operations (FDOs), and 11 have been transferred to Litigation for possible administrative enforcement action. FDOs are data-driven initiatives that detect the potential for waste or wrongdoing by first identifying providers with unusual billing patterns when compared to their peers.

Typical violations identified in the investigations included solicitation of services, providing medically unnecessary services, upcoding services and not maintaining appropriate medical records to support billing. In FY 2022, FDOs were reduced from four per fiscal year to two, allowing for more detailed planning and selection of provider types, practices and operations.

OIG RAC Program educates providers to increase compliance

In FY 2021, the OIG began an initiative to increase provider compliance, including addressing the high rate of technical denials in the Recovery Audit Contractor (RAC) program. Technical denials occur when a provider does not supply any response to a record request or when a response is given that does not include a valid affidavit. The Social Security Act requires states to engage one or more recovery audit contractors for the purpose of identifying underpayments and overpayments and recouping overpayments in Medicaid fee for service. The OIG assumed responsibility for the RAC program in 2016 and has engaged in ongoing continuous improvement efforts.

The OIG credits recent efforts to increase provider engagement with a decrease in technical denials. Overall RAC program compliance increased from 87 percent in May 2021 to 96 percent as of May 2022. Additionally, the overall technical denial rate has decreased, from 16 percent in May 2021 to less than seven percent as of May 2022. The OIG credits the following initiatives for some of the positive developments:

- Increased communications with providers to ensure that providers do not overlook RAC record requests or updates.
- Deployment of an efficient provider portal for submitting documents, which simplified document submission and tracking.
- Use of an electronic attestation (instead of an affidavit) for document submission via the portal, which reduces technical denials based on affidavit issues.

The OIG met with providers with high technical denials in FY 2022 to discuss the RAC program and the providers' processes for responding to medical record requests. The OIG hopes the meeting will further improve compliance. The OIG will continue to track, monitor and oversee the RAC to produce the maximum recoveries and best outcomes for Texas taxpayers.

Enhancing OIG training

The OIG's Program Support and Training (PST) team guides training throughout the agency to meet a Legislative Budget Board (LBB) key performance measure. During FY 2022, the agency provided 179 staff trainings, surpassing the performance measure target of 150

The OIG Program Support and Training team's expertise in professional development ensures training is effective, includes sound objectives, and is applicable to the agency's mission. FY 2022 trainings included Researching Statues, Code of Federal Regulations and Texas Administrative Code; Clear and Credible Communication; Time Management for Audit, Inspections and Investigations; and Children's Medical Services.

The agency also continues to expand a library of computer-based and on-demand training opportunities. The digital library contains a variety of content relating to new employee orientation, leadership skills and Medicaid basics. The agency plans to continue to move more resources to the new platform.

OIG team members gives the agency high marks

Serving the people of Texas requires a talented and engaged team of professionals. The OIG regularly examines the workplace attributes required to attract and retain committed team members. A biannual survey of employee engagement drives that effort.

The survey measures employee development, benefits, supervision, job satisfaction, the work environment and seven other categories. More than half of all team members responded to the survey, a high response rate suggesting an investment in the agency and a willingness to contribute toward workplace improvements.

Eighty-six percent of employees responding to the survey ranked themselves as highly engaged, engaged or moderately engaged. Employees highly ranked the agency's supervisory relationships, strategic vision and workplace environment. Reflecting national trends, pay and employee development appeared as areas to improve.

IV. 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	$130,515,530
Audit and Inspections	
Audit collections	**$1,069,697**
Investigations and Reviews	
Provider overpayments	$20,095,098
Data review overpayments	$2,586,366
Acute Care provider overpayments	$245,060
Hospital overpayments	$3,377,541
Hospital underpayment	($34,411)
Nursing facility overpayment	$121,935
Nursing facility underpayments	($4,072)
Recovery Audit Contractor recoveries	$11,197,690
Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC)	$15,872,516
Voluntary repayments by beneficiaries	$46,837
WIC collections	$0
Total Investigation and Reviews Recoveries	**$53,504,560**
Third Party Recoveries	**$75,689,915**
Peace Officers	
Electronic Benefits Transfer trafficking retailer and beneficiary overpayments	$254,359
State Centers Investigations Team recoveries	$0
Total Peace Officers Recoveries	**$254,359**

Dollars identified for recovery

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

Total dollars identified for recovery	$233,872,215
Audit and Inspections	
Provider overpayments	**$5,589,925**
Investigations and Reviews	
MCO identified overpayments	$10,551,493
Acute Care provider overpayments	$1,200,698
Hospital overpayments	$3,992,792
Nursing facility overpayments	$3,034,670
Data review overpayments	$2,614,983
Recovery Audit Contractor recoveries	$19,113,160
Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, CHIP, WIC)	$16,099,534
WIC collections	$322
Total Investigation and Reviews Identified Recoveries	**$56,607,652**
Third Party Identified Recoveries	**$171,289,687**
Peace Officers	
Electronic Benefits Transfer trafficking retailer and beneficiary overpayments	$384,952
State Centers Investigations Team recoveries	$0
Total Peace Officers Identified Recoveries	**$384,952**

Cost avoidance

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

Total cost avoidance	$44,324,975
Investigations and Reviews	
Medicaid provider exclusions	$4,265,695
Client disqualifications	$1,666,787
WIC vendor monitoring	$0
Pharmacy Lock-In	$2,157,956
Third Party Recoveries	
Fee-for-service front-end claims denials	**$35,970,538**
Peace Officers	
Disqualification of Electronic Benefits Transfer recipients	**$264,000**

V. Provider Integrity

Trends

Medicaid Provider Field Investigations (PFI) continues to examine pharmacies whose billing patterns suggest possible fraud, waste and abuse. Pharmacies that exhibit patterns such as billing for pharmaceuticals for which they do not maintain enough inventory to dispense or that have a high percentage of complete refill rates are flagged for further investigation. Invoices, obtained through the pharmacies directly or through their wholesale suppliers, are compared to inventory levels to identify unsupported claims for payment. PFI also reviews pharmacy records to determine if medications were dispensed according to the prescriptions. Provider Field Investigations also may interview clients and prescribers as needed, based on the allegations or other evidence. Pharmacies that are found to have billed for one drug code but dispensed another, higher-paying code are subject to recoupment and other sanctions.

Provider Investigations performance	
Preliminary investigations opened	500
Preliminary investigations completed	523
Full-scale investigations completed	43
Cases transferred to full-scale investigation	48
Cases referred to OAG's Medicaid Fraud Control Unit	209
Open/active full-scale cases at end of quarter	68

Case Highlights

Harnessing the power of data continues to lead to settlements

The OIG's Data Initiatives Project Team (DIPT) is a multi-disciplinary collective comprised of investigators, data analysts, policy specialists, clinicians and attorneys who work collaboratively to increase FWA prevention and detection by using data to identify patterns that indicate Medicaid policy violations across providers.

The following cases are examples of how the agency's use of sophisticated data analysis to analyze billing patterns resulted in settlements:

- In June, the OIG settled 18 cases with a national home health provider whose medical records did not support the use of the UA modifier for some clients. The UA modifier provides additional reimbursement for patients who are ventilator-dependent or have a tracheostomy. The provider worked with the OIG to resolve these issues, and the OIG agreed to a settlement of $1,834,150.

- The OIG settled four cases in July with a hospital system. The cases involved hospital outpatient facilities in Amarillo, Denison, Edinburg and Laredo that billed for and were paid separately for injections/infusions

Surveillance Utilization Review Team	
Acute care provider recoveries	$245,060
Acute care services identified overpayments	$1,200,698
Hospital and nursing home (UR) recoveries	$3,460,993
Hospital (UR) claims reviewed	5,866
Nursing facility reviews completed	112
Average number of Lock-in Program clients	3,880

Provider enrollment and exclusions	
Provider enrollment inventory (applications and informal desk reviews) processed	5,876
Individual screenings processed	13,043
Medicaid providers excluded	51

Fraud Analytics and Data Operations	
Internal Data requests received	214
Internal Data requests completed	166
Algorithms executed	53
New algorithms developed	9

when the same services were already covered by another billing code paid on the same date of service. Injections and infusions are included in an emergency room service charge and are not reimbursed separately. The provider worked with the OIG to resolve these issues, and the OIG agreed to a settlement of $1,200,000.

- In July, the OIG settled a case with a neurological clinic in Houston. Neurologists and other clinicians billed for electroencephalographic (EEG) services which require 24-hour monitoring by a clinician who can intervene in the monitoring and/or patient care as needed. The OIG identified providers who equipped patients with mobile EEG units and sent them home for overnight monitoring without 24-hour monitoring by a clinician. As a result, the providers inappropriately received a higher reimbursement amount. The provider worked with the OIG to resolve these issues, and the OIG agreed to a settlement of $250,000.

OIG settles case with a pediatric home health care provider

The OIG settled a case in June involving a Plano pediatric home health care provider. The provider billed incorrectly for claims and lacked doctors' authorizations to support some of the services billed. The provider agreed to pay $54,014 in overpayment and $143,029 in penalties to resolve this case.

Personal care attendant excluded from Medicaid

In June, the OIG settled four cases with four home health providers in Hidalgo County. A personal care attendant who worked for all four providers double billed each provider for services for two different clients who lived in the same household. The attendant was excluded for 10 years. The four providers worked with the OIG to resolve these issues, and the OIG agreed to a settlement of $30,840.

Provider Investigations case summary

Referral sources for cases	
MCO/DMO	27%
Government agency	26%
Public	22%
Provider	10%
Anonymous	10%
OIG initiated	5%

Types of preliminary investigations opened	
Attendants	41%
Physician (individual/group/clinic)	17%
Home health agency	13%
Dental	6%
Pharmacy	4%
Nursing facility	3%
Case management	3%
Durable medical equipment	3%
Hospital	2%
Therapy (physical/occupational/social)	1%
Adult day care	1%
Therapy (counseling)	1%
11 other categories at less than 1%	5%

Types of full-scale investigations opened	
Physician (individual/group/clinic)	29%
Home health agency	25%
Nursing facility	15%
Pharmacy	11%
Attendants	6%
Durable medical equipment	6%
Case management	2%
Dental	2%
Intermediate care facility	2%
Parent/guardian	2%

Rounded to nearest whole number

Settlement reached with a North Texas dental provider

In June, the OIG settled a case involving a dentist in Dallas. The case involved allegations that the provider billed for services not rendered, upcoded services, maintained inadequate/incomplete medical records, failed to provide or maintain x-rays and provided medically unnecessary services. The provider agreed to pay $200,000 in overpayment to resolve this case.

Agency highlights

Update on fraud detection operation examining DME providers

Investigations of two durable medical equipment (DME) providers were opened following an OIG Fraud Detection Operation (FDO). An FDO involves multiple OIG divisions analyzing large volumes of data to identify providers that appear as statistical outliers among their peers. Investigators evaluate additional evidence to determine if an outlier's status is attributable to possible fraud, waste or abuse or program violation. DME includes medical equipment and supplies such as incontinence products, shower/bath chairs, blood pressure monitors and enteral feeding supplies.

Referral to a full-scale investigation on the two identified DME providers allows for a closer look at the providers' billing and documentation patterns and can include additional interviews and records requests. The next FDO, which will focus on home health providers, is scheduled for the first quarter of FY 2023.

OIG obtains new data analytics tool

In this quarter, the OIG Data Initiatives Project Team (DIPT) is using a new online research subscription service that will allow the team greater insight into current and historical medical coding and billing practices employed by health care providers. This new information will enable data initiatives investigators to efficiently access industry-wide information and expertise to conduct thorough research and help the OIG better understand billing patterns and trends more globally – beyond the Medicaid program.

Data initiative focuses on outpatient emergency departments

DIPT focused a significant amount of time working through the logistics of an initiative involving disallowed payments to outpatient hospital emergency departments. The project involved six improper payment scenarios observed as a pattern within claims data that, across providers, accounts for millions of Medicaid dollars at risk. In recognition of the critical work that these providers do for Texans, the initiative deployed complex algorithms to calculate fair recoupments and credit providers for services which could have been rendered even if the billing was completed inaccurately.

Additionally, the initiative involves an education and prevention component so that providers understand how to avoid these mistakes in the future. The OIG will send an education letter to MCOs about the scenarios with new paid claims data requests and intends to address the topic at a Texas Fraud Prevent Partnership meeting. The agency is also exploring how to help inform the provider community of billing errors to prevent future overpayments. Through these efforts, the OIG seeks to achieve balance between enforcing Medicaid program integrity and promoting fair compensation for quality care in Medicaid.

Third Party Recoveries increases cost avoidance and recoveries

During the fourth quarter of FY 2022, OIG Third Party Recoveries (TPR) achieved a 16 percent increase in cost avoidance of medical claims compared to the same time period last fiscal year. Third party recovery involves any individual, entity or program, including health insurance, that may be legally liable to pay all or part of a client's medical costs before Medicaid dollars are spent. The cost recoveries for the Motor Vehicle Program (MVP) increased 69 percent in the fourth quarter compared to last year. Through the MVP, data matching occurs with the insurance industry's casualty claim database to identify claims involving Texas Medicaid clients that may be subject to recovery by the state.

Completed reports - Audit

Selected Memory Care Facilities: Silverado Barton Springs Memory Care Community

The OIG conducted an audit of Silverado Barton Springs Memory Care Community (Silverado Barton Springs), an assisted living facility licensed by HHSC to provide care for people with Alzheimer's disease or related disorders. The OIG's annual audit risk assessment included the identification of risks regarding assisted living facilities advertising as providing memory care services without disclosing whether the facility holds a certification to serve residents with Alzheimer's disease.

Silverado Barton Springs complied with most of HHSC's health and safety requirements tested, including disclosing the facility's certification status, conducting required background checks prior to employment, completing resident assessment and service plan documentation, and providing the required number and type of resident activities. However, opportunities exist for Silverado Barton Springs to improve processes related to (a) annual employability checks of facility employees and (b) emergency preparedness and response planning. Specifically:

- Silverado Barton Springs did not perform annual Employee Misconduct Registry checks. Without these required checks, there is an increased risk that the facility may not identify facility employees who are no longer eligible to work in the facility, and residents may be at a higher risk of abuse, neglect and exploitation.

- Silverado Barton Springs had an emergency preparedness and response plan; however, it did not comply with all selected Texas Administrative Code requirements. Specifically, it did not (a) maintain a complete and current emergency preparedness and response plan, (b) communicate the emergency preparedness and response plan to residents and residents' legally authorized representatives, or (c) request an annual fire marshal inspection.

- Silverado Barton Springs should (a) perform required annual Employee Misconduct Registry checks, (b) complete the emergency preparedness and response plan, and (c) comply with Texas Administrative requirements regarding emergency preparedness.

Audits issued 24

- Selected Memory Care Facilities: Silverado Barton Springs Memory Care Community
- The Sexually Transmitted Disease/Human Immunodeficiency Virus Prevention Services Grant Program: San Antonio Metropolitan Health District
- Security Controls Over Confidential HHS Information: Community Health Choice
- Selected Memory Care Facilities: Matagorda House Healthcare Center
- The Sexually Transmitted Disease/Human Immunodeficiency Virus Prevention Services Grant Program: Dallas County Health and Human Services
- The Sexually Transmitted Disease/Human Immunodeficiency Virus Prevention Services Grant Program: City of Houston Health Department
- Home and Community Support Services Agencies Oversight of Attendants: Elara Caring
- Home and Community Support Services Agencies Oversight of Attendants: Girling Community Care
- Administrative Expenses Reported by Molina Healthcare of Texas, Inc. on Its Financial Statistical Report
- Managed Care Pharmacy Claims Paid to ReCept Pharmacy #1: A Managed Care Network Provider Contracted Under Aetna Better Health of Texas, Inc.
- Emergency Ambulance Services at American Medical Response: A Texas Medicaid Ambulance Provider

Audits in progress 12

- Selected Health, Developmental, and Independence Services Contract
- Selected Pharmacy Benefits Managers
- FC Thompson Emergency Shelter (Tammie and Scott)
- Durable Medical Equipment Providers Oversight

The Sexually Transmitted Disease/Human Immunodeficiency Virus (STD/HIV) Prevention Services Grant Program: San Antonio Metropolitan Health District

Audit performance	
Overpayments recovered	$1,069,697
Overpayments identified	$5,589,925
Audit reports issued by OIG	24
Audit reports issued by contractors	-

The OIG completed an audit of the San Antonio Metropolitan Health District (Metro Health), a local health department administering sexually transmitted disease (STD) and human immunodeficiency virus (HIV) control and prevention activities under the Texas Department of State Health Services (DSHS) STD/HIV Prevention Services Grant Program. Metro Health performed grant agreement activities; however, Metro Health consistently did not meet program objectives designed to measure the effectiveness of the STD/HIV Prevention Services Grant Program.

Specifically, Metro Health did not meet (a) seven out of eight program objectives in 2019, (b) nine out of ten program objectives in 2020, and (c) nine out of ten program objectives in 2021. Additionally, Metro Health did not ensure expenditures were incurred or reported in the correct grant year. Specifically, Metro Health (a) received reimbursement of $2,890 in 2020 for expenses incurred in 2021 and (b) included non-program information on the financial status reports, which resulted in expenses that were understated by $63,124 in 2021. Further, Metro Health did not have effective security and confidentiality controls in place to ensure (a) access to systems and information was appropriate or (b) required documentation was maintained.

Metro Health should:

- Implement (a) processes to identify when grant activities are not meeting program objectives and (b) initiatives to improve performance.
- Ensure it has processes and controls in place to limit reimbursement requests to allowable grant activities for the STD/HIV Prevention Services Grant Program.
- Ensure it has processes and controls in place to prepare accurate financial status reports with relevant program information for the STD/HIV Prevention Services Grant Program.
- Strengthen its security and confidentiality controls for STD/HIV data.

Security Controls Over Confidential HHS Information: Community Health Choice

The OIG completed an audit of Community Health Choice. The objectives of the audit were to assess the design and effectiveness of selected security controls over confidential HHS System information stored and processed by Community Health Choice, as well as business continuity and disaster recovery planning for selected activities related to the delivery of managed care services to HHS members enrolled with Community Health Choice.

Access to confidential HHS System information must be managed in accordance with HHS information security controls (IS-controls). Community Health Choice complied with the information security requirements tested and established procedures to ensure continuation of the operations necessary to deliver services to Medicaid and CHIP members in the event of an emergency or disaster. However, Community Health Choice did not comply with certain information security requirements applicable to confidential HHS System information.

Community Health Choice did not (a) consistently ensure that network and claims management accounts and applications were disabled when user access was no longer required, (b) enforce requirements for locking accounts when unsuccessful log on attempts occurred, and (c) enforce all authentication requirements as required by HHS IS-Controls.

Community Health Choice should ensure access and authentication controls for its network and claims management accounts and applications are managed in accordance with HHS IS-Controls requirements.

Selected Memory Care Facilities: Matagorda House Healthcare Center

The OIG conducted an audit of Matagorda House Healthcare Center (Matagorda House), an assisted living facility licensed by HHSC. The OIG's annual audit risk assessment included the identification of risks regarding assisted living facilities advertising as providing memory care services without disclosing whether the facility holds a certification to serve residents with Alzheimer's disease.

Matagorda House complied with some of the HHSC's health and safety requirements tested during the OIG unannounced site visit. Specifically, Matagorda House complied with requirements related to having fully furnished resident rooms, secured access to the memory care unit, and secured handrails throughout the facility. Additionally, Matagorda House had most of the required postings on display, including HHSC contacts, resident rights, and suspected abuse, neglect or exploitation notice. However, the facility did not comply with select requirements related to (a) direct care staffing and training, (b) exterior facility safety, (c) medication storage, and (d) providing the Alzheimer's disclosure statement to applicable individuals.

Since the audit scope, Trinity Healthcare bought Matagorda House, which was previously under the management of Pinnacle Health Facilities of Texas. When applicable in the future, the facility should ensure staff comply with applicable training requirements, ensure staff-to-resident ratios comply with requirements, perform all required pre-employment checks, ensure the exterior areas of its nursing facility are secure and free of safety hazards, ensure medication security, and provide residents and individuals assisting prospective residents with the Alzheimer's disclosure statement prior to admission.

The Sexually Transmitted Disease/Human Immunodeficiency Virus Prevention Services Grant Program: Dallas County Health and Human Services

The OIG completed an audit of the Dallas County Health and Human Services, a local health department administering sexually transmitted disease (STD) and human immunodeficiency virus (HIV) control and prevention activities under the Texas Department of State Health Services (DSHS) STD/HIV Prevention Services Grant Program. Dallas County Health and Human Services performed grant agreement activities; however, Dallas County Health and Human Services consistently did not meet program objectives designed to measure the effectiveness of the STD/HIV Prevention Services Grant Program.

Specifically, Dallas County Health and Human Services did not meet (a) seven out of eight program objectives in 2019, (b) nine out of ten program objectives in 2020, and (c) nine out of ten program objectives in 2021. Additionally, Dallas County Health and Human Services did not ensure expenses were incurred and allocated to the correct grant year. Specifically, of the expenses tested, Dallas County Health and Human Services did not provide sufficient documentation to support 13 of 22 expenses totaling $90,759 in 2019, 10 of 14 expenses totaling $101,939 in 2020, and 10 of 12 expenses totaling $85,425 in 2021. Further, Dallas County Health and Human Services did not always sufficiently support the salaries it charged to the STD/HIV Prevention Services Grant Program. In addition, Dallas County Health and Human Services did not have effective security and confidentiality controls in place to ensure required documentation was maintained.

Dallas County Health and Human Services should:

- Implement (a) processes to identify when grant activities are not meeting program objectives and (b) initiatives to improve performance.

- Ensure it has processes and controls in place to limit reimbursement requests to allowable grant activities for the STD/HIV Prevention Services Grant Program.
- Ensure salaries charged to the STD/HIV Prevention Services Grant Program are appropriate and supported.
- Ensure staff with access to confidential information sign an annual confidentiality agreement.

The Sexually Transmitted Disease/Human Immunodeficiency Virus Prevention Services Grant Program: City of Houston Health Department

The The OIG completed an audit of the City of Houston Health Department, a local health department administering sexually transmitted disease (STD) and human immunodeficiency virus (HIV) control and prevention activities under the Texas Department of State Health Services (DSHS) STD/HIV Prevention Services Grant Program. The City of Houston Health Department performed grant agreement activities; however, the City of Houston Health Department consistently did not meet program objectives designed to measure the effectiveness of the STD/HIV Prevention Services Grant Program.

Specifically, the City of Houston Health Department did not meet (a) seven out of eight program objectives in 2019, (b) nine out of ten program objectives in 2020, and (c) nine out of ten program objectives in 2021. Additionally, the City of Houston Health Department did not ensure expenses were incurred exclusively for grant activities performed during the grant year and spent a disproportionate amount of their 2019 (49 percent) and 2020 (45 percent) grant agreement budgets during the fourth quarters of each year. Specifically, of the expenses tested, the City of Houston Health Department did not provide sufficient documentation to support seven of 10 expenses totaling $137,016 in 2019; seven of 10 expenses totaling $174,615 in 2020; and four of 10 expenses totaling $192,349 in 2021.

Further, the City of Houston Health Department did not have sufficient documentation to support 40 salaries tested, totaling $79,913, charged to the STD/HIV Prevention Services Grant Program in 2019. In 2020, the DSHS contract monitoring completed a review of the City of Houston Health Department's payroll records and identified payroll expenses were not properly supported. As a result, the City of Houston Health Department implemented a new process, and sampled payroll expenses charged to the grant program during 2020 and 2021 were based on scheduled work hours and certified as required. In addition, the City of Houston Health Department did not have effective security and confidentiality controls in place to ensure (a) access to systems and information was appropriate or (b) required documentation was maintained.

The City of Houston Health Department should:

- Implement (a) processes to identify when grant activities are not meeting program objectives and (b) initiatives to improve performance.
- Ensure it has processes and controls in place to limit reimbursement requests to allowable grant activities for the STD/HIV Prevention Services Grant Program.
- Continue to ensure it has processes and controls in place to verify salaries charged to the STD/HIV Prevention Services Grant Program are appropriate and supported.
- Strengthen its security and confidentiality controls for STD/HIV data.

Home and Community Support Services Agencies Oversight of Attendants: Elara Caring

The OIG completed an audit of Elara Caring, a provider of behavioral home health, hospice care, personal care and skilled home health in Texas. OIG Audit's annual risk assessment included risks identified by a federal OIG report indicating, in general, personal care services provided do not always comply with state requirements. During the audit scope, Elara Caring developed individualized service plans that matched the frequency, duration, and number of approved units from the managed care organizations' (MCOs') prior authorizations; performed attendant orientations; and conducted attendant supervisory visits for all the clients in the audit sample. Elara Caring supervisors had the required qualifications to oversee attendants' performance. However, Elara Caring has opportunities to improve its processes for visit verification and staff vetting. Specifically:

- 105 out of 12,482 transactions that were missing one or more required electronic visit verification elements (0.84 percent) did not comply with visit maintenance requirements, resulting in an overpayment of $5,122.
- One out of 30 attendant background checks (3.3 percent) were not conducted timely.

Elara Caring should strengthen controls over the visit maintenance process, repay the state of Texas $5,122, and conduct all required background checks timely, as required.

Home and Community Support Services Agencies Oversight of Attendants: Girling Community Care

The OIG completed an audit of Girling Community Care (Girling), a provider of behavioral home health, hospice care, personal care and skilled home health in Texas. OIG Audit's annual risk assessment included risks identified by a federal OIG report indicating, in general, personal care services provided do not always comply with state requirements. During the audit scope, Girling developed individualized service plans that matched the frequency, duration, and number of approved units from the managed care organizations' (MCOs') prior authorizations; performed attendant orientations; and conducted attendant supervisory visits for sampled clients who had been receiving care from the same attendant for at least one year.

However, Girling has opportunities to improve its processes for visit verification, staff vetting and ensuring attendant supervisors meet supervisor qualification requirements. Specifically:

- 307 out of 5,071 transactions that were missing one or more required EVV elements (6.1 percent) did not comply with visit maintenance requirements, resulting in an overpayment of $15,358.
- Three out of 40 (7.5 percent) attendant background checks were not conducted timely.

One out of eight (12.5 percent) supervisors did not meet supervisor qualification requirements because Girling could not provide support that it had verified education requirements.

Girling should strengthen controls over the visit maintenance process, repay the state of Texas $15,358, conduct all required background checks timely, and maintain documentation to demonstrate that supervisors meet qualification requirements.

Administrative Expenses Reported by Molina Healthcare of Texas, Inc. on Its Financial Statistical Report

The OIG conducted an audit of Molina Healthcare of Texas's (Molina's) Combined Financial Statistical Report (FSR) based on an identified risk of incorrectly reported expenses on the FSR, including unallowable expenses without sufficient documentation. When unallowable and questioned expenses are included on FSRs, the

reported net income may be inaccurate. As a result, there is a risk that HHSC may rely on inaccurate information when setting capitation rates and calculating experience rebates. The audit objective was to determine whether Molina reported expenses on its Combined FSR submitted to HHSC correctly and had effective related internal controls.

Molina had a process for preparing FSRs, which included effective controls related to completing internal checklists and obtaining approval before submission; however, Molina's Combined FSR included some unallowable expenses, unsupported expenses, expenses incurred in a different fiscal year, and inaccurately reported expenses. As a result, Molina overstated expenses by $1,509,835.

Molina should:

- Develop and implement a reasonable allocation methodology for all its indirect business units.
- Ensure indirect expenses reported on the Combined FSR are based on actual expenses.
- Strengthen its processes to identify and remove unallowable expenses.
- Develop a process to ensure other lines of business are not included in direct expenses on the Combined FSR.
- Review business units to determine if unallowable indirect expenses are being included prior to allocation.
- Report indirect and direct expenses in the period corresponding to the dates the services were incurred.
- Maintain documentation that meets the standard in the cost principles for salaries reported on the Combined FSR to justify the amount allocated for individuals with some unallowable job duties.
- Ensure unallowable indirect and direct expenses are not included on the Combined FSR.
- Provide a bonus plan to FRAC in accordance with required time frames and prior to reporting bonus expenses on its FSRs.

Managed Care Pharmacy Claims Paid to ReCept Pharmacy #1: A Managed Care Network Provider Contracted Under Aetna Better Health of Texas, Inc.

The OIG conducted an audit of Medicaid managed care claims paid to ReCept Pharmacy #1 (ReCept) by Aetna Better Health of Texas, Inc. (Aetna), a managed care organization. During the period from September 1, 2020, through August 31, 2021, ReCept was paid $435,989 for 324 Medicaid and CHIP managed care claims for prescriptions dispensed to Aetna members. The audit objective was to determine whether ReCept (a) properly billed for paid claims associated with Medicaid and CHIP members enrolled with Aetna and (b) complied with applicable contractual, state and federal requirements.

ReCept properly billed for paid claims and complied with applicable contractual, Texas Administrative Code, and federal requirements for most claims tested; however, ReCept did not consistently comply with certain requirements for accurate claims submissions and dispensing labels.

ReCept should ensure the number of authorized refills remaining stated on the dispensing label is accurate prior to dispensing medications.

Emergency Ambulance Services at American Medical Response: A Texas Medicaid Ambulance Provider

The OIG conducted an audit of ground emergency ambulance services at American Medical Response (AMR). Emergency ambulance services are allowable when the client has an emergency medical condition. For this audit, auditors examined payments from two selected managed care organizations. The audit objective was to determine whether AMR ensured its contractor billed claims to Superior HealthPlan, Inc. and Amerigroup Texas, Inc. in accordance with applicable statutes, rules, and procedures in the managed care environment. for the period from September 1, 2019, through August 31, 2021.

American Medical Response's (AMR's) contractor billed ground emergency transport claims to Superior and Amerigroup in accordance with most requirements. AMR maintained support for the transport and level of service performed. However, AMR inaccurately reported mileage from the pickup to the destination for two claims tested, resulting in an overpayment of $1,145. Additionally, AMR billed for the incorrect patient for 14 out of 193 emergency transports tested as part of a risk-based sample selected, resulting in an overpayment of $4,221.

AMR should:

- Repay HHSC $5,365.
- Implement a process to ensure mileage entered by the medical crew reasonably matches the distance between the pickup and destination facilities.
- Have a process to verify patient information prior to submitting the information to its billing contractor for claims submission.
- Have a process to verify patient information prior to submitting the information to its billing contractor for claims submission.

Completed reports - Inspections

Clinical Laboratory Improvements Amendments Certification: 16 Managed Care Organizations

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

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

- Use the information provided by HHSC to develop processes to ensure the lab certification codes listed on providers' CLIA certificates correspond to procedure codes in their claims payer system.

- Ensure their claims payer system denies claims for procedure codes that do not correspond to the laboratory certificate codes listed on a provider's CLIA certificate.

Nursing Facility Staffing Hours Verification: Winchester Lodge Healthcare Center

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

Winchester accurately reported direct care licensed nursing hours to CMS for 88 percent of the 514 payroll records reviewed as part of this inspection. However, Winchester did not:

- Have documented processes for reporting complete and accurate direct care licensed nursing hours to CMS through the Payroll-Based Journal reporting system. As a result, Winchester (a) both overreported and underreported some direct care licensed nursing hours worked and (b) inconsistently accounted for required meal break deductions.

- Consistently maintain complete payroll records to document (a) all direct care licensed nursing hours worked or (b) the number of direct care hours worked by administrative staff.

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

Nursing Facility Staffing Hours Verification: Westchase Health and Rehabilitation Center

The OIG conducted an inspection of Westchase Health and Rehabilitation Center (Westchase), a skilled nursing facility. The OIG initiated this inspection because of potential health and safety concerns caused by staffing

Inspections issued 9

- Clinical Laboratory Improvements Amendments Certification: Community Health Choice, FirstCare Health Plans, Scott and White Health Plan, and Texas Children's Health Plan
- Clinical Laboratory Improvements Amendments Certification: Aetna Better Health of Texas, Community First Health Plans, Driscoll Health Plan, and Parkland Community Health Plan
- Clinical Laboratory Improvements Amendments Certification: Amerigroup, Blue Cross and Blue Shield of Texas, Dell Children's Health Plan, Molina Healthcare of Texas, and United Healthcare Community Plan
- Clinical Laboratory Improvements Amendments Certification: Cook Children's Health Plan, El Paso Health, and Superior HealthPlan
- Nursing Facility Staffing Hours Verification: Winchester Lodge Healthcare Center
- Nursing Facility Staffing Hours Verification: Westchase Health and Rehabilitation Center
- Nursing Facility Staffing Hours Verification: Mira Vista Court
- Clinical Laboratory Improvement Amendments Certification: Texas Medicaid and Healthcare Partnership
- Nursing Facility Emergency Preparedness: Mystic Park

Inspections in progress 8

- Nursing Facility Staffing
- Nursing Facility Emergency Preparedness

shortages at nursing facilities. The inspection objective was to determine whether the direct care licensed nursing hours recorded at Westchase supported the hours submitted to the U.S. Centers for Medicare and Medicaid Services (CMS) in compliance with federal requirements. The inspection scope covered the period from January 1, 2021, through June 30, 2021.

Westchase accurately reported direct care licensed nursing hours to CMS for 85 percent of the 964 payroll records reviewed as part of this inspection. However, Westchase did not:

- Have documented processes for reporting complete and accurate direct care licensed nursing hours to CMS through the Payroll-Based Journal reporting system. As a result, Westchase (a) both overreported and underreported some direct care licensed nursing hours worked and (b) inconsistently accounted for required meal break deductions.
- Consistently maintain complete payroll records to document (a) all direct care licensed nursing hours worked or (b) the number of direct care hours worked by administrative staff.
- Maintain historical daily nurse staffing data.

The OIG offered recommendations to Westchase, which, if implemented, will help ensure that Westchase (a) reports accurate and complete direct care licensed nursing hours to CMS and (b) complies with state and federal requirements.

Nursing Facility Staffing Hours Verification: Mira Vista Court

The OIG conducted an inspection of Mira Vista Court, a skilled nursing facility, because of potential health and safety concerns caused by staffing shortages at nursing facilities. The inspection objective was to determine whether the direct care licensed nursing hours recorded at Mira Vista Court supported the hours reported to U.S. Centers for Medicare and Medicaid Services (CMS) in compliance with federal requirements.

Mira Vista Court accurately reported direct care licensed nursing hours worked to CMS for 77 percent of the 799 payroll records reviewed as part of this inspection. However, Mira Vista Court overreported some direct care licensed nursing hours worked due to not accounting for all required meal break deductions. OIG Inspections did not identify any instances of Mira Vista Court underreporting direct care licensed nursing hours to CMS.

Mira Vista Court should program Kronos, the electronic timekeeping system used by the facility, to deduct one hour for meal breaks when a staff member works a shift of 16 hours or more to conform to the CMS requirement.

Clinical Laboratory Improvement Amendments Certification: Texas Medicaid and Healthcare Partnership

The OIG conducted an inspection of Texas Medicaid and Healthcare Partnership (TMHP) processes to ensure laboratory service providers have the appropriate Clinical Laboratory Improvement Amendments (CLIA) certification prior to paying submitted claims.

The inspection objective was to determine whether TMHP has controls to ensure payments made to laboratories are only for services covered under the laboratory's CLIA certification level. TMHP has processes for obtaining the CLIA certificate information at the time a laboratory enrolls in Texas Medicaid. TMHP receives a file from the U.S. Centers for Medicare and Medicaid Services weekly, which is used in an automated process to update CLIA information in its claims payer system. However, TMHP does not have processes for denying claims from laboratory providers that bill for laboratory procedures not covered by their CLIA certificate.

The TMHP claims payer system should include lab certification codes in its claims adjudication process and deny claims for procedure codes that do not correspond to the lab certification codes listed on a provider's CLIA certificate. TMHP should ensure procedure codes in its claims payer system correspond to the lab certification codes listed on the provider's CLIA certificate.

Nursing Facility Emergency Preparedness: Mystic Park

The OIG conducted an inspection of Mystic Park Nursing and Rehabilitation Center (Mystic Park), a skilled nursing facility, because of potential health and safety concerns caused by inadequate emergency preparedness programs at nursing facilities. The inspection objective was to determine whether Mystic Park followed select state and federal requirements for emergency preparedness.

Mystic Park's emergency preparedness plans and processes complied with most state and federal emergency preparedness requirements for nursing facilities reviewed as part of this inspection. Mystic Park had an updated emergency preparedness (a) plan and (b) training and testing program. Mystic Park also had updated procedures related to alternative power sources and subsistence needs for residents and staff. During a site visit to Mystic Park's facility, inspectors saw multiple emergency preparedness elements, including a generator used as an alternate energy source and supplies for resident and staff subsistence.

However, Mystic Park did not consistently comply with four emergency preparedness requirements. Specifically, Mystic Park did not (a) document initial employee training on emergency preparedness, (b) ensure its emergency preparedness plan identified how alternate energy sources should be used to maintain the power needs of key systems, (c) maintain a printed copy of its current emergency preparedness plan at each workstation assigned to a personnel supervisor who had responsibilities under the plan, or (d) document the required contact information for the state licensing and certification agency in its communication plan.

Mystic Park should ensure:

- All employees complete emergency preparedness plan training within 30 days of assuming applicable job duties and document each completion.
- Its emergency preparedness policies and procedures identify how alternate energy sources should be used to maintain required temperatures; emergency lighting; fire detection, extinguishing, and alarm systems; and sewage and waste disposal.
- A copy of its current emergency preparedness plan is present at the workstation of each personnel supervisor who has responsibilities under the plan.
- Its communication plan includes the required contact information for the state licensing and certification agency.

VI. Client Accountability

Trends

The Benefits Program Integrity (BPI) division completed 3,046 investigations involving client overpayment or fraud allegations. This quarter, 94 percent of all completed investigations involved unreported income or an issue with the reported household composition. Household composition cases usually involve an unreported household member who has income or a reported household member who does not actually live in the same residence. Both scenarios result in the household receiving more benefits than they are eligible for. For this quarter, BPI referred seven investigations for prosecution and 194 investigations for administrative disqualification hearing.

Benefits Program Integrity performance	
Overpayments recovered	$15,872,516
Cases completed	3,046
Cases opened	3,385
Cases referred for prosecution	7
Cases referred for administrative disqualification hearings	194

Case highlights

SNAP client disqualified

In June, BPI resolved a case in Webb County where a client committed fraud by failing to report on her SNAP benefits applications her marital status, children's father and his associated income. From September 2016 to March 2022, the client received $33,045 in excessive benefits. During an interview, the client admitted being legally married to, and living with, her children's father. The client signed a waiver of disqualification hearing, agreed to pay $33,045 and was disqualified from the SNAP program for 12 months.

SNAP client accused of committing fraud

BPI investigated a client in Tom Green County who committed an intentional program violation by failing to report on her SNAP benefits applications from March 2018 to August 2021 her children's father and his associated income. During the investigation, the investigator obtained corroborating evidence that proved the father was living in the home and receiving income, and the case was referred for an administrative disqualification hearing. In July, the hearings officer determined the client committed fraud. The client was disqualified from the SNAP program for 12 months and ordered to pay back $33,465 in excessive SNAP benefits.

SNAP client concealed household income

In July, BPI resolved a case in Kleberg County where a client committed fraud by failing to report her children's father and his associated income on her SNAP benefits applications. From May 2017 to March 2022, the client received $23,718 in excessive SNAP benefits. After evidence proved the father and his income should have been reported on the applications, and the client admitted the father lived with the family, the client signed a waiver of disqualification hearing, agreed to pay $23,718 and was disqualified from the SNAP program for 12 months.

VII. Retailer Monitoring

Trends

The Electronic Benefits Transfer (EBT) Trafficking Unit continues to receive referrals regarding the cloning and skimming of EBT client cards and personal data from the point-of-sales devices in retail stores. This scheme involves suspects altering the point-of-sales unit with another device that is designed to record the client's information. Once the information is recorded, it is forwarded to an unknown location, and a card is created. That card is then used in other cities to deplete the account's benefit balance without the client's knowledge. OIG investigators are working closely with state and federal partners to address this issue.

Electronic Benefits Transfer Trafficking Unit performance

Overpayments recovered	$254,359
Cases opened	129
Cases completed	152

This quarter, the Women, Infants, and Children (WIC) Vendor Monitoring Unit (VMU) conducted 86 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 Electronic Benefits Transfer (EBT) food card to make purchases to ensure vendors are following WIC rules. Violations were cited during 22 (26 percent) of the 86 store visits.

The team also completed 66 invoice audits 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 100 percent compliance for all vendors.

The WIC VMU also conducted 23 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

Candy retailer investigated for fraud

The EBT Trafficking Unit completed an investigation on a candy shop in Pharr who allegedly allowed SNAP clients to purchase party goods and decorations, including superhero and cartoon cardboard cutouts and personalized candy bags and boxes, with SNAP benefits. An undercover OIG investigator purchased these items using SNAP benefits. The retail owner and 10 SNAP clients were interviewed, and all confessed to allowing and making these purchases with their SNAP benefits. Administrative disqualification action against the clients is pending. The total amount of benefit loss is $6,311. The case has been referred for prosecution.

San Antonio restaurant owner accused of SNAP fraud

San Antonio's EBT Trafficking Unit received a referral alleging a restaurant owner was purchasing SNAP benefits from clients to be used to buy inventory items for the business. An investigation obtained evidence to support the allegation, and the restaurant owner admitted to exchanging cash for SNAP benefits. The owner's daughter also admitted to purchasing food for the restaurant. SNAP clients were also interviewed and confessed to selling their benefits. Administrative disqualification investigations are being conducted on the two clients. The owner's case was submitted to the Bexar County District Attorney's Office for prosecution.

OIG collaborates with USDA to disqualify two retailers

The EBT Trafficking Unit investigated two retailers in Hidalgo County accused of trafficking SNAP benefits by allowing clients to establish credit accounts and use SNAP benefits to pay for them, as well as to purchase ineligible items, such as alcohol and cigarettes. The cases were referred to the U.S. Department of Agriculture Food and Nutrition Services, and in the fourth quarter the federal agency permanently disqualified the retailers from participating in SNAP.

Dallas vendor cited

After three covert compliance buys in October, April and July at a Dallas store, a WIC inspector cited the store for failing to display prices for WIC products. The store's pattern of non-compliance was referred to WIC program staff. As a result of the store's non-compliance, $2,164 has been identified for recovery using a formula based on average store sales over time.

Agency highlights

Vendor agreement revisions

A revision in the Texas WIC vendor agreement policy clarified language pertaining to sanctions resulting from a WIC VMU compliance buy investigation. WIC VMU defined a "pattern of violations" composed of criteria that are consistent and fair to all vendors. The criteria also established procedures requiring compliance cases to be closed within one fiscal year. Previously, the cases routinely stayed open for two years or more. Closing cases within one fiscal year reduces operating costs and prevents subjecting vendors to lengthy investigations.

VIII. HHS Oversight

Trends

In the fourth quarter, Internal Affairs (IA) worked 77 active investigations, closed 39, and processed 124 referrals and investigated 52. The remainder were forwarded to the appropriate business areas, including the Office of the Independent Ombudsman for State Supported Living Centers; Department of Family and Protective Services (DFPS), Office of Internal Affairs; and HHS Complaint and Incident Intake.

Approximately 50 percent of Internal Affairs' open cases continue to involve Child Protective Services (CPS) client/supervisor allegations of DFPS employees falsifying documents. This may be the result of increased DFPS scrutiny, DFPS management establishing quality assurance processes to identify misconduct, as well as more clients alleging caseworker misconduct.

In this quarter, IA saw an increase in referrals. These referrals came from the public and agency programs. There has not been an increase in any specific type of allegation,

Open Internal Affairs cases by type	
Falsifying information/documents	36%
Unprofessional conduct	12%
Contract fraud	7%
Tampering with a governmental record	4%
Benefit fraud	3%
Time/leave abuse	3%
Computer misuse	2%
Privacy incident/breach	2%
Unauthorized release of information	2%
Other	29%

Internal Affairs performance	
Investigations opened	56
Investigations completed	39

although most referrals received are related to DFPS. Due to an increase in referrals, the average number of cases per investigator increased. Despite increased caseloads, case completion times have not increased.

State Centers Investigations Team performance	
Cases opened	182
Cases completed	159

The OIG's State Center Investigations Team (SCIT) opened 182 investigations and completed 159 investigations in the fourth quarter, with an average completion time of 20.5 days. This compares to 123 opened investigations and 134 completed investigations in the fourth quarter of FY 2021.

Case highlights

Employee accused of tampering with a governmental record

Internal Affairs investigated two sustained cases of tampering with a governmental record. In each case, DFPS supervisors reported employees who allegedly falsified case documentation in their internal database and filed false claims for travel reimbursement. Internal Affairs completed an extensive investigation of each employee and filed criminal charges with the Harris County and Smith County District Attorney's Offices. One employee was terminated and criminally indicted. The other employee resigned in lieu of termination.

Employees cleared of wrongfully providing differential pay

HHS state hospital supervisory nursing staff, some of whom were not entitled, allegedly received differential pay to circumvent the agency's compensation guidelines. Differential pay is an increase in salary when an employee works an evening, night or weekend shift. Internal Affairs investigators reviewed the salary and work hours of 11 employees. The investigation revealed an established practice of possible misapplication of the differential pay policy due to the policy's vague language, lack of guidance on how to implement the policy and the need to have nursing staff available for off-prime shift coverage. The investigation determined that the differential pay for nurses was implemented solely based on the need to fill nursing positions, resulting in nurses being required to work other shifts when needed. This investigation revealed no willful or reckless violations of HR Policy E3-Employee Compensation-Shift Differentials due to the vagueness of the policy, which does not address the difference between an employee working an off shift and an employee assigned to an off shift.

DFPS employee accused of conflict of interest

Internal Affairs investigated a DFPS Adult Protective Services (APS) employee after actions that allegedly created a conflict of interest with an APS client. The investigation revealed the APS employee testified in court on behalf of the client without notifying APS or documenting the hearing. Furthermore, the APS employee accepted money from the client's estate to run personal errands. The investigation determined there was sufficient evidence to support the allegation of the appearance of impropriety and a conflict of interest. The employee retired.

Patient injured at state hospital

A recent SCIT case involved an injury to a patient at the Terrell State Hospital. An employee was accused of assaulting and injuring the patient. Subsequent interviews and video review by the SCIT investigator confirmed the allegation. The case was referred to the Kaufman County District Attorney for prosecution. The employee pled guilty and received one-year deferred adjudication with court costs and fines imposed.

Client injured at Austin facility

A recent SCIT case involved an assault to a client at the Austin State Supported Living Center. Subsequent interviews and video review by the SCIT investigator confirmed the allegation. The case was referred to the Travis County district attorney for prosecution.

Agency highlights

BPI trains HHS employees

In July, as part of BPI's ongoing regional outreach initiative, the BPI San Antonio team trained a group of 12 Access and Eligibility Services (AES) Texas Works advisors. Access and Eligibility Services employees are responsible for delivering public assistance programs, disability determinations services and community-based programs and services to millions of Texans every year. BPI provided an overview of OIG responsibilities and trained AES employees on how and when to submit referrals. The training also included what details to enter in referrals to effectively and efficiently identify areas of potential fraud.

Policy recommendations

OIG provides program integrity feedback on policy changes

The OIG continues to review and provide feedback related to HHS policy changes. This quarter, the OIG reviewed the THSteps Dental Preventive Services policy and recommended clarified timelines for written consent and when, and to whom, oral hygiene instructions are provided. Recommendations were also made regarding payments for the removal of space maintainers in certain circumstances.

The OIG also reviewed the THSteps Preventive Care Medical Checkups policy and recommended language clarifying which procedure codes require a specific modifier to identify a Social Determinants of Health screening, noting that the lack of clarity may increase the likelihood of provider billing errors.

In addition, the OIG reviewed updates to the Mental Health Targeted Case Management (MHTCM) and Mental Health Rehabilitation (MHR) Services policy, which allows non-Local Mental Health Authorities (LMHAs) to provide MHTCM and MHR services to clients in fee-for-service Medicaid, in accordance with Senate Bill 1921 (87th Texas Legislature, Regular Session, 2021). The OIG provided information to HHS regarding non-LMHA providers and the usage of the Clinical Management for Behavioral Health Services application.

The OIG also reviewed the School Health and Related Services policy and provided HHS feedback regarding billing guidelines for psychotherapy procedure codes.

This quarter, the OIG created and implemented a standardized method for Internal Affairs to submit policy-related issues discovered during HHS investigations. A new form is being used to submit general information to the Policy and Strategic Initiative Unit, who will then analyze the information and submit observations to the appropriate division within HHS, Department of Family and Protective Services, and Department of State Health Services.

Rules

Nursing Facility Utilization Review Rules

The OIG recently posted draft rule changes for informal comment related to nursing facility utilization reviews (NFUR). The draft rules would replace the existing rules to update and re-organize NFUR procedures and provider requirements; the new rules provide procedures for desk reviews, delete redundant language excerpted from the Resident Assessment Instrument manual, re-organize the structure of the NFUR rules, and provide for using a case mix classification system that succeeds resource utilization groups. The proposed rules are expected to be posted in the Texas Register for formal comment in October 2022.

IX. Stakeholder Engagement

Texas Fraud Prevention Partnership update

A Texas Fraud Prevention Partnership (TFPP) Special Investigative Unit (SIU) meeting held in June included SIU staff from managed care organizations and dental maintenance organizations (MCOs), along with representatives from the Texas Office of Attorney General Medicaid Fraud Control Unit (MFCU). The OIG shared information about a recent fraud detection operation involving durable medical equipment. Community Health Choice gave an overview of their prepayment review process and the resulting cost avoidance and savings. Amerigroup presented a case study on a COVID scheme involving improper online digital evaluation and management billing.

Fraud Hotline performance

Fraud Hotline contacts handled	7,841
Fraud Hotline referrals within OIG	
Benefit recipients	1,472
Medicaid provider	145
HHS employee/contractor	54
EBT retailer	171
State Supported Living Center/State Hospital	2

Training summary

Trainings conducted this quarter	45

External Relations performance

Communication products produced	76
Website page views	83,298

The OIG held TFPP SIU one-on-one meetings with Superior and United to discuss referrals, pending OIG investigations and current fraud, waste and abuse schemes. Both MCOs are looking into the high frequency of laboratory billing in Texas, including add-on billing such as allergy testing billed in addition to COVID testing. MFCU staff also participated in the meetings and discussed referrals and new trends.

OIG produces home health fraud prevention video

The OIG produced a video to educate personal care attendants about the most common administrative errors to avoid. Personal care attendants — also known as community attendants, personal care assistants and direct service workers — work hard to help people with disabilities live independently in their own homes. However, some attendants do not consistently follow Medicaid rules or provide quality care. The most frequent Medicaid allegations to the OIG Fraud Hotline involve attendant care.

The newly produced video is part of the OIG's ongoing effort to proactively address potential FWA within the home health care industry. The video reminds attendants that they must personally log their time in the EVV system. No one else can clock in or out of the electronic visit verification (EVV) system on someone else's behalf; that's potential fraud. Attendants can clock in and out only when the client in their care is living in the client's home. Attendants may not log hours in EVV when a client is hospitalized or at an adult day care. Attendants cannot share their pay with the person in their care as an incentive to dishonestly say the attendants were working when they were not. The video also reminds attendants that they may not accept gifts or money to persuade the person in their care to switch home health care agencies.

The OIG investigates suspected violations in home health care services. If fraud is discovered, the OIG may impose penalties, require reimbursement of misappropriated funds, and disallow future employment with Medicaid clients.

The video is available on the OIG website, both in English and with Spanish subtitles.

Collaborating with providers to uphold a standard of care

One way the OIG protects the health and welfare of Medicaid clients is by preventing certain people or businesses from participating in the program. Medicaid providers are responsible for not employing excluded individuals, whether as health care practitioners, assistants, or clerical staff. In the fourth quarter, the Texas Medical Association and the Texas Pharmacy Association published OIG articles about the importance of checking the state and federal OIG exclusions lists on a monthly basis and before each hire. The articles included examples of penalties imposed on providers with excluded employees.

The Texas Dental Association's *TDA Today* published an article outlining the process for providers to self-report billing irregularities to the OIG; it included the potential benefits to health care professionals who voluntarily disclose payment errors and potentially avoid a full investigation. An article for the Texas Association of Home Care and Hospice pointed readers toward the educational video for attendants produced by the OIG and HHS. Collaborating with health care associations helps share the OIG's educational messages with a wider audience.

Educating stakeholders about utilization review activities

The Surveillance Utilization Review (SUR) unit continues to conduct virtual stakeholder meetings, providing a forum for education on utilization review activities and service delivery updates impacting Medicaid stakeholders. The SUR unit held a virtual quarterly meeting in August. Discussions focused on coding trends resulting in recoupments and addressing questions directed to the OIG coding team.

Internal Affairs educates staff about tampering with a government record

A regular quarterly meeting with Department of Family and Protective Services (DFPS) executive management provided an opportunity for Internal Affairs (IA) to help DFPS educate employees about policies and laws involving tampering with a government record. A typical scenario involves an employee anticipating a poor performance issue – such as falling behind on cases – and entering false information in the DFPS database system, likely unaware that their strategy to avoid administrative issues is a serious criminal violation. At the May meeting, Internal Affairs (IA) suggested training to inform employees of the penal code violation so they could make better decisions. IA hopes to collaborate with DFPS on additional issues in the new fiscal year.

Conferences, Presentations and Trainings

- Members of the OIG team presented at the 2022 National Association for Medicaid Program Integrity. Attendees from across the country gather on an annual basis to discuss the current technology and trends in safeguarding Medicaid resources. The OIG's Chief of Investigations and Reviews and Chief Counsel presented about the OIG's innovative approach to utilizing data analytics to detect fraud, waste and abuse. The agency's Chief of Staff was on a panel with Medicaid staff from American Samoa and North Dakota to discuss the differences between large and small states' programs. Members of the audit and inspections team presented about audits of MCO financial statistical reports and payments to pharmacy benefit managers, including how audit results can impact the experience rebate and rate setting process.

- In August, the Data Initiatives Project Team (DIPT) delivered specialized training to investigators in the OIG's Medicaid Program Integrity division regarding a data initiative involving improper Medicaid payments in outpatient emergency hospital settings. In addition to detailing six distinct policy violations within the initiative (e.g., double-billing, billing for services covered in other payment rates), DIPT developed and trained investigators on the specific tools, documentation requirements and data involved in investigations under this initiative. The DIPT process is designed to promote efficiency by standardizing similar information across cases while enabling customization tailored to each provider's unique circumstances.

- The Surveillance Utilization Review team completed required training that assists clinical teams' expertise in interpretation of diagnosis codes, etiologies of the disease process, understanding complications of care, the basis for medical necessity, support coverage for payment purposes, identifying incidence of disease and supporting statistical tracking for health care practices. Continuing education remains an OIG and state requirement and ensures that training needs and skills are continually monitored for OIG nurse staff members.

X. OIG in Focus

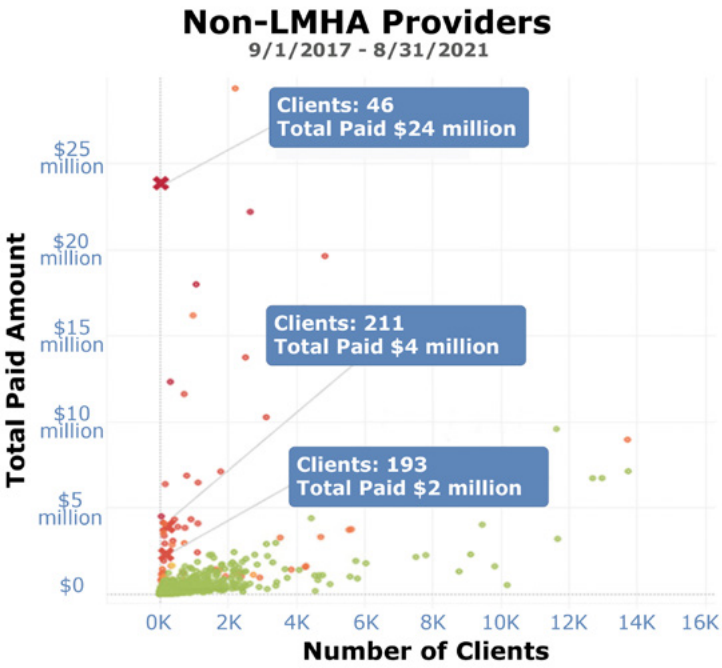
The Year in Data

The OIG's evolution in fraud, waste and abuse (FWA) detection is based on a foundation of data analytics. Capitalizing on the power of data drives the agency forward, to ever more efficient and comprehensive investigations, reviews, audits and inspections. With each passing year, OIG teams master increasingly sophisticated technology to identify FWA trends in their early stages and more quickly respond to those emerging threats. By assessing billing trends and patterns of providers, clients and retailers participating in HHS programs, data analytics enables faster recognition of potential problems across the health care system.

Fraud Detection Operations

The OIG's data team created more than 34 new algorithms during this fiscal year to support fraud detection operations (FDOs) conducted by OIG Investigations and Reviews. FDOs detect the potential for waste or wrongdoing by first identifying providers with unusual billing patterns when compared to their peers.

The creation of the new algorithms led to the identification of potential policy violations and suspicious billing behaviors for Non-Local Mental Health Authorities and durable medical equipment providers. The graphic highlights providers billing for significantly higher amounts when seeing fewer clients, when compared to their peers. Outlier status is not an automatic indicator of wrongdoing; it simply points out providers who may warrant a closer look due to unusual billing activity. The initiatives are in various stages of review and investigation.



In the span of a few years, the OIG's provider investigation inventory has evolved from approximately 95 percent referral cases with a few self-initiated projects, to approximately 60 percent self-initiated, almost all of which are data initiative cases. By harnessing the power of data analytics, the OIG can handle cases in a more efficient manner from the moment a case is initiated to its final resolution.

Data Initiatives Project Team

The OIG made significant strides in fiscal year 2022 in broadening its use of data analytics to uncover improper billing trends in Medicaid delivery across the entire HHS system. When OIG staff identify an issue with one provider – whether it comes from data analytics or a referral from an MCO or the public – the OIG's Data Initiatives Project Team (DIPT) can analyze statewide data to determine whether similar issues are occurring with other Medicaid providers. This process

identified a repeated issue with emergency room injection and infusion reimbursements. The data indicated outpatient hospital facilities were billing for the administration of injections or infusions in the emergency department, when those services were already covered by the ER evaluation and management reimbursement.

The team has settled 21 ER injection/infusion cases for more than $30 million in overpayments. Based on analysis of billing patterns, the OIG is exploring several other potential overpayments associated with providers being inappropriately reimbursed for the administration of injections and infusions. The OIG is also working to develop education and outreach to help providers and MCOs prevent future overpayments. Chart 1 lists DIPT case settlements since its inception in 2015.

Chart 1. DIPT case settlements

Scheme or scenario	Settlement amount
Unbundling ER administration of injection/infusion	$30,906,761
Critical care improper/double billing	$7,538,149
ER observation duplicate payment	$6,325,174
Improper billing for private duty nursing duration UA modifier	$2,427,289
Non-covered genetic testing	$2,467,287
Private duty nursing reimbursement for “impossible hours”	$1,964,261
Non-covered benefits	$750,603
Electroencephalographic without monitoring	$410,778
Total	$52,790,302

Advancing analysis

Through a competitive procureement, the OIG has contracted with a vendor that works in both the government and private sectors, to develop more advanced analytical tools to help identify potential indicators of FWA throughout state health and human services. The work performed over the past fiscal year with the vendor will allow the OIG’s data team to enhance the agency’s ability to perform highly complex data analysis work, increase operational efficiencies, and advance its analytical capabilities.

Sharing data and information

The OIG’s data team facilitates a cross-divisional data analytics information-sharing session with data analysis staff throughout HHS. The quarterly meetings include representatives from the OIG and HHS Medicaid/CHIP Services, Actuarial Analysis, and the Office of Data, Analytics, and Performance.

During these meetings, staff share data anomalies and utilization trends, along with program and financial updates that may impact Medicaid services. The information exchanged during these collaborative meetings is considered by the OIG when performing any data analysis on topics of interest and can lead to recommendations for reviews in the future.

Going forward

Leveraging advanced technology with talented team members who deploy and interpret it, helps the OIG uncover the latest threats to program integrity as they begin to emerge. In FY 2023, the agency looks to expand its data capabilities to anticipate and keep pace with those trends. The personnel behind the technology are vital to OIG operations; hiring additional data analysts, investigators and attorneys will allow the state to fully realize the benefit the OIG’s data initiatives.

The OIG has found using data analytics to be the most effective use of state resources. While referrals to the OIG identify potential risk in a specific set of circumstances, a data-driven approach can identify risks program-wide. This approach helps the agency focus on areas of high risk, increases recoveries and ensures better compliance across the Texas health and human services system.

Texas Health and Human Services Office of Inspector General

Sylvia Hernandez Kauffman, Inspector General

Mailing address: P.O. Box 85200, Austin, TX 78708

Main phone number: 512-491-2000

Email: OIGCommunications@hhs.texas.gov

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

OIG on Twitter: @TexasOIG

OIG on Facebook: TxOIG

Produced by OIG Communications:

Susan Biles, Chief of Staff; Andres Araiza, manager; Emily Hummel and Bob Seyller, staff

Content contributors: Andy Abrams, Collette Antoine, Monica Arroyave, Rose Barrera, Mo Brantley, Jim Day, Merrie Duflot, Anne Dvorak, Harriett Ellison, David Garcia, Jeff Goldstein, George Hanko, Jill Heath, Steve Johnson, Jen Kauffman, Randell Klein, Andreana Ledesma, Mario Martinez, Upton Mathers, Tiesha Miller, Christen Nedwick, Tara Olah, Katie Reyes, George Sabatino, Diane Salisbury, Jennifer Stansbury, Fallon Seitz, Deeana Tilly, Mark Tolerico, Jill Townsend, Stephen Tran, Chelsea Wallace, Katrina West, Sheri Wilson and Stephanie Wilson.

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)