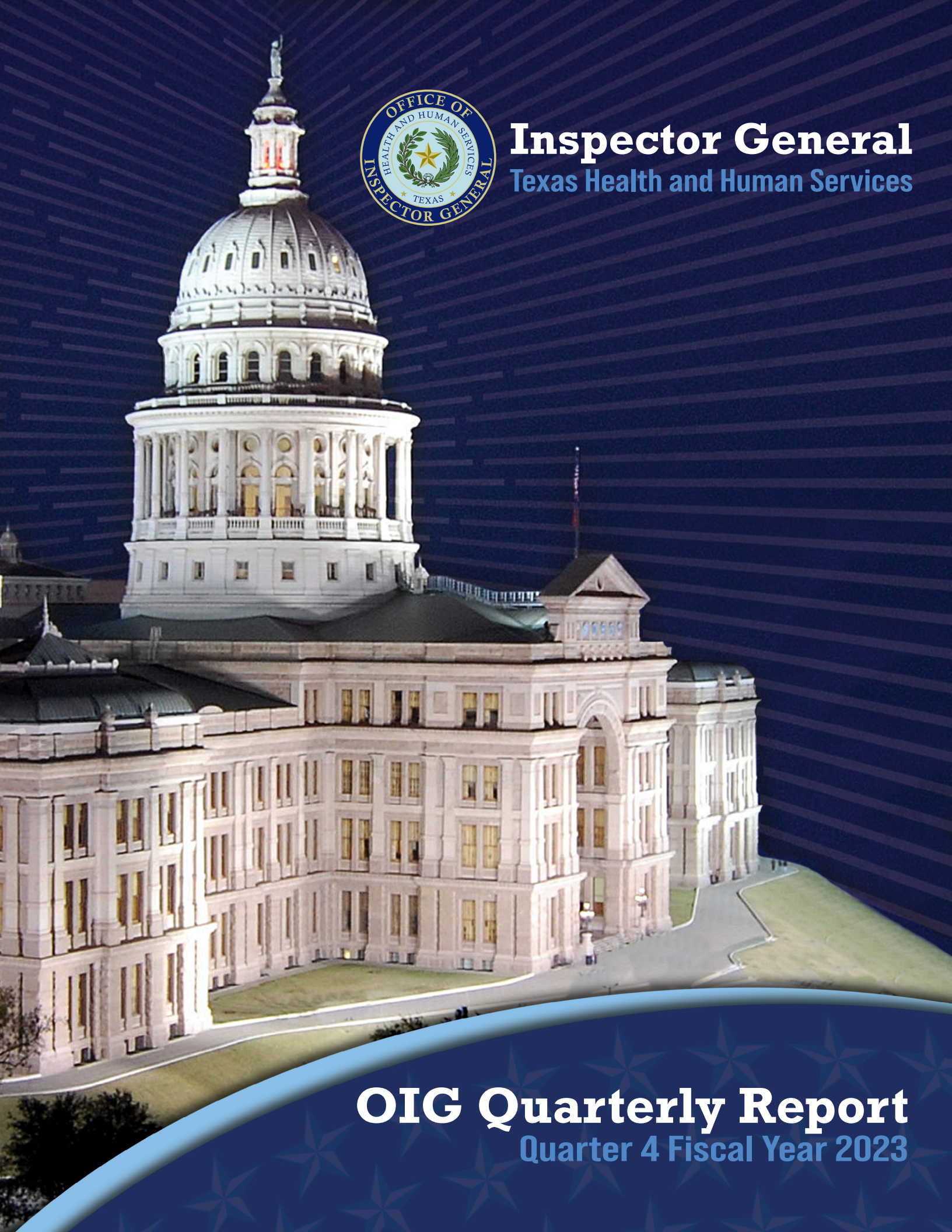

Inspector General

Texas Health and Human Services

OIG Quarterly Report

Quarter 4 Fiscal Year 2023

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I. Executive Summary

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

From June 1, 2023, to August 31, 2023, the Texas Health and Human Services Office of Inspector General (OIG) recovered more than $142 million. In addition, we identified more than $298 million in potential future recoveries and achieved more than $46 million in cost avoidance.

As the final quarterly report of the fiscal year, I am also pleased to announce the results of the OIG's performance over the entirety of FY 2023, which include the recovery of more than $532 million. Other outstanding achievements throughout the year have continued to advance the agency's capabilities to prevent, detect and investigate fraud, waste and abuse in the health and human services system. In particular, advances in data analytics have improved the early detection of questionable behavior and industry-wide trends, while specific initiatives targeted problem areas to recoup misspent tax dollars. Additional year-end results and analysis can be found in the following two sections of the report, beginning on page four.

After six years as Inspector General, this will be my final quarterly report. I am deeply honored that Governor Abbott entrusted me with this responsibility and appointed me to work with such a talented team.

I am also incredibly proud of all that was accomplished during this time. The OIG team worked together to implement system and process improvements that transformed the agency into an efficient, data-driven organization. We have increased the rigor of our work and built positive relationships with our stakeholders by being fair, reasonable and professional in all we do and holding ourselves to the highest standard of integrity. Thanks to the hard work and dedication of all involved, we achieved more than $2.4 billion in recoveries for Texas taxpayers over those six years and built a solid reputation for success.

The OIG in Focus on page 33 shares some additional insights from my tenure at the agency. I look forward to the great things the OIG will accomplish as it continues to build upon the foundation our team laid in recent years.

It was an honor and privilege to serve as your Inspector General. Thank you.

Sylvia Hernandez Kauffman
Inspector General

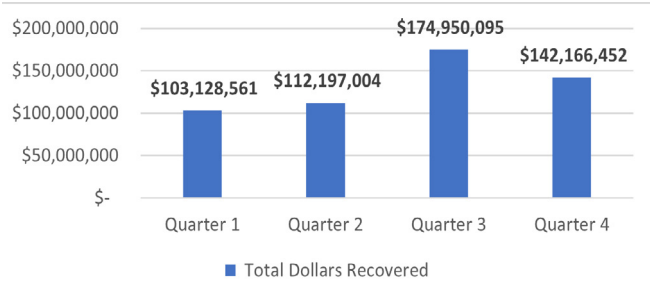
II. Fiscal Year 2023 Results

Dollars recovered

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

Total dollars recovered	$532,442,112
Providers and managed care organizations	**$485,623,624**
Provider overpayments from audits and inspections	$961,603
Provider overpayments from investigations and MCOs	$22,243,588
Provider overpayments from automated review scenarios	$9,000,640
Acute care provider overpayments	$2,336,935
Hospital utilization review overpayments	$13,788,588
Hospital utilization review underpayments	($30,250)
Nursing facility utilization review overpayments	$1,933,774
Nursing facility utilization review underpayments	($16,477)
FFS Recovery Audit Contractor provider recoveries	$125,875,094
Third Party Recoveries	$309,530,131
Clients	**$46,818,077**
Beneficiaries overpayments (SNAP, TANF, Medicaid, CHIP, WIC)	$45,946,708
Voluntary repayments by beneficiaries	$153,248
Electronic Benefits Transfer trafficking beneficiary overpayments	$718,121
Retailers	**$320**
Electronic Benefits Transfer trafficking retailer recoveries	$0
WIC collections	$320
HHS employees and contractors	**$90**
State Centers Investigations Team recoveries	$90

Total Dollars Recovered By Quarter



Peace Officer Recoveries

Dollars identified for recovery

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

Total dollars identified for recovery $1,117,381,635

Providers and Managed Care Organizations	**$1,044,932,909**
Provider overpayments from audits and inspections	$5,234,672
Provider overpayments from investigations and MCOs	$30,569,538
Provider overpayments from automated scenarios	$9,765,145
Acute care provider overpayments	$2,573,374
Hospital utilization review overpayments	$19,167,297
Hospital utilization review underpayments	($0)
Nursing facility utilization review overpayments	$16,184,670
Nursing facility utilization review underpayments	($0)
FFS Recovery Audit Contractor provider recoveries	$142,269,690
Third Party Recoveries	$819,168,523
Clients	**$72,448,720**
Beneficiaries overpayments (SNAP, TANF, Medicaid, CHIP, WIC)	$70,865,140
Voluntary repayments by beneficiaries	$0
Electronic Benefits Transfer trafficking beneficiary overpayments	$1,586,581
Retail	**$6**
Electronic Benefits Transfer trafficking retailer recoveries	$6
WIC collections	$0
HHS Employees and Contractors	**$0**
State Centers Investigations Team recoveries	$0

Cost avoidance

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

Total cost avoidance $172,948,830

Providers and Managed Care Organizations	**$148,353,847**
Medicaid provider exclusions	$0
Fee-for-service front-end claims denial	$148,353,847
Clients	**$24,594,983**
Client disqualifications	$10,730,158
WIC vendor monitoring	$0
Pharmacy Lock-In	$9,916,333
Disqualification of Electronic Benefits Transfer recipients	$3,948,492

III. Fiscal Year 2023 Review

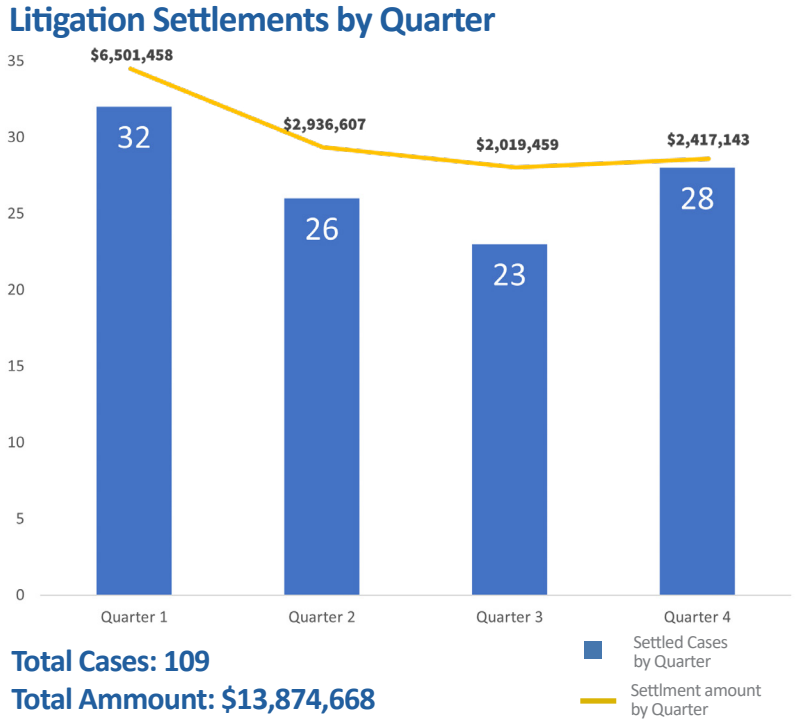
FY 2023 Performance Overview

Audit reports issued	36
Audits in progress	7
Inspections reports issued	12
Inspections in progress	4
Total investigations opened	17,148
Total investigations completed	18,742
BPI client investigations completed	13,258
EBT retailer investigations completed	342
Internal Affairs investigations completed	178
State center investigations completed	1,057
Medicaid provider investigations completed	2,313
Preliminary	2,097
Full-scale	216
Provider integrity cases transferred to full-scale investigation	263
Cases referred to Medicaid Fraud Control Unit	866
Hospital utilization claims reviewed	23,457
Nursing facility reviews completed	412
Provider enrollment screenings performed	77,488
Medicaid providers excluded	208
Fraud Hotline handled contacts	33,034

OIG settles 109 cases in FY 2023

During FY 2023, the Chief Counsel Division's Litigation Section settled 109 cases totaling $13,874,668 in recoveries.

In addition, the team closed 450 cases that did not result in monetary settlements. Of these cases, 309 resulted in administrative actions or sanctions, including 209 exclusions, 45 reinstatement requests, 41 terminations, 10 written educational contacts, and four contract cancellations. While non-monetary settlements do not add to the agency's recovery total, they often have substantial long-term benefits in preventing future fraud, waste and abuse.



OIG investigation uncovers $111 in fraudulent claims

The OIG initiated an extensive investigation of Inspired Behavioral Health at La Jarra Ranch (IBH) that uncovered more than $111 million in potentially fraudulent Medicaid claims, according to a federal civil asset forfeiture lawsuit. Allegedly, IBH used a jail diversion program to obtain patients for its mental health treatment facility and subsequently billed and received payment for Medicaid for services never performed.

From 2018 to 2022, Cameron County sent arrestees to IBH, where they were supposed to receive mental health treatment in lieu of jail time. Cameron County paid IBH a daily fee per resident for inpatient and outpatient services. According to the lawsuit, IBH was the highest billing mental health provider in Texas, even though it housed only 59 patients. IBH submitted claims that averaged $1.8 million per patient, including billing care for patients who were no longer at the facility. The OIG continues to assist federal authorities in this matter.

OIG targets providers billing for services after a client's death

In FY 2023, the Targeted Queries (TQ) Team initiated a review of Medicaid providers who billed for services rendered after a client's death. In total, nearly $2 million in potential overpayments were observed through the data. Using an algorithm developed by the OIG Fraud Analytics Team, the TQ Team conducted further review of the matched claims and notified impacted providers of potential overpayments. Providers then had an opportunity to substantiate any of the suspect claims. Since February 2023, the OIG has recovered approximately $250,000 in improper payments as a result of the continuing initiative.

Driven by data, provider investigations increase despite fewer investigators

The Provider Investigations Unit completed 216 investigations this year. The team surpassed the prior fiscal year's case completion rate for several years despite having fewer field investigators. Data-driven projects took center stage in Provider Investigations' work this year with 155 new OIG-initiated investigations developed from data analysis.

Texas providers continue to self-report

Medicaid providers continue to use the OIG's self-disclosure process to address self-identified issues. Self-disclosures in FY 2023 led to the resolution of 32 cases.

Self-Disclosure Resolutions		
FY 2020	33	$23,507,585
FY 2021	45	$8,171,252
FY 2022	50	$6,375,481
FY 2023	32	$541,757

Providers and managed care organizations may use the ReportTexasFraud.com website or OIG Fraud Hotline at any time to disclose any compliance or overpayment matters relating to themselves. In FY 2023 self-disclosed cases included clinics, hospitals, home health agencies and mental health rehabilitative services.

The OIG considers self-disclosing a mitigating factor that may warrant less severe or restrictive administrative action or sanction. Resolved self-disclosures in 2023 resulted in settlements totaling $541,757. The OIG also opened 11 new cases as a result of self-disclosure in 2023.

New efficiencies realized with increased electronic communication

As part of the OIG's continuous improvement process, the TQ Team began using an electronic solution to reduce paper correspondence sent to providers. The process reduced postage costs by more than $10,000 in FY 2023 and has increased efficiency by reducing the number of letters sent via certified mail. It has also demonstrated promising results in reaching the provider faster, therefore maximizing the time that the provider has to gather responsive information and address potential overpayments.

Data operations automates claims encounter data requests and reconciliation

In FY 2023, the OIG Data Operations Team automated previously manual processes for requesting and reconciling claims and encounter data from the 19 managed care organizations (MCOs) across Texas. Since implementation in September 2022, the automated tool has halved the time required to process a data request and, as a result, the Data Operations Team eliminated its backlog of outstanding requests. The change ensures staff across the OIG are quickly armed with information when reviewing an allegation of fraud, waste or abuse, and it improves consistency in data requests to the MCOs. It also helps Data Operations continue exploring ways to better support OIG activities through innovative technology solutions.

Motor vehicle program achieves record recoveries

The Motor Vehicle Program (MVP) matches Texas Medicaid member information with insurance claims to identify instances where a Texas Medicaid client was injured and received a settlement or judgement against a liable third party, such as an auto insurance carrier. If the settlement resulted in a financial award, the state may seek to recover its Medicaid costs. Since 2018, when the program began in Texas, the data warehouse used to match claims has expanded to include several large insurance carriers, which has resulted in a significant increase in matches and recoveries. MVP recoveries climbed to $7,767,298 in FY 2023, a 49% increase over FY 2022.

More inspections completed in FY 2023

The OIG Inspections Team continued its recent trend of increasing inspections performed each fiscal year. This year, the team completed 12 inspections, which included:

- Seven on nursing facility emergency preparedness.
- One on nursing facility staffing hours verification.
- Three on ambulance claims oversight.
- One on mental health private psychiatric bed funds.

New Benefits Program Integrity training academy a success

In 2023, the Benefits Program Integrity Unit (BPI) revamped its training structure for new employees. BPI created a new-hire academy consisting of in-person, virtual and practical application training that utilizes mentoring to develop investigative skills. Seventeen individuals graduated from the academy in 2023, and 16 remain employed with the OIG. Those 16 new investigators accounted for $4.4 million in identified recoveries in FY 2023.

WIC Vendor Monitoring Unit exceeds monitoring goals for year

The WIC Vendor Monitoring Unit assessed 880 of 2,200 Texas WIC vendors in FY 2023. Active monitoring of 40% of WIC vendors far exceeded the necessary average of 25%, which is required to meet its goal of visiting and monitoring all vendors within a four-year period. The team continues to improve its statewide compliance monitoring, using tools such as covert compliance buys, on-site store reviews and inventory reviews.

WIC VMU saw a 35% increase in completed on-site inspections and a 9% increase in cases closed compared to FY 2022. The increases can be partly attributed to improved relationships with WIC vendors and wholesalers. Additionally, process improvements, such as completing documentation at the end of each day instead of after each inspection, have boosted productivity and allowed inspectors to spend more time in the field. A new tracking system to better identify each case's progress also improved overall efficiency. Vendors are taking note of the increased presence and have been more proactive in their compliance responsibilities.

Medicaid Lock-In Program tackles prescription drug abuse

The Texas health care community plays a critical role in reducing prescription drug misuse through 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 should be locked-in to a single designated pharmacy or prescriber. MCOs play a key role in identifying and referring clients to the program. In FY 2022, the OIG received 1,817 referrals and reported $7,282,610 in cost savings for Texas taxpayers. For FY 2023, the Medicaid Lock-In Program received 2,185 referrals and achieved $9,916,333 million in cost avoidance, a 36% increase over the previous year.

Communicating the OIG mission

The OIG updates the public and agency stakeholders through various platforms, including the website, monthly newsletters, social media and informational articles. The OIG website is regularly updated with new information, and web articles provide overviews of OIG cases and initiatives. Over FY 2023, the website exceeded 269,000 page views, an 11% increase over the prior year. OIG stakeholders also stay current through the monthly OIG Update digital newsletter, which provides the agency's top stories to more than 20,000 subscribers. Subscriptions grew by 12% in FY 2023.

Communications Performance

Website views	269,000	↑11%
OIG Update subscribers	20,488	↑12%
Facebook followers	1,035	↑31%
Twitter followers	802	↑ 4%
LinkedIn followers	737	↑45%
Editorial articles	12	N/A
Editorial reach	20,000	N/A

Three social media feeds with a collective 2,551 followers round out the OIG's digital media platforms. Leading the way is Facebook, which surpassed the 1,000-follower milestone in July. While Facebook boasted a 31% increase over the previous year, LinkedIn was the fastest-growing network, increasing by 45% to 735 followers. X, previously known as Twitter, ended the year growing by 4% to 802 followers. The agency's increased commitment to creating and sharing original content was responsible for much of the growth, and group tagging increased distribution to relevant audiences.

The OIG also provides informational articles for stakeholder publications. Over FY 2023, the agency provided a total of 12 articles to three associations with approximately 20,000 combined members. Each article contains tailored information critical to the prevention of fraud, waste and abuse within the Medicaid provider community. Topics this year included self-reporting, investigation trends, record requirements, current OIG initiatives and much more.

The OIG Communications Team also undertook an ambitious project in FY 2023 to standardize the OIG seal. Since the agency's inception, numerous iterations of the OIG seal and document templates were created. However, older versions were never fully phased out, leaving the office with at least eight versions of the seal in simultaneous use. The standardization project unified the office under a single seal and included updates to all agency stationary, electronic communications and documents. The OIG now has its first-ever branding guide to ensure consistent standards that properly convey the office's mission, vision and values to Texans.

IV. Quarterly Metrics

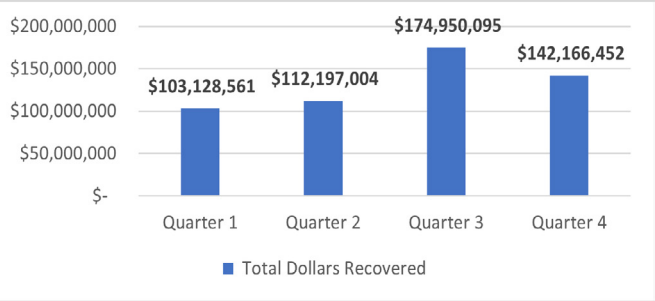
Dollars recovered

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

Total dollars recovered $142,166,452

Providers and managed care organizations	**$129,873,479**
Provider overpayments from audits and inspections	$588,215
Provider overpayments from investigations and MCOs	$4,875,348
Provider overpayments from automated review scenarios	$2,783,225
Acute care provider overpayments	$510,081
Hospital utilization review overpayments	$4,150,394
Hospital utilization review underpayments	($7,619)
Nursing facility utilization review overpayments	$149,150
Nursing facility utilization review underpayments	($5,230)
FFS Recovery Audit Contractor provider recoveries	$46,351,495
Third Party Recoveries	$70,478,421
Clients	**$12,292,973**
Beneficiaries overpayments (SNAP, TANF, Medicaid, CHIP, WIC)	$12,088,095
Voluntary repayments by beneficiaries	$58,991
Electronic Benefits Transfer trafficking beneficiary overpayments	$145,887
Retailers	**$0**
Electronic Benefits Transfer trafficking retailer recoveries	$0
WIC collections	$0
HHS employees and contractors	**$0**
State Centers Investigations Team recoveries	$0

Total Dollars Recovered By Quarter



Peace Officer Recoveries

Dollars identified for recovery

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

Total dollars identified for recovery $298,359,289

Providers and Managed Care Organizations	**$277,415,585**
Provider overpayments from audits and inspections	$5,234,672
Provider overpayments from investigations and MCOs	$11,488,182
Provider overpayments from automated scenarios	$2,905,920
Acute care provider overpayments	$580,812
Hospital utilization review overpayments	$5,983,670
Hospital utilization review underpayments	($0)
Nursing facility utilization review overpayments	$2,285,400
Nursing facility utilization review underpayments	($0)
FFS Recovery Audit Contractor provider recoveries	$52,418,484
Third Party Recoveries	$196,518,445
Clients	**$20,943,704**
Beneficiaries overpayments (SNAP, TANF, Medicaid, CHIP, WIC)	$20,572,345
Voluntary repayments by beneficiaries	$0
Electronic Benefits Transfer trafficking beneficiary overpayments	$371,359
Retail	**$0**
Electronic Benefits Transfer trafficking retailer recoveries	$0
WIC collections	$0
HHS Employees and Contractors	**$0**
State Centers Investigations Team recoveries	$0

Cost avoidance

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

Total cost avoidance $46,377,380

Providers and Managed Care Organizations	**$40,458,248**
Medicaid provider exclusions	$0
Fee-for-service front-end claims denial	$40,458,248
Clients	**$5,919,132**
Client disqualifications	$2,408,792
WIC vendor monitoring	$0
Pharmacy Lock-In	$2,456,584
Disqualification of Electronic Benefits Transfer recipients	$1,053,756

V. Provider Integrity

Trends

The Provider Investigations Team is always on the lookout for new trends in potential fraud, waste or abuse. The Intake Team carefully analyzes each complaint from MCOs, dental maintenance organizations (DMOs) and other sources to determine if a new trend is emerging. Once a trend is identified, investigators look at billing patterns across other payors and providers to gauge how pervasive the issue may be. Self-initiated, full-scale investigations may then be opened to address the issue. Staff also participate in multiple monthly information-sharing sessions with other states and review trends reported by national organizations and law enforcement agencies to assess if similar trends are present in Texas.

Provider Investigations Performance

- **548 Preliminary investigations opened**
- **588 Preliminary investigations completed**
- **73 Cases transferred to full-scale investigation**
- **58 Full-scale investigations completed**
- **238 Cases referred to OAG Medicaid Fraud Control Unit**
- **115 Open/active full-scale cases at end of quarter**

This quarter, preliminary investigations from multiple sources focused on standard-of-care allegations involving dental providers. Concerns included inappropriate administration of sedation, discharging the patient before they fully recovered from anesthesia, billing for sedation levels the provider was not credentialed to perform, providing non-medically necessary restorations and extractions, billing for failed sedation, and abnormally high numbers of dental services billed on a single date of service. Cases were transferred to full-scale investigations when warranted.

The OIG also initiated full-scale investigations on several pharmacy providers after data analysis showed billing for COVID-19 home testing kit refills without a prescription. To receive coverage for COVID-19 home testing kits that were not prescribed, pharmacies should not provide their own information but instead use the following information:

NPI: 3070440003 in the Prescriber ID field, "Test Kit Prescriber" as the provider's last name, "COVID" as the provider's first name, "HHSC" in the address section and CTK001 in the license section.

Medicaid and other HHS program dollars may be at risk if the pharmacist's NPI was utilized in lieu of the foregoing information on COVID-19 testing kit refill claims when there was no associated physician's prescription. An initial claim for a COVID test is authorized without a prescription, but refills are not authorized when there is no prescription. The full-scale investigations are currently ongoing.

Surveillance Utilization Review Team

Acute care provider recoveries	$510,081
Acute care services identified overpayments	$580,812
Acute care services cases closed	70
Hospital and nursing home (UR) recoveries	$4,150,394
Hospital (UR) claims reviewed	7,110
Nursing facility reviews completed	64
Average number of Lock-in Program clients	3,894

Provider Enrollment and Exclusions

Provider enrollment inventory (applications and informal desk reviews) processed	8,037
Individual screenings processed	21,682
Medicaid providers excluded	54

Case highlights

OIG settles case with East Texas hospice provider

The OIG settled a case in August with a Lufkin hospice provider. The OIG received the case after an investigation by a Centers for Medicare and Medicaid Services contractor. The contractor's investigation suggested that the provider was billing hospice services for ineligible patients. A review of medical records showed several patients did not meet initial requirements for admission or continued participation in hospice. The OIG pursued the resulting overpayment, reaching a settlement of $1,101,056.

OIG settles case with San Antonio home health agency

In July, the OIG settled a case with a San Antonio-area 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 agreed to a settlement of $49,392.

OIG settles with South Texas pediatrician

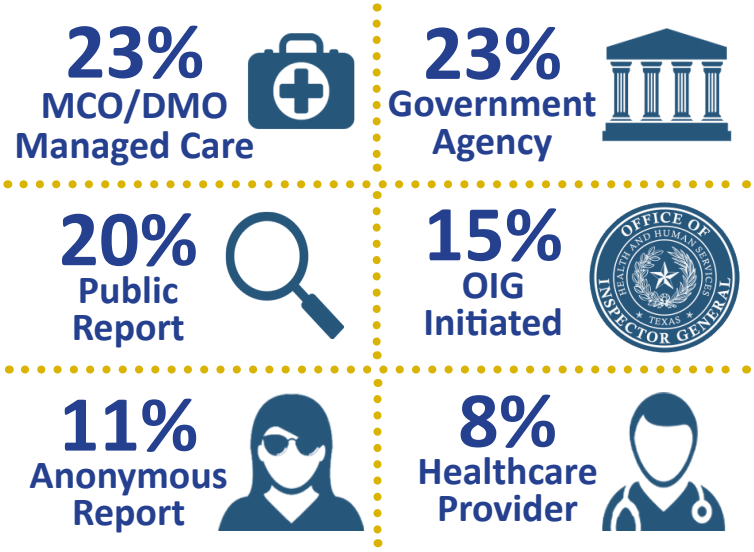
The OIG settled a case in June with a pediatric practice in Pharr. The provider inappropriately billed for hearing screenings as a separate service although hearing screenings are already included in Texas HealthSteps medical checkups. From March 1, 2018, through February 28, 2022, the provider billed for both services on the same date for the same recipient. The provider worked collaboratively with the OIG to resolve the issue, agreeing to repay the full $76,445 in overpayments.

Preliminary Provider Investigations Opened

Attendants	34%
Home health agencies	11%
Physicians (individual, group and clinic)	11%
Hospitals	9%
Dentists	5%
Pharmacies	5%
Durable medical equipment	5%
Nursing facilities	4%
Therapists (counseling)	3%
Parents, guardians, recipients,	3%
Case management	2%
Adult Day Care	2%
Therapists (physical, occupational and speech)	1%
Eleven other categories at less than 1%	5%

*Rounded to nearest whole number

Investigation Referral Sources



OIG reaches settlement with second Pharr pediatrician

The OIG settled a case in July with a different pediatric practice in Pharr. The provider inappropriately billed for molecular strep tests and rapid strep tests on the same day, even though they are mutually exclusive and cannot be reimbursed for the same date of service. During the investigation period, from January 1, 2018, through December 31, 2021, the provider received $66,761 in overpayments, which they agreed to repay as a result of the investigation.

OIG settles case with Houston dentist

In July, the OIG settled a case with a Houston-area dentist who used a substandard pulpotomy filling material for a Texas Medicaid recipient. Further investigation revealed that the dentist also provided unnecessary services to seven patients. The provider worked with the OIG to resolve these issues and settled for $40,000.

Types of Full-Scale Provider Investigations	
Hospitals	55%
Home health agencies	19%
Pharmacies	11%
Dentists	7%
Physicians (individual/group/clinic)	4%
Case management	1%
Durable medical equipment	1%
Lab and radiology	1%

Rounded to nearest whole number

OIG settles case with Central Texas home health agency

The OIG settled a case in August with an Austin-area home health provider. The OIG received the case in coordination with an investigation by the Texas Office of Attorney General, Medicaid Fraud Control Unit (OAG-MFCU). OAG-MFCU's investigation suggested that two personal care attendants were ineligible to provide services to a Medicaid client. One personal care attendant was a minor, and the other was the spouse of the client. The OIG worked with the provider to resolve the case, which ultimately resulted in a settlement of $39,079.

West Texas general practitioner settles case

In June, the OIG settled a case with a primary care physician involving several issues, including inadequate medical records for breathing tests, incorrect use of COVID-19 antibody testing for diagnostic purposes, and improper use of a CPT code for smoking cessation counseling to receive reimbursement for smoking prevention counseling. The provider and OIG were able to quickly resolve the issues and reached a settlement agreement for $58,309.

Self-report by Gulf Coast community services facility results in settlement

The OIG settled a case with a community living assistance and support services facility in Houston. Between September 2017 and October 2022, one of the provider's employees billed for services for multiple clients using the names of seven other caregivers. Those services were never provided. The individual then cosigned the checks made out to the caregivers to collect a portion of the proceeds. The provider terminated the employees involved and reported the incident to the OIG. They subsequently repaid $128,523 to Medicaid.

OIG settles case with South Texas home health provider

The OIG settled a case in June with a Laredo home health provider who improperly submitted claims for personal care attendant services. A personal care attendant working for the provider submitted records indicating that she provided services to a patient when, in fact, she was not present in the patient's home and never provided the service. She later admitted the wrongdoing to her employer, who worked with the OIG to resolve the issue. The OIG agreed to a settlement of $12,232.

OIG reaches settlement after nurse falsifies records

The OIG settled another self-report case in July with a nursing and rehabilitation center in Central Texas. A case management nurse at the center falsified records to support billing for IV fluids and IV medications from June 16, 2021, through November 4, 2022. After identifying the violation, the provider worked with the OIG and settled for the full overpayment of $228,064.

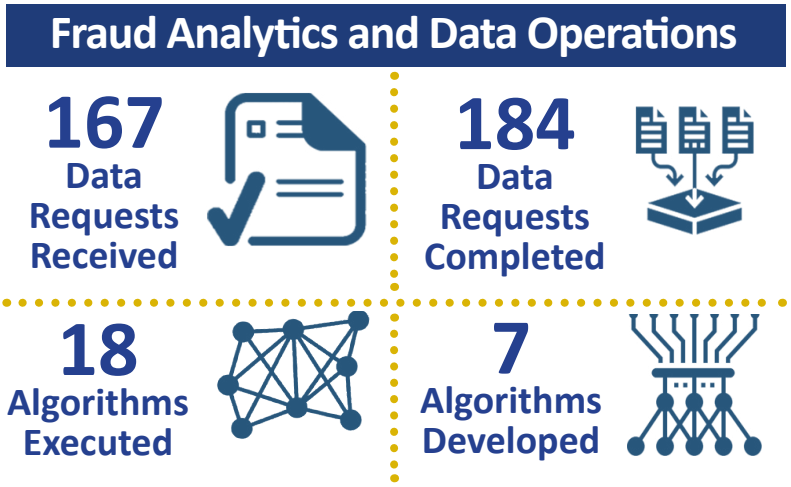
OIG settles case with South Texas pharmacy

The OIG settled a case in August with an Edinburg pharmacy. The investigation showed that the pharmacy billed for medications that were not supported by purchase records. The OIG worked with the provider to resolve the case by agreeing to a settlement of $130,000.

Agency highlights

Update: Fraud detection operation examines chemical dependency treatment facilities

An OIG fraud detection operation (FDO) is a data-driven investigative operation that identifies providers who are statistical outliers among their peers and assesses whether they are outliers because of fraud, waste or abuse or some other cause. Outlier status is not a conclusive indicator of wrongdoing, nor will every outlier be automatically selected for a full-scale investigation.



The OIG's FDO conducted in May was focused on chemical dependency treatment facilities and substance use disorders. The OIG FDO Team identified four providers that billed for substance use disorder residential and outpatient counseling services that stood out amongst other facilities.

After records collection, interviews and records reviews, the OIG opened four full-scale investigations, which will allow for a closer look at billing and documentation for those providers. Full-scale investigations could include additional interviews and review of a larger set of client clinical records to gain a broader understanding of the provider's operations.

The next FDO is scheduled for the first quarter of FY 2024 and will focus on pharmacy providers.

Data Operations and Surveillance Utilization Review Teams collaborate for streamlined case processing

This quarter the OIG Data Operations Team developed enhanced support and technology tools for the Surveillance Utilization Review (SUR) Team. This included the creation and implementation of new data-driven methods to identify viable clinical review scenarios, as well as modifying internal SUR systems to increase productivity and streamline case processing.

Fraud Analytics Team develops and shares innovative ways to identify potential fraud

The OIG's Fraud Analytics Team developed a set of complex algorithms to identify potentially improper practitioner and outpatient hospital claims. The algorithms flagged payments that do not meet National Correct Coding Initiative (NCCI) rules for services that should not be billed on the same day for the same patient. The team analyzed more than two million NCCI code pairs, identifying more than $100 million in potential improper practitioner and outpatient hospital payments, which will be further examined by the OIG.

Additionally, the Fraud Analytics Team began hosting quarterly interstate calls with counterparts in California, Illinois, New York and Tennessee to discuss data analytics technology, strategies and techniques. The calls provide a forum for data practitioners to share information on challenges and best practices that improve the data-driven discovery of fraud, waste and abuse. Discussion topics have included the structure of the analytics function within organizations and the comparison of analytics frameworks across states.

Data Initiatives Project Team develops new data exploration tools

The Data Initiatives Project Team (DIPT) developed and enhanced internal policies and procedures to streamline the team's work. Advances include a new risk matrix template, which is an initial exploration tool that uses different combinations of data elements to assess at-risk dollars and a new DIPT data flow diagram template that provides visualization of data sources involved in a particular case or group of cases. Additionally, DIPT implemented interactive workgroups – in lieu of numerous emails and separate discussions – for more comprehensive and immediate case resolution.

New Audit and Inspections Plan

The OIG updated the Audit and Inspections Plan for fiscal year 2024, which outlines potential areas of focus for future OIG work. The OIG Audit and Inspections Division conducts a continuous risk assessment to identify topics of interest. Potential audit and inspections topics consist of programs, services, providers and contractors with an elevated potential for fraud, waste and abuse. Topics identified for FY 2024 include telemedicine services, MCO financial statistical reports, and Home and Community Based Services cost reporting, among others. The new work plan is available on the OIG website.

OIG develops new system to identify potential fraud, waste or abuse

The OIG recently developed a system to track new Medicaid benefits and analyze utilization data at regular intervals after implementation to identify billing patterns and potential outliers. Based on this analysis, the OIG will determine whether the new benefit should be subject to an audit, inspection, investigation or review, and whether a policy clarification or technical assistance, such as provider training or education, is warranted. Evaluating new Medicaid benefits through data analysis will inform future OIG work.

Completed audit reports

Family Violence Prevention Services: A Texas Health and Human Services Commission Family Violence Program Contractor

Family Violence Prevention Services (FVPS) receives grant funding under the Residential and Non-Residential Family Violence Services Grant Program. The audit scope was September 1, 2020, through August 31, 2022. During the audit scope, FVPS was awarded $2,138,906 from the grant program. FVPS used grant funding for the scope period exclusively for salaries and fringe benefits. The OIG conducted this audit to determine whether FVPS had financial processes and controls in place to help ensure grant expenditures were accurate, allowable and supported. The audit determined FVPS had the required financial processes and controls in place according to the terms of the grant, and the audit had no findings.

Audit Performance

$588,215
Overpayments Recovered

$5,234,672
Overpayments Identified

20
Audit Reports Issued by OIG

7
Audit Reports In Progress

Audits in Progress	7
Managed Care Vendor Drug Program Provider	
Managed Care Telemedicine Provider	
Dental Maintenance Organization Financial Statistical Reporting	
Local Mental Health Authority Provider	
Pharmacy Benefit Services Provider	
Prescribed Pediatric Extended Care Center	

Audit Reports Issued 20

Family Violence Prevention Services: A Texas Health and Human Services Commission Family Violence Program Contractor (June 15, 2023)

Bridge Emergency Shelter Operated by Roy Maas Youth Alternatives (June 30, 2023)

Women's Protective Services of Lubbock: A Texas Health and Human Services Commission Family Violence Program Contractor (June 30, 2023)

Follow-Up Assessment on Previously Issued Audit Recommendations: Security Controls Over Confidential HHS System Information at El Paso Health (July 14, 2023)

Fred and Mabel R. Parks Emergency Shelter Operated by Parks Youth Ranch (July 18, 2023)

Summary of Results: Security Controls Over Confidential HHS Information - Selected Entities Contracted to Provide Services for Texas Medicaid and CHIP (July 27, 2023)

Follow-Up Assessment on Previously Issued Audit Recommendations: Security Controls Over Confidential HHS System Information at DentaQuest USA Insurance Company (July 28, 2023)

Follow-Up Assessment on Previously Issued Audit Recommendations: Security Controls Over Confidential HHS Information at Aetna Better Health of Texas (August 4, 2023)

Administrative and Medical Expenses Reported on Financial Statistical Reports: Texas Children's Health Plan, Inc. (August 7, 2023)

Follow-Up Assessment on Previously Issued Audit Recommendations: Security Controls Over Confidential HHS Information at Parkland Community Health Plan, Inc. (August 7, 2023)

Managed Care Pharmacy Encounters Paid to Texas Children's Hospital–Specialty Pharmacy: A Managed Care Network Provider Contracted Under UnitedHealthcare Community Plan of Texas, L.L.C. and UnitedHealthcare Insurance Company, Inc. (August 8, 2023)

Parkland Community Health Plan: Special Investigative Unit (August 10, 2023)

Security Controls Over Confidential HHS Information: Driscoll Health Plan (August 15, 2023)

Texas Medicaid (Title XIX) Home Health Durable Medical Equipment and Supplies: Informational Report (August 15, 2023)

The PsyClinic: A Texas Medicaid Provider (August 18, 2023)

Follow-Up Assessment on Previously Issued Audit Recommendations: Fee-for-Service Claims Submitted by Aveanna Healthcare Medical Solutions (August 21, 2023)

Lauve's Pediatric Extended Care: A Prescribed Pediatric Extended Care Center in Longview, Texas (August 22, 2023)

Oversight of the Sexually Transmitted Disease/Human Immunodeficiency Virus (STD/HIV) Prevention Services Program: Texas Department of State Health Services (August 22, 2023)

Driscoll Children's Health Plan: Special Investigative Unit (August 23, 2023)

The Bridge Over Troubled Waters, Inc.: A Texas Health and Human Services Commission Family Violence Program Contractor (August 30, 2023)

Bridge Emergency Shelter Operated by Roy Maas Youth Alternatives

The OIG conducted an audit to determine whether Roy Maas Youth Alternatives, Inc. (RMYA) had processes and controls in place to ensure it provided foster care services at Bridge Emergency Shelter in accordance with selected statutes, contract terms and minimum standards. The audit scope included processes and controls related to staff, child services and revenue from September 1, 2021, through August 31, 2022, as well as processes and controls related to selected expenses from July 1, 2020, through June 30, 2021.

RMYA is a non-profit children's home and shelter. This audit focused on operations at the Bridge Emergency Shelter in San Antonio, Texas, which provides emergency care for children ages 5 through 17, for up to 90 days. During that time, RMYA identifies more permanent placement options for those children.

RMYA had processes and controls in place to ensure the Bridge Emergency Shelter met selected requirements designed to ensure the health and safety of children in its care. Specifically, for the sample tested in each category, RMYA completed preliminary and initial service plans that included all selected elements and performed health screenings for all the children's records tested, had caregivers on duty to meet the required ratios, ensured staff passed their background checks and drug tests and met training requirements, and verified the accuracy of payments it received.

However, the audit concluded RMYA should strengthen its processes and controls over expenses. RMYA did not always ensure expenses reported on its 2021 cost report were allowable or supported, as required. Including unallowable, inaccurate or unsupported expenses on the cost report makes HHSC's rate setting less reflective of the actual cost of providing foster care services. RMYA should strengthen its processes to support the allowability and accuracy of expenses included on its cost report, include only allowable costs on its cost report, and include expenses in the correct account on its general ledger.

Women's Protective Services of Lubbock: A Texas Health and Human Services Commission Family Violence Program Contractors

Women's Protective Services of Lubbock (WPS) is a Family Violence Program contractor that provides crisis intervention, emergency shelter and support services to battered women and their dependent children in Lubbock, Texas, and surrounding communities. HHSC passed through to WPS $1.07 million in grant funding for services delivered in 2021 and $1.08 million in grant funding for services delivered in 2022.

The OIG audited WPS to determine whether WPS had financial processes and related controls to help ensure it complied with selected rules and contract requirements and appropriately revised the budget for the selected grant to account for Paycheck Protection Program funding. The audit scope covered the period from April 1, 2020, through August 31, 2022.

WPS had processes and controls in place to ensure that expenses were allowable. However, WPS should strengthen controls to ensure assets are secured and adequately tracked and expenses are accurate and supported. Specifically:

- A $1,600 laptop computer was not opened and tested promptly. It was opened and discovered to be inoperable after the 30-day warranty had passed. Further, there was no record of the disposal of the computer.
- WPS paid $1,200 for the installation of a heating, ventilation and air conditioning system that had been received in June of 2021 but not installed more than a year later.
- Of the 76 items observed during on-site testing, 46 (61%) were not in use by WPS clients. Of the 46 items, 25 (54%) had not been placed in use for 12 months or longer after the purchase date.

- Inaccuracies in the general ledger resulted in WPS's grant expense report supporting funding of an order for $2,880 for a storage cabinet split between two HHSC grants. WPS received the funding, but the order was canceled, and the vendor refunded the cost to WPS. The amount should be repaid to HHSC.

WPS should:

- Develop and define a process to ensure all items purchased are received, inventory processes for consumable items, and inventory processes for non-consumable assets such as appliances and electronics.
- Repay HHSC $2,880 for the item refunded and determine if there were additional instances of overstating expenses for purchases not completed, work with HHSC to correct its reporting and repay unexpended grant funds, strengthen processes and controls related to receiving and, implement monitoring controls associated with financial processes if segregation of duties is not possible.

Fred and Mabel R. Parks Emergency Shelter Operated by Parks Youth Ranch

This audit focused on operations at the Fred and Mabel R. Parks Emergency Shelter (Parks Emergency Shelter) in Richmond, Texas, which is licensed to provide emergency care for services for up to 30 children, ages 7 through 17, for up to 90 days. During this time, Parks Youth Ranch, Inc. (Parks Youth) identifies more permanent placement options for those children. Parks Emergency Shelter served 56 children during FY 2022. The audit objective was to determine whether Parks Youth had processes and controls in place to provide foster care services at the Parks Emergency Shelter in accordance with selected statutes, contract terms and minimum standards.

Parks Youth had processes and controls in place over the Parks Emergency Shelter for it to meet selected requirements designed to protect the health and safety of children in its care. Specifically, (a) Parks Youth performed initial health screenings or verified that other acceptable medical examinations had been completed mostly within required timelines, (b) Parks Youth mostly completed initial service plans within 72 hours of admission, (c) Parks Youth mostly completed initial service plans to address all of the child's needs and within 45 days of admission as required, (d) Parks Youth had caregivers on duty to meet the required ratios over the 25 days tested and (e) Parks Youth's staff passed their background checks, passed drug tests and met training requirements. Additionally, for the tested payments it received from the Department of Family and Protective Services, Parks Youth verified the accuracy of all 15 payments.

However, Parks Youth did not always include only allowable costs on its 2021 cost report. Specifically, 7 of 25 expenses tested (28%) included sales tax, which is an unallowable cost. Including unallowable costs on the cost report inflates reported expenses, which makes HHSC's rate setting less reflective of the actual cost of providing childcare services.

Parks Youth should develop and strengthen its processes to include only allowable costs on its cost report and strengthen its processes and controls to complete health screenings within required timeframes and complete service plans within required timelines that include all required needs and support required individuals' participation and approval.

Summary of Results: Security Controls Over Confidential HHS Information - Selected Entities Contracted to Provide Services for Texas Medicaid and CHIP

During the period from August 2017 through June 2022, the OIG conducted 11 audits of security controls over confidential HHS information. The summary report provided additional detail about the confidential findings of noncompliance identified by the OIG. Distribution of the confidential issues was limited to HHS System personnel, responsible contractors and applicable state officials that are authorized to receive this information.

Administrative and Medical Expenses Reported on Financial Statistical Reports: Texas Children's Health Plan, Inc.

The OIG audited Texas Children's Health Plan, Inc.'s (TCHP's) process for preparing and submitting expenses on its 334-day 2021 Medical financial statistical reports (Medical FSRs) and Combined Administrative and Quality Improvement Expenses financial statistical report (Combined FSR) based on the risk of incorrectly reported expenses on the financial statistical reports (FSRs), including unallowable expenses without sufficient support.

Overall, TCHP's processes and related controls for preparing and submitting expenses on its 334-day 2021 Medical FSRs and Combined FSRs were effective but had some control deficiencies. TCHP had a process for preparing FSRs, which included effective controls related to identifying and removing unallowable general ledger amounts and reconciling FSR data to the general ledger.

However, TCHP (a) did not determine the fair market value of affiliate fee-for-service and capitation expenses for four affiliates reported on the Medical FSRs prior to the reporting on the FSRs, (b) did not provide detailed fair market value analysis for affiliate expenses reported on the Medical FSRs, (c) overstated affiliate fee-for-service and capitation expenses on the Medical FSRs for two affiliates, (d) did not report all affiliate expenses on the total related party expenses line on the Medical FSRs and (e) had control deficiencies in corporate allocations related to (a) reporting of estimates resulting in an understatement on the FSR and (b) reporting accruals. As a result of these issues, TCHP overstated expenses by $5 million.

When unallowable and questioned expenses are included on FSRs, there is a risk that the Texas Health and Human Services Commission (HHSC) may rely on inaccurate information when setting capitation rates. Additionally, reported net income may be inaccurate when calculating experience rebates. TCHP should:

- Prepare and maintain support for determining the qualification to report affiliate expenses at fair market value prior to reporting on the FSRs.
- Request guidance from HHSC Financial Reporting and Audit Coordination (FRAC) regarding the appropriateness of using the Medicare Advantage Plan bid instructions as a basis for determining the fair market value of affiliate medical fee-for-service and capitation expenses. While the use of fair market value reporting does not require HHSC's prior approval, failure to obtain assurance for utilizing non-Medicaid guidelines could be subject to HHSC's determination of allowability.
- Implement a process to ensure all subcontractors provide HHSC and its designees prompt, reasonable and adequate access to any support that is related to the scope of the contract between HHSC and TCHP, as required by the Uniform Managed Care Contract.
- Implement a process to determine when adjustments to fair market value are required for affiliate fee-for-service and capitation medical expenses reported on the Medical FSRs and adjust the reported expenses to fair market value when required.
- Include all affiliate medical expenses it reports in the total related party expenses on the Medical FSRs, Part 5.
- Implement a process to true-up all estimates to actual expenses before it submits the 334-day FSRs to HHSC.
- Implement a process to track actual payments and true up administrative expenses to report costs actually incurred in the FSRs.

TCHP is a managed care organization (MCO) contracted to provide Medicaid and CHIP services to Texas Medicaid and CHIP members through its network of providers. During the period from September 1, 2020, through August 31, 2021, TCHP reported $2.45 billion in total gross revenue and served an average of 514,865 members per month for all programs and service areas.

Managed Care Pharmacy Encounters Paid to Texas Children's Hospital–Specialty Pharmacy: A Managed Care Network Provider Contracted Under UnitedHealthcare Community Plan of Texas, L.L.C. and UnitedHealthcare Insurance Company, Inc.

The OIG conducted an audit of managed care encounters paid to Texas Children's Hospital–Specialty Pharmacy (TCH–SP) to determine whether TCH–SP (a) properly billed for selected paid encounters associated with Texas Medicaid members enrolled with UnitedHealthcare and (b) complied with applicable contractual, state and federal requirements.

TCH–SP properly billed for paid pharmacy encounters and complied with applicable contractual, Texas Administrative Code and federal requirements for most encounters tested; however, TCH–SP did not consistently comply with certain requirements for medication dispensing and accurate claims submission. TCH–SP did not consistently comply with some requirements for medication dispensing and claims submission. Specifically:

- For 118 of 120 encounters tested, TCH–SP dispensed prescribed medication as required. However, TCH–SP submitted one claim with a dispensed quantity of 90 mL when the prescription was written with a quantity of 150 mL and a second claim's dispensing label indicated a 30 days' supply when the prescribed days' supply was 25 days.
- For 44 of 120 encounters tested, the number of authorized refills on the prescription did not match the number of refills authorized on the encounter.

TCH–SP should:

- Dispense prescriptions in quantities that align with the prescribed quantity.
- Print dispensing labels with the correct days' supply based on the prescribed dispensing instructions.
- Verify that the authorized refills it submits for each pharmacy claim are complete and accurate.

During the audit scope, which covered the period from September 1, 2017, through August 31, 2022, TCH–SP was paid $15.4 million for 20,205 Texas Medicaid managed care encounters for prescriptions dispensed to UnitedHealthcare members.

Parkland Community Health Plan: Special Investigative Unit

Managed care organizations must have a special investigative unit to investigate potential fraud, waste or abuse by members and health care service providers. The OIG audited Parkland Community Health Plan (Parkland) to determine whether its SIU complied with certain state and contractual requirements related to (a) preventing, detecting and investigating fraud, waste and abuse and (b) reporting reliable information on SIU activities, results and recoveries to the OIG. Parkland met certain requirements related to staffing, performing recovery efforts when fraud or abuse was identified and remitting half the money recovered to the OIG. However, its investigations did not always include all required elements, it did not always refer investigations that identified possible fraud, waste or abuse to the OIG timely, and its new employees did not always receive required training timely. Parkland should:

- Strengthen processes and controls to include all required elements of preliminary investigations.
- Develop and implement processes and controls to complete preliminary investigations within required timeframes.
- Develop and implement processes and controls to complete extensive investigations within required timeframes and document dates of completion.
- Select samples that meet minimum size requirements.

- Strengthen processes and controls to include all required elements of extensive investigations.
- Complete timely notification and referrals of possible acts of fraud, waste or abuse to the OIG as required.
- Strengthen processes and controls to provide employees directly involved with Texas Medicaid or CHIP with fraud, waste and abuse training within 90 days of employment.

Security Controls Over Confidential HHS Information: Driscoll Health Plan

During FY 2022, Driscoll Health Plan (Driscoll) provided services to Texas members through the Medicaid STAR program, the Medicaid STAR Kids program and CHIP. For these services, Driscoll received capitation payments totaling $1.25 billion.

The OIG audited Driscoll to determine whether Driscoll had select information and security controls that effectively protected confidential HHS System information. Driscoll complied with most of the information security requirements tested; however, it did not comply with certain information security requirements applicable to confidential HHS System information. HHS System information must be managed in accordance with HHS Information Security Controls (IS-Controls) as required by the Uniform Managed Care Contract and the STAR Kids Managed Care Contract. The OIG made recommendations which, if implemented by Driscoll, will further protect confidential HHS System information.

Texas Medicaid (Title XIX) Home Health Durable Medical Equipment and Supplies: Informational Report

Texas Medicaid and CHIP cover durable medical equipment (DME), expendable medical supplies provided to eligible recipients at their place of residence and certain nutritional products. This topic is of interest to oversight agencies because of the nature of DME and supplies being delivered to patients for home use.

This informational report provides:

- An overview of how Texas Medicaid and CHIP patients can access DME and supplies.
- Texas Medicaid and CHIP requirements for DME and supplies providers.
- Research and analysis of DME and supplies completed by the OIG.
- A discussion of the different types of DME and supplies.

The PsyClinic: A Texas Medicaid Provider

Due to the increased risk associated with teleservices claims for evaluation and management with add-on psychotherapy services caused by the increase in teleservices provided during the COVID-19 pandemic, the OIG conducted an audit of teleservices provided by the PsyClinic. During the audit scope, which covered the period from June 1, 2021, through December 31, 2021, the PsyClinic was paid $381,574 for 4,363 Medicaid managed care claims for evaluation and management services provided via teleservices with add-on codes for psychotherapy.

The audit objective was to determine whether (a) teleservices provided by the PsyClinic were billed accurately and in accordance with applicable requirements and (b) related internal controls over teleservices were designed and operating effectively. The audit scope includes Medicaid managed care teleservices claims paid for evaluation and management services with add-on psychotherapy services for the period from June 1, 2021, through December 31, 2021, as well as a review of relevant internal controls.

The PsyClinic provided behavioral health services to its patients via teleservices; however, the PsyClinic incorrectly billed for some add-on psychotherapy services. Additionally, the PsyClinic received reimbursement for teleservices delivered by providers who were not enrolled in Texas Medicaid. As a result, the PsyClinic was

overpaid $1,719 and should repay the state of Texas the total extrapolated overpayment amount of $54,087. The PsyClinic should:

- Implement processes to ensure that claims for services billed as time-based CPT codes are based on the actual length of services provided, medical records include documentation to support the CPT codes billed and medical records separately identify services provided.
- Verify its providers are enrolled in Texas Medicaid prior to the providers delivering services to patients.

Oversight of the Sexually Transmitted Disease/Human Immunodeficiency Virus (STD/HIV) Prevention Services Program: Texas Department of State Health Services

The OIG conducted an audit of the Texas Department of State Health Services (DSHS), which managed oversight activities for the Sexually Transmitted Disease/Human Immunodeficiency Virus (STD/HIV) Prevention Services Program. DSHS acts as a pass-through entity between the U.S. Centers for Disease Control and Prevention (CDC) and the contracted local health departments for STD prevention and control programs. Contracts for all 17 contracted local health departments were valued at $35.2 million for the period from January 1, 2021, through August 31, 2022.

DSHS performed contracting and program management activities for the STD/HIV Prevention Services Program, such as verifying that contracts were reviewed and approved before execution and program reimbursements did not exceed total budgets. However, management functions did not always effectively ensure (a) program performance measures were met, (b) financial expenditures were supported, (c) security and confidentiality requirements were communicated and (d) contract development quality assurance checklists were completed timely. DSHS should:

- Enforce contract requirements and direct contracted local health departments to report program performance measures.
- Use information obtained from program performance measure reports to enforce compliance with program requirements and identify opportunities for program improvement.
- Establish processes and controls to limit expenditures to allowable program activities for the STD/HIV Prevention Services Program.
- Develop a process to verify that submitted voucher support forms describe the goods and services provided in sufficient detail to meet state and federal contracting requirements.
- Develop processes to include and update all relevant security requirements in DSHS guidance manuals, instructions and contract language, as applicable.
- Develop a process to complete the contract development quality assurance process timely and align its STD/HIV Prevention Services Program contracts and amendments with internal DSHS requirements as well as requirements from the Code of Federal Regulations and Texas grant management standards.

Driscoll Children's Health Plan: Special Investigative Unit

Driscoll Children's Health Plan (Driscoll) Special Investigative Unit (SIU) did not consistently comply with certain state and contractual requirements related to (a) preventing, detecting and investigating fraud, waste and abuse and (b) reporting reliable information on SIU activities, results and recoveries to the OIG. The OIG performed a similar audit of Driscoll's SIU in 2018, and several issues of noncompliance identified at that time remained uncorrected. Specifically, Driscoll did not:

- Allocate staff and resources to effectively conduct Texas investigations.
- Maintain support that it met required timelines in its preliminary investigations.

- Maintain a complete and accurate incidence log.
- Always meet required timelines or maintain support that it met required timelines in its extensive investigations.
- Always submit information to the OIG on the MCO Open Case List Report timely, completely and accurately.
- Always refer possible acts of fraud, waste and abuse to the OIG.

This audit also includes previously unidentified issues, including that Driscoll did not always include required elements in preliminary investigations, remit half of fraud or abuse recoveries to the OIG and verify that all its subcontractors received fraud, waste and abuse training. Driscoll should:

- Strengthen resource commitment to the SIU to perform all tasks required by the SIU function.
- Strengthen or implement processes and controls for preliminary investigations to include all required elements, complete investigations within required timeframes and document dates of completion.
- Capture all required data accurately in its internal incidence log.
- Ensure it meets and adequately documents the timelines of completion of all extensive investigation elements.
- Capture complete and accurate data on the open case list and submit the open case list to the OIG by the required deadlines.
- Submit referrals to the OIG for the four investigations that were not referred in which the SIU investigation determined possible acts of fraud, waste or abuse had occurred in Medicaid or CHIP and submit all findings of possible fraud, waste or abuse to the OIG.
- Remit $14,369 to the OIG and designate sufficient staff or other resources to timely remit half of recovered funds when an SIU investigation determined fraud or abuse occurred in Medicaid or CHIP.
- Include training requirements in subcontracts and verify subcontractors directly involved with Texas Medicaid or CHIP receive fraud, waste and abuse training within 90 days of employment and annually thereafter.

Follow-Up Assessment on Previously Issued Audit Recommendations: Fee-for-Service Claims Submitted by Aveanna Healthcare Medical Solutions Unit

The OIG conducted a follow-up assessment of the previously issued audit report titled “Fee-for-Service Claims Submitted by Aveanna Healthcare Medical Solutions: A Texas Medicaid Durable Medical Equipment and Supplies Provider” to determine the implementation status of previous audit recommendations. The previously issued audit report was published on July 30, 2020, and the objective was to determine whether there was valid support for the authorization and delivery of fee-for-service durable medical equipment (DME) and supplies associated with Medicaid claims submitted by and paid to Aveanna as required by state laws, rules and guidelines. Aveanna did not fully implement all reported audit recommendations. As a result, the OIG reissued two recommendations from the previous audit. Aveanna should:

- Update its staffing and scheduling procedures to meet staffing ratio requirements.
- Maintain scheduling and attendance documentation to support it met the requirements.
- Improve its coordination with therapy providers to verify each patient receives the therapy services to be provided in the PPECC setting as prescribed on the patient’s plan of care.
- Implement procedures to update (a) current plans of care for each patient to reflect the amount, duration and frequency of occupational, physical and speech therapy services the patient will receive in the PPECC setting and (b) changes to patient needs for therapy services to be received in the PPECC setting.

- Complete annual employee checks of both the Employee Misconduct Registry and the Nurse Aide Registry.
- Implement a secondary review process to verify it provided services before claims are submitted. If the associated documentation does not support services were provided, Lauve's Pediatric should make corrections prior to submitting the claim.

The Bridge Over Troubled Waters, Inc.: A Texas Health and Human Services Commission Family Violence Program Contractor

The Bridge Over Troubled Waters, Inc. (The Bridge) is a Family Violence Program contractor that provides crisis intervention, emergency shelter and support services to families in Harris County, Texas. An HHSC grant awarded The Bridge $986,376 for services delivered in 2021 and $1.6 million for services delivered in 2022. The OIG audited The Bridge to determine whether The Bridge had financial processes and controls to ensure grant expenditures were accurate, allowable and supported.

The Bridge complied with requirements related to support for salary expenses and usually followed its internal salary processes and procedures. Specifically for items tested:

- Pay rate forms were approved by human resources and management.
- The employee's supervisor signed most timesheets to certify time as accurate.
- The payroll register included the approved rates for most of the employees.
- Most timesheet grant distribution sheets were signed and dated by a supervisor and listed the correct hours.

However, (a) some expenditures were unallowable or unsupported, (b) some salary allocations did not align with the HHSC-approved budget and (c) The Bridge could not support how costs were allocated to the Family Violence Program grant. The OIG offered recommendations to The Bridge, which, if implemented, will help The Bridge comply with grant contract requirements to document accurate and allowable expenditures and have effective controls.

Follow-Up Assessment on Previously Issued Audit Recommendations: Security Controls Over Confidential HHS System Information at El Paso Health, DentaQuest USA Insurance Company, Aetna Better Health of Texas and Parkland Community Health Plan, Inc.

The OIG conducted a follow-up assessment of four previously issued audit reports to determine the implementation status of audit recommendations previously issued by the OIG. The audit reports were published between August 2020 and January 2021. The three managed care organizations and one dental maintenance organization each fully implemented all reported audit recommendations. As a result, the OIG did not reissue any recommendations from the previous audits.

Completed inspection reports

Ambulance Claims Oversight: Molina Healthcare of Texas, Inc.

The OIG performed an inspection of ambulance services claims paid by Molina Healthcare of Texas, Inc. (Molina Healthcare), a Texas Medicaid MCO to determine whether Molina Healthcare has processes and controls to ensure ambulance claim payments comply with select requirements during FY 2022. Molina Healthcare's claims system has controls in place to identify non-medically necessary claims and deny the claims as required. However, Molina Healthcare's claims system did not have controls to consistently ensure compliance with required prior authorizations, claims modifiers, or procedure code combinations. Specifically, Molina Healthcare allowed payment for:

Inspections Completed 4

Ambulance Claims Oversight: Molina Healthcare of Texas, Inc. (June 1, 2023)

Mental Health Private Psychiatric Bed Funds: PermiaCare (June 16, 2023)

Ambulance Claims Oversight: Driscoll Health Plan (August 29, 2023)

Ambulance Claims Oversight: Community First Health Plans (August 31, 2023)

Inspections in Progress 4

Durable Medical Equipment Wound Care Supplies Billing (3 inspections)

Mental Health Private Psychiatric Funds

- 10 of 45 tested nonemergency ambulance claims, without required prior authorization.
- Six tested emergency ambulance claims, without the required modifier. Additionally, three of the six did not have the required transport procedure codes.

Molina should:

- Strengthen its claims processing controls to identify claims requiring a prior authorization and deny the claim if a prior authorization is not obtained.
- Clarify its standard operating procedures language and train its claims processing staff on nonemergency and emergency transport claims processing.

Mental Health Private Psychiatric Bed Funds: PermiaCare

PermiaCare is a local mental health authority that provides outpatient clinical services and subcontracts with private psychiatric hospitals for inpatient services. It serves eight counties in West Texas. In August 2021, PermiaCare signed a contract with HHSC for $449,684 in mental health private psychiatric bed funds for FY 2022. The OIG conducted this inspection to determine whether PermiaCare used mental health private psychiatric bed funds in accordance with certain elements of the statement of work in its HHSC contract during FY 2022.

For the inspection scope period, PermiaCare facilitated 78 client hospitalizations using the mental health private psychiatric bed funds available. However, of the 78 inpatient hospitalizations, PermiaCare:

- Overpaid a total of $15,569 for eight hospitalizations (10.3%).
- Underpaid $30,909 for 11 hospitalizations (14.1%).
- Paid two invoices twice.
- Paid for nine continued stays that were not approved.

PermiaCare should:

- Strengthen internal controls over payment processes for accurate payment of invoices.

- Review all payments made from the beginning of its contract with HHSC in 2021 to identify and resolve any potential overpayments, underpayments or duplicate payments.
- Strengthen its internal controls to ensure continued stay authorizations meet contract requirements.

Managed Care Claims Submitted by Byram Healthcare Centers: A Texas Medicaid Durable Medical Equipment and Supplies Provider

Recent litigation involving durable medical equipment (DME) and supplies providers who submitted false Medicare wound care supply claims prompted an interest in reviewing the potential risk for wound care supplies in Texas Medicaid. The OIG initiated this inspection to determine whether claims for wound care supplies were supported. The objective was to determine whether Byram Healthcare Centers (Byram) supported its wound care supply claims according to guidelines. The inspection scope covered the period from January 1, 2022, through July 20, 2022.

The OIG tested 15 invoices for inventory purchased for Byram's Flower Mound distribution center and the associated payments. All 15 invoices and payments showed Byram purchased items comparable to the items distributed to Medicaid clients. The OIG also tested 30 managed care claims for wound care supplies delivered to 24 Medicaid clients. All selected managed care claims for this inspection exceeded monthly quantity limitations for supplies without prior authorization according to the Texas Medicaid Provider Procedures Manual (TMPPM). For the claims tested, while the quantity and type of supplies ordered matched the quantity and type prescribed and billed, Byram's records did not always support the medical necessity of the supplies or contain all practitioner information. Of the 30 claims tested:

- 20 (67%) included complete order form information.
- 10 (33%) did not have complete order form information, including seven with one instance of noncompliance and three with multiple instances of noncompliance.
- Eight (27%) did not have support for the medical necessity of the DME supplies.

Byram's client records should contain practitioner notes to support the need for supplies. Byram should retain the support for the orders in its records. Byram should also ensure client records are complete. The records must include the order, the quantity of supplies ordered, the practitioner's signature, and the date of the last client visit.

Ambulance Claims Oversight: Community First Health Plans and Driscoll Health Plan

In 2021 and 2022, the OIG audited ground emergency ambulance services and identified that some MCOs paid non-medically necessary ambulance claims as medically necessary, even though ambulance providers correctly coded them as non-medically necessary. These inspections were to determine whether Community First Health Plans and Driscoll Health Plan have processes and controls to ensure non-medically necessary ambulance claims are denied in compliance with applicable requirements.

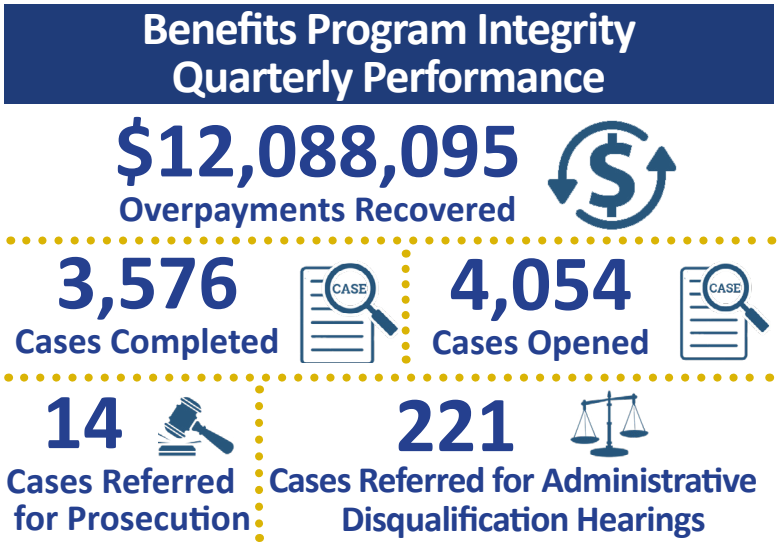
- Community First's claims processing staff did not consistently deny the claims, as required. Consequently, Community First paid Texas Medicaid funds for 33 non-medically necessary ambulance transport claims.
- Driscoll paid for nine non-medically necessary ambulance claims.

The OIG offered recommendations to Community First and Driscoll, which, if implemented, will help their ambulance claim payments comply with applicable requirements.

VI. Client Accountability

Trends

The Benefits Program Integrity (BPI) Unit completed 3,576 investigations involving benefit recipient overpayments or fraud allegations. Concerns involving a client's household composition made up 72% of all completed BPI investigations, with an additional 22% involving unreported income. Household composition cases usually involve an unreported household member who has reportable income or a reported household member who does not live in the same residence. Both instances cause the household to receive more benefits than they are eligible for. For this quarter, BPI referred 14 investigations for prosecution and 221 investigations for administrative disqualification.



Case highlights

Dallas SNAP client pleads guilty to felony charges

A Dallas woman pleaded guilty in district court to felony Securing Execution of a Document by Deception after an OIG investigation. The individual applied to receive SNAP and Medicaid benefits, but OIG investigators found that she failed to report all of her earned income. If the defendant had truthfully disclosed her household's income, her eligibility benefits would have been drastically reduced. In total, the defendant obtained more than $54,407 in SNAP and Medicaid benefits to which she was not entitled. On June 23, 2023, the defendant was sentenced to 30 days of deferred probation and ordered to pay $54,407 in restitution to Texas Health and Human Services, which she did. The individual was also disqualified from the SNAP program for 12 months.

Dallas area SNAP client pleads guilty to felony charges

A Garland, Texas woman pleaded guilty in district court to felony charges of Securing Execution of a Document by Deception following another OIG investigation. The individual applied to receive SNAP and Medicaid benefits but failed to report a required household member. OIG investigators found evidence the unreported required household member was employed and receiving regular income. Eligibility for SNAP and Medicaid is tied to household resources. Therefore, applicants are legally required to provide truthful information regarding income, financial resources and household composition. In total, the defendant obtained more than $51,493 in SNAP and Medicaid benefits she was not entitled to. On August 2, 2023, the defendant was sentenced to five years deferred probation and ordered to pay $51,493 in restitution to Texas Health and Human Services. The defendant was also disqualified from the SNAP program for 12 months.

Agency highlights

BPI records two top-producing months in Q4

BPI had two of its highest producing months in the fourth quarter of FY 2023. The team identified $6.6 and $6.5 million in future recoveries in June and July, respectively. These future recoveries are based on criminal and civil investigations involving fraud, waste and abuse of recipient benefits where recoveries are expected after the legal process concludes.

BPI expands internship opportunities

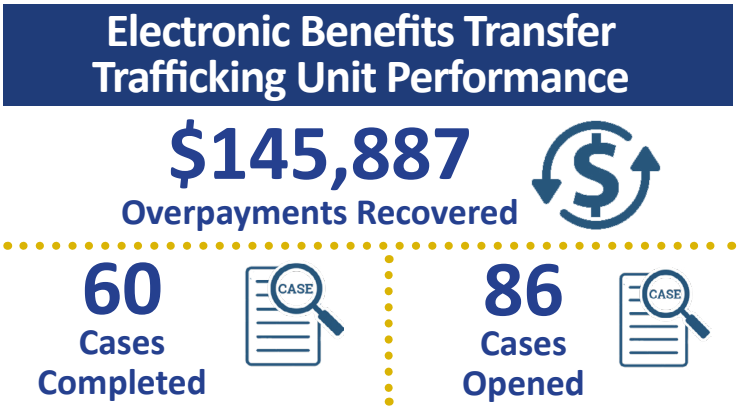
Over the last several years, BPI has engaged with local universities to establish internship programs in areas with a high volume of cases. The programs benefit the OIG by providing extra workers and broader community engagement. After successful pilot programs with the University of Texas San Antonio and the University of Texas Rio Grande Valley, BPI expanded the 2023 internship program to the University of Texas Arlington. The Dallas-Fort Worth area is one of the state's highest volume regions for benefits fraud cases. We look forward to working with our university partners and expanding the internship program further in 2024.

VII. Retailer Monitoring

Trends

Electronic Benefits Transfer Trafficking Unit

This quarter, the Electronic Benefits Transfer (EBT) unit completed 60 investigations, presenting 33 cases for administrative disqualification hearings and two for prosecution The most common occurrence across cases involves clients selling their SNAP benefits to a small store or food truck in exchange for cash. The retailers typically pay a discounted rate to the EBT cardholders, who welcome the cash, and the retailers use the full amounts of the benefits to buy inventory for their businesses.



WIC Vendor Monitoring Unit

This quarter, the Women, Infants, and Children (WIC) Vendor Monitoring Unit (VMU) conducted 18 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. No violations were cited.

The team also completed 79 inventory reviews across the state. An inventory review is a comparison of a vendor's paid claims and purchase invoices for WIC food items. The purpose of the inventory review is to determine if the vendor had a sufficient inventory of WIC food items to justify submitted claims. All vendors reviewed this quarter were in compliance.

The WIC VMU also conducted 110 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

Tortilleria permanently disqualified from SNAP for program violations

The EBT Trafficking Unit received a complaint alleging a drive-through tortilleria allowed hot prepared food to be purchased using EBT SNAP benefits, which violates SNAP rules. The owner also allegedly provided cash loans to employees who were EBT recipients and allowed them to repay the loans using SNAP benefits. OIG investigators conducted an undercover operation in which they purchased ineligible items from the store. They also interviewed SNAP recipients with questionable transactions, two of whom admitted to obtaining a cash loan from the owner and repaying the loan with SNAP benefits and pre-ordering hot foods with their benefits. The owner was later interviewed and admitted to the allegations. The case was referred to USDA Food and Nutrition Services for administrative action. The retailer was permanently disqualified as an authorized retailer, resulting in a cost avoidance of $875,040.

Tarrant County store owner faces prosecution for trafficking SNAP benefits

The EBT Trafficking Unit initiated an investigation after OIG data analysis discovered that three small retail stores, all owned by the same couple, did not have sufficient inventory to support their high SNAP redemption levels. An undercover operation corroborated the allegation. Additional data analysis identified several SNAP recipients with unusually high transaction amounts at the suspect stores as well as at a nearby major retailer. That retailer provided transaction records and surveillance video to assist the investigation, which showed that the suspect purchased items on multiple dates with multiple EBT cards that were not assigned to him. Investigators conducted several interviews of SNAP recipients who admitted to giving the suspect their EBT cards in exchange for cash. The owner later admitted to unauthorized use of the benefits. The investigation ultimately revealed more than $17,231 in fraudulently used SNAP benefits and was referred to the district attorney's office for criminal prosecution.

Anonymous complaint leads to benefit trafficking bust

The EBT Trafficking Unit received an anonymous complaint alleging that a restaurant owner purchased SNAP benefits from multiple recipients and used the benefits to purchase inventory for his restaurant. OIG investigators obtained transaction records from the store where the suspect was believed to be shopping, which showed the restaurateur used 16 different EBT cards to purchase items consistent with the operation of a restaurant. Investigators conducted multiple interviews where recipients admitted to selling their benefits to the restaurant owner in exchange for cash. The owner confessed to using the ill-gotten SNAP benefits to purchase supplies for his restaurant. In total, the investigation found more than $15,348 in fraudulently used SNAP benefits. This case was referred to the county district attorney's office for prosecution.

VII. HHS Oversight

Trends

Internal Affairs

Internal Affairs (IA) processed 100 referrals this quarter. IA worked on 56 active investigations and closed 34 investigations in the fourth quarter. The remaining referrals were forwarded to the appropriate business areas, including the Office of the Independent Ombudsman for State Supported Living Centers; the Department of Family and Protective Services Office of Internal Affairs; and HHS Complaint and Incident Intake.

Internal Affairs Performance

45 Cases Completed

57 Cases Opened

Approximately 35% of Internal Affairs' open cases involve Child Protective Services (CPS) client or supervisor allegations of DFPS employees falsifying documents. Overall, IA continues to surpass 100 referrals received for each quarter, with many referrals coming from outside entities not involved with a state agency or HHS.

In FY 2023, IA saw an 18% increase in referrals received, an 11% increase in cases opened, and a 13% increase in case closure averages. Although workloads have increased, IA maintains an average open case time of 122 days, well below the 180-day deadline.

State Center Investigations Team

The OIG State Center Investigations Team (SCIT) is comprised of commissioned peace officers who investigate allegations of abuse and other wrongdoing at state hospitals and state supported living centers. In the fourth quarter of FY 2023, SCIT opened 271 investigations and completed 242 investigations with an average completion time of 23.8 days. This compares to 249 opened investigations and 306 completed investigations in the prior quarter of FY 2023. In the fourth quarter of 2022, SCIT opened 182 investigations and completed 159 investigations.

State Centers Investigations Team Performance

242 Cases Completed

271 Cases Opened

Case highlights

Investigation finds employee committed benefit fraud

IA investigated a case involving a Texas Works Advisor who allegedly committed an intentional program violation by submitting several fictitious benefits applications for herself and her children. The employee omitted the father's income information to qualify her family for benefits they were not legally entitled to receive. As a result, the employee received over $22,000 in excess benefits. The employee admitted to the conduct and is in the process of repaying the benefits.

Open Internal Affairs Cases by Type

Falsifying information/documents	26%
Contract fraud	19%
Unprofessional conduct	18%
Tampering with a government record	13%
Law enforcement assist	4%
Theft	4%
Time/leave abuse	4%
Misuse of state property	3%
Moonlighting	3%
Conflict of interest	2%
Unauthorized release of information	2%
Whistleblower violation	1%
Workplace harassment	1%

Texas Works Advisor terminated after accessing sensitive client information

IA investigated a case involving a Texas Works Advisor who allegedly accessed a client's benefit records without a business need. The employee admitted to using her computer to access benefit records to provide a child's Social Security number to the child's father (the employee's boyfriend). The employee admitted to the conduct and was terminated.

Physical abuse cases investigated at two State Supported Living Centers

Two separate SCIT cases involved alleged physical abuse to clients at State Supported Living Centers in southeast and north central Texas. In each case, subsequent interviews and video reviewed by the SCIT investigators confirmed the allegations. The cases were referred to their respective county district attorney offices for prosecution.

Agency highlights

Technology advancements on the horizon

The OIG and HHS IT are working together to prepare for technology projects funded through exceptional items awarded by the 88th Texas Legislature. The collaboration will help expedite procurement and implementation of the new systems in the new biennium. These projects include replacing the beneficiary provider integrity case management system, automating beneficiary fraud detection, obtaining a new case management system for OIG special investigations, and replacing the OIG's public-facing online fraud reporting system with a streamlined and more user-friendly interface.

Policy recommendations

The OIG provides program integrity feedback on policy changes

The OIG continues to review and provide feedback on HHS policy changes. This quarter, the OIG reviewed a policy related to Certified Family Partner (CFP) services, a new Medicaid benefit that provides an array of services and supports to parents and caregivers of certain Medicaid-eligible children or youth diagnosed with a mental health or substance use condition. The OIG recommended that the CFP policy specify that: :

- Services are subject to retrospective review and recoupment if records do not support the service billed.
- Services are not reimbursed separately when included in provider-specific encounter rates.
- A CFP may not provide services relating to the CFP's own child or a child within the CFPs guardianship.

Rules

Proposed

The OIG is processing three proposed Texas Administrative Code (TAC) rule projects.

Two of the projects, 1 TAC §371.1721, concerning Recoupment of Overpayments Identified by Inspection, and 1 TAC §371.1723, concerning Recoupment of Overpayments Identified by Retrospective Payment Review, are proposed to codify existing OIG inspections and review processes related to records requests, notices, final reports and due process. They were posted for informal comment in August.

Several sections in 1 TAC, Part 15, Chapter 354, Subchapter J, concerning Third-Party Recoveries (TPR), are proposed for amendment as a result of changes to federal rules and legislation passed during the Texas legislative session.

Adopted

In addition, the statutorily required four-year rule review for Title 1, Texas Administrative Code, Chapter 371 Medicaid and Other Health and Human Services Fraud and Abuse Program, has concluded and was adopted August 8, 2023. The Notice of Adopted Review Rule appeared in the August 18, 2023 issue of the Texas Register.

IX. Stakeholder Engagement

Texas Fraud Prevention Partnership leadership meeting

The Texas Fraud Prevention Partnership (TFPP) is an ongoing collaboration between the OIG and Texas Medicaid and CHIP MCOs. Group meetings and individual sessions promote collaboration in support of a common goal: to prevent fraud, waste and abuse in the delivery of health and human services. The sessions also support evaluating areas for future improvements and coordination.

In July, the OIG held a meeting for OIG and MCO leaders to discuss current initiatives and their combined efforts to strengthen the program integrity of Medicaid in Texas. Topics included the latest trends in waste and wrongdoing; MCO referrals; and updates on legislation, audits, surveillance utilization reviews and the increase in referrals to the prescription lock-in program. The next TFPP leadership meeting is in September 2023.

Texas Fraud Prevention Partnership SIU meeting

A separate TFPP Special Investigative Unit (SIU) meeting was held June 29, 2023, at the OIG's headquarters. MCO SIU staff from across the state attended the in-person meeting, the first since 2020. The OIG's Acute Care Surveillance and Pharmacy Lock-In Program Units provided overviews of their programs and MCO outreach efforts. The OIG's Chief Dental Officer, Dr. Janice Reardon, and dental hygienist Jeannie Swink discussed recent dental investigations with findings including billing for services not rendered, upcoding, medically unnecessary treatments, and treatment below the standard of care. The Attorney General's Medicaid Fraud Control Unit staff also participated in the meetings.

Fraud Hotline Performance

9,521 Fraud Hotline Contacts Handled

1,714 Fraud Hotline Referrals Within OIG

1,404 Benefit Recipients

131 Medicaid Providers

40 HHS Employees, Contractors

136 EBT Retailers

3 State Supported Living Centers/ State Hospitals

External Relations Performance

75 Communication Products

90,118 OIG Page Views

FY 2023 fraud, waste and abuse prevention strategy

The OIG's fraud, waste and abuse prevention strategy emphasizes stakeholder partnerships and opportunities for collaboration, training and education to raise awareness of common schemes and emerging trends. In FY 2023, the OIG administered 32 targeted prevention activities for clients and the public, providers, agency staff and contractors.

The OIG worked with HHSC's Procurement and Contracting Services (PCS) Division to improve educational materials for grant recipients, highlighting their fiduciary responsibilities for grant funds. OIG staff also advised PCS of various audit scenarios and frequently observed issues, including the need to ensure program objectives are met, expenditures are allowable, and grant activities are appropriately allocated.

Additional stakeholder engagement activities included the OIG's development of numerous online articles and communications educating providers, MCOs and clients on issues including SNAP skimming, common errors in outpatient emergency hospital billing, bundling services, self-reporting overpayments to the OIG, the Medicaid Pharmacy Lock-In Program and Lock-In referrals, pharmacy invoicing, recent dental investigation findings, fraud detection operation findings, use of billing modifiers, informed consent, audit procedures, SIUs and the fraud hotline.

HHS Health Care Regulation staff enlisted to fight fraud

MPI staff gave a presentation to HHS Health Care Regulation (HCR) staff about OIG oversight and fraud prevention. Additionally, HCR nurse surveyors, investigators and inspectors who work with acute care facilities were interested in learning how to generate a referral to the OIG for suspected Medicaid fraud, waste or abuse. The presentation resulted in a beneficial exchange of information between the OIG and 55 HCR program staff, who are now helping the OIG in its fight to prevent fraud, waste and abuse in Texas Medicaid.

Conferences, presentations and trainings

National Association for Medicaid Program Integrity

Training Summary

39
Trainings Conducted This Quarter

Members of the OIG team presented at the 2023 National Association for Medicaid Program Integrity in Scottsdale, Arizona. 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 an OIG Audit Director moderated discussion groups focused on ensuring Medicaid clients receive needed behavioral health services.

Members of the investigations and fraud analytics teams presented about how to use data analytics to identify potential provider Medicaid fraud and how to follow the flow of illicit funds through multiple bank accounts and shell companies. Members of the audit team explained what pharmacy benefit managers are and how auditing them can improve Medicaid managed care.

Texas Association for Home Care and Hospice

Inspector General Sylvia Hernandez Kauffman spoke at the annual meeting of the Texas Association for Home Care and Hospice. She gave an overview of the OIG's work, discussed common fraud, waste and abuse scenarios involving home health agencies, and underscored the importance of self-disclosing any identified Medicaid billing errors to the OIG.

HHS Procurement and Contracting Services

The agency's Chief of Staff and members of the Operations and Data Reviews Divisions provided training to the HHS Procurement and Contracting Services (PCS) division. The session conveyed how the OIG carries out its mission and how those activities interact with the work performed by PCS on a daily basis.

Getting to know Texas' public community centersl

This year's legislative session resulted in a requirement for the OIG to audit each local behavioral health authority (LBHA) and each local mental health authority (LMHA) at least once every five years. In addition to internal planning to meet that goal, the OIG Audit Division met with the Texas Council of Community Centers at its quarterly member meeting on August 17, 2023, to introduce ourselves and the upcoming audits. The Texas Council of Community Centers represents the 39 public community centers, comprising both LMHAs and LBHAs, throughout Texas that provide services and support for people with intellectual and developmental disabilities, serious mental illness and substance use disorders. Additionally, it facilitates policies and funding decisions that support the public mission of the Centers.

X. OIG in Focus: Looking Back With Inspector General Kauffman

Sylvia Hernandez Kauffman was appointed Inspector General in 2018. However, she began her career at the Office of Inspector General in 2015 as Senior Advisor and Deputy Inspector General for Data and Technology. Now, after eight years at the forefront of protecting Texas' health and human services, she is leaving to embark on a new phase in her career as a consultant in the private sector.

Kauffman has made an indelible impact on the state of Texas during her time at the OIG, implementing transformative methods to combat fraud, waste and abuse that resulted in $2.4 billion in recoveries for Texas taxpayers. This "OIG In Focus" offers an opportunity to look back with the Inspector General.

What brought you to the OIG?

Initially it was the data. Fraud, waste and abuse are all about patterns, and that's what math is about. I love math and patterns as well as public service, so I thought it was a fantastic fit for my passions and background. My first undertaking was to figure out how to use data to detect fraud, waste and abuse. That is still a huge priority, and we have gotten really good at it, but I quickly realized there was a bigger mission. Every dollar we recover goes back into the system to help Texans who actually need those services.

Soon after I started, I wanted to understand more about the people we help, so I went on a ride-along with a managed care coordinator making home visits. One woman we visited couldn't get out of bed. She needed her personal care attendant to feed her, to change her clothes, to do everything for her. The attendant would put her in a wheelchair and take her outside to the balcony so she could see the trees and get some fresh air. The money that we recover goes to help that woman sitting in her wheelchair looking at the trees. It was incredibly powerful to be right there and see the people that we're impacting.

What has changed at the OIG during your time here?

From the very beginning, our people have been doing great work, but when I got here, I realized we were missing a lot of the foundational systems and processes and policies. How do you do public audits? How do you do public investigations? What standards do you follow? We were basically starting over. We redid all the policies and procedures. We evaluated our technology and what needed to be improved. We also worked really hard to increase the rigor of everything we did.

The culture and people were also a huge priority. We evaluated the workforce and skill sets necessary to keep up with the constantly changing health care landscape. We created training plans for staff and hired more data scientists and helped investigators get certified in necessary areas. Now, we have a nimble team that is able to adapt to those changes.

When you work as a team, bring everybody together, and empower them to bring ideas, it creates meaning because we're doing it together. We talked with all the different divisions and field offices and asked them for one thing we could do differently to make the office better. People told us, and we followed up on those things. Tiny, incremental changes every day over eight years resulted in transformational change.

In the past, nobody knew how the OIG picked people to audit or investigate. Establishing those standards and creating that culture of accountability was a boon for our relationship with stakeholders. Now we have defensible processes that stakeholders, the legislature and the public can verify and really place their trust in.

It has been a very rewarding experience for me to work with a group of dedicated people to achieve the mission of this agency, really focusing on the data pieces, but also on incremental change. At the end of eight years, we are in a great place.

What are you going to miss about the OIG?
The people. The OIG is full of amazing people who really care about this office, its mission and each other. It's a group of compassionate leaders that we've brought together, with everyone working towards the same mission. It's been amazing working with everyone here.

I believe that each one of us is the culmination of the people we meet during our lifetime, and we keep a little piece of everyone we meet in our hearts. And I am changed for the better because I have known those teammates and because of the work we did here together.

Do you have any parting advice?
We have an incredible, talented team and a great foundation for the next Inspector General to build upon. They are going to bring new ideas, new perspectives and priorities, and I hope they will keep asking those tough questions. "Why are we doing it this way? Does it make sense? How can we do it better?" There's always room for improvement.

Last, but not least, we all have a moral compass and know right from wrong. Stay true to that moral compass and do the right thing. You will never regret doing the right thing, and it gives you the character and courage you need to do this job.

Do you have any final thoughts?
It's been the honor of my life to be your Inspector General. Thank you to Governor Abbott and the people of Texas for entrusting me with this incredible responsibility. Most of all, thank you to the amazing team at the OIG — your expertise and dedication are unparalleled, and this office is successful because of you.

We have made a difference. We have made this office stronger. We have made Texas health and human services programs better and touched so many lives through our efforts to protect the health and safety of Texans. Keep up the amazing work.

Texas Health and Human Services Office of Inspector General

Sylvia Hernandez Kauffman, Inspector General

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To report fraud, waste or abuse

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

Website: ReportTexasFraud.com

OIG on LinkedIn: Company/TxHHS-OIG

OIG on X: @TexasOIG

OIG on Facebook: TxOIG

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