
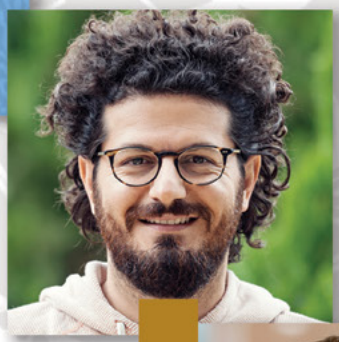



Inspector General

Texas Health and Human Services

21D0634

OIG

Quarterly Report

Quarter 2 Fiscal Year 2022

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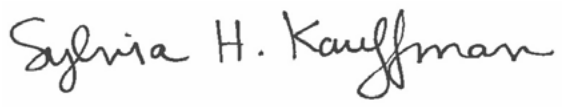
I. Executive Summary

I am pleased to present to Governor Greg Abbott, Executive Commissioner Cecile Young, the Texas Legislature and the citizens of Texas the second quarterly report for fiscal year 2022, summarizing the excellent work this office has performed between December 2021 and February 2022.

The Office of Inspector General recovered more than $86 million this quarter. In addition, we identified nearly $222 million in potential future recoveries and achieved more than $41 million in cost avoidance by deterring potentially questionable spending before it could occur.

The OIG team continues to do outstanding work on behalf of Texas taxpayers. Within this quarterly report, you will read about our collaborations with district attorneys across the state to protect the integrity of Texas health and human services. The report also details the agency's innovative approach to deploying sophisticated data analysis to detect, deter and prevent fraud, waste and abuse within the state health care delivery system. It also features examples of how increasingly more Texas providers are working collaboratively with the OIG to voluntarily disclose Medicaid overpayments. The OIG views the self-report program as a way to save state resources and develop partnerships with health care professionals while offering an opportunity for providers to potentially reduce their legal and financial exposure.

The OIG team follows its core values – Accountability, Integrity, Collaboration and Excellence – in performing our work in service to the State of Texas. This agency's dedication to recovering lost funds is matched by a commitment to preventing waste and wrongdoing from happening in the first place. I am honored to work with this outstanding team.



Sylvia Hernandez Kauffman
Inspector General

II. Quarterly Metrics

Dollars recovered

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

Total dollars recovered	$86,360,370
Audit and Inspections	
Audit collections	**$382,370**
Investigations and Reviews	
Provider overpayments	$3,356,149
MPI targeted queries	$2,291,718
Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC)	$5,604,952
Voluntary repayments by beneficiaries	$40,543
Acute Care provider overpayments	$168,935
Hospital overpayments	$3,644,106
Nursing facility overpayment	$653,634
Recovery Audit Contractor recoveries	$11,427,314
WIC collections	$13
Hospital underpayment	($1,921)
Nursing facility underpayments	($2,661)
Total Investigation and Reviews Recoveries	**$27,565,152**
Third Party Recoveries	**$58,652,069**
Peace Officers	
Electronic Benefits Transfer trafficking retailer overpayments	$143,149
State Centers Investigations Team recoveries	$0
Total Peace Officers Recoveries	**$143,149**

Dollars identified for recovery

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

Total dollars identified for recovery	$221,842,194
Audit and Inspections	
Provider overpayments	**$0**
Investigations and Reviews	
MCO identified overpayments	$14,803,799
MPI targeted queries	$2,430,485
Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, CHIP, WIC)	$16,141,132
Acute Care provider overpayments	$187,910
Hospital overpayments	$3,066,793
Nursing facility overpayments	$919,715
Recovery Audit Contractor recoveries	$6,476,362
WIC collections	$0
Total Investigation and Reviews Identified Recoveries	**$44,026,196**
Third Party Identified Recoveries	**$177,468,258**
Peace Officers	
Electronic Benefits Transfer trafficking retailer overpayments	$346,631
State Centers Investigations Team recoveries	$1,110
Total Peace Officers Identified Recoveries	**$347,741**

Cost avoidance

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

Total cost avoidance	$41,538,567
Investigations and Reviews	
Medicaid provider exclusions	$7,006,771
Client disqualifications	$1,971,550
WIC vendor monitoring	$0
Pharmacy Lock-In	$1,986,183
Third Party Recoveries	
Fee-for-service front-end claims denials	**$30,461,455**
Peace Officers	
Disqualification of Electronic Benefits Transfer recipients	**$112,608**

III. Provider Integrity

Trends

Investigations and Reviews (I&R) continues to receive complaints related to physicians, which includes individual, groups, and clinics. Complainants report a lack of documentation for services billed, up-coding office visits and billing for unnecessary services. The OIG continues to conduct preliminary and full investigations involving physicians and recommend administrative action based on findings.

Provider Investigations performance

Preliminary investigations opened	435
Preliminary investigations completed	441
Full investigations completed	53
Cases transferred to full investigation	57
Cases referred to OAG's Medicaid Fraud Control Unit	165
Open/active full investigations cases at end of quarter	135

Case Highlights

Texas providers continue to self-report overpayments

More providers are participating in the OIG self-report process so they can determine if they need to disclose overpayments received from participation in Texas Health and Human Services (HHS) programs.

The OIG developed guidance for health care providers choosing to voluntarily disclose irregularities related to Medicaid claims and other HHS programs. The OIG views the program as a way to collaborate with providers, allowing the state to reduce fraud, waste and abuse while offering an opportunity for providers to potentially reduce their legal and financial exposure. Working with the OIG may also lead to providers better understanding the OIG's audit and investigatory processes.

The following cases are examples of recent self-reported cases:

- The OIG settled a case in January against a Dallas hospital provider after the hospital conducted its own internal investigation and discovered that the hospital was billing for outpatient and inpatient renal dialysis for patients who did not qualify for Medicaid. The

Surveillance Utilization Review Team

Acute care provider recoveries	$168,935
Acute care services identified overpayments	$187,910
Hospital and nursing home (UR) recoveries	$4,293,158
Hospital (UR) claims reviewed	6,630
Nursing facility reviews completed	100
Average number of Lock-in Program clients	3,511

Provider enrollment and exclusions

Provider enrollment inventory (applications and informal desk reviews) processed	3,732
Individual screenings processed	15,057
Medicaid providers excluded	39

Fraud, Waste and Abuse Research and Analytics performance

Data requests received	214
Data requests completed	204
Algorithms executed	51

provider proactively self-reported the incident and collaborated with the OIG to resolve the situation. The provider correctly reported that it owed the Medicaid program $5,521,578 and took corrective action.

- The OIG settled a case in February involving a South Texas adult day care provider. The provider determined that it had failed to have at least one registered nurse (RN) or licensed vocational nurse (LVN) working at the facility for at least eight hours per day. The provider erroneously billed for and received payment for services for days that at least one RN or LVN was not at the facility for at least eight hours. The provider reported the errors to OIG and worked collaboratively with OIG Litigation to resolve these issues. The OIG agreed to a settlement of $111,617.
- The OIG settled a series of self-reports in December and January with a Richardson home health care provider who through an internal investigation discovered that six caregiver-employees caused services to be billed that were not rendered over various, unrelated time periods. For the six self-reports, the provider correctly reported that it owed the Medicaid program a total of $7,221. They agreed to resolve the claims in question through settlement.

Houston dentist excluded from Medicaid

In December, OIG Litigation reached a settlement of $66,804 with a Houston dentist to resolve four investigations. During the period of December 2015 through November 2019, the OIG determined that violations included insufficient or incomplete patient records and billing for services not provided. The provider also agreed to a two-year exclusion from enrollment in the Texas Medicaid program.

Provider Investigations case summary

Referral sources for cases	
MCO/DMO	27%
Government agency	22%
Public	22%
Provider	9%
Anonymous	7%
OIG initiated	13%

Types of preliminary investigations opened	
Attendants	35%
Hospital	13%
Physician (individual/group/clinic)	13%
Home health agency	10%
Dental	6%
Therapy (physical/occupational/Social)	5%
Durable medical equipment	2%
Nursing facility	2%
Pharmacy	2%
Therapy (counseling)	2%
Adult day care	2%
Rehabilitation center	2%
Ambulance	1%
Assisted living	1%
Case management	1%
Lab-radiology-x-ray	1%
3 other categories at less than 1%	3%

Types of full investigations opened	
Hospital	77%
Lab-radiology-x-ray	5%
Home health agency	4%
Nursing facility	4%
Adult day care	2%
Dental	2%
Physician (individual/group/clinic)	2%
Rehabilitation center	2%
Therapy (counseling)	1%
Therapy (physical/occupational/social)	1%

*rounded to nearest whole number

South Texas provider employed excluded individual

The OIG settled a case in December against a McAllen medical provider who employed an individual who was excluded from participating in Medicaid. Every service provider is responsible for making sure that no excluded individuals or entities are receiving state funds; employers are encouraged to check the state exclusion list every month. The provider had checked the list at the time of hire, but the individual was added to the exclusion list two months later. The provider worked collaboratively with OIG Litigation to resolve this issue, and the OIG agreed to a settlement of $1,095.

OIG settles case over EEG services

In February, the OIG resolved two cases against a Cleveland physician providing electroencephalograms (EEGs) – a test that detects electrical activity in the brain. Between September 2014 and August 2018, the provider submitted claims for EEG services that require the capacity to intervene and alter care or test by a clinician throughout the 24-hour recording period; however, the services provided were unattended, ambulatory EEGs. The provider worked collaboratively with OIG Litigation to resolve the issue and agreed to a settlement of $141,697.

North Texas hospital settles case

The OIG settled a case in January against a Dallas-area hospital that improperly billed for injections and infusions administered by either a nurse or other hospital personnel in the emergency department. Injections and infusions are included in an emergency room charge and are not reimbursed separately. The provider worked collaboratively with OIG Litigation to resolve this issue, and the OIG agreed to a settlement of $104,381.

OIG settles case with North Texas behavioral health provider

The OIG settled a case in January against a Fort Worth behavioral health provider whose documentation did not support some of the billed services, e.g., missing/incomplete documentation or upcoding of units (in part due to missing start/stop times), and provided services by a non-enrolled/uncredentialed staff provider. The provider worked collaboratively with OIG Litigation to resolve this issue, and the OIG agreed to a settlement of $1,370.

Pediatrician bills inappropriately for hearing tests

The OIG settled a case in January against a Houston pediatric office. The provider was improperly submitting claims for hearing tests on the same date as they were billing for preventative exams for the same patients. Concurrent billing is not permitted for the same patient because the hearing test is a component of the pediatric visit and is not reimbursed separately. The provider worked collaboratively with OIG Litigation to resolve these issues, and the OIG agreed to a settlement of $129,204.

Home health agency agrees to settlement

The OIG settled cases in February against a Fort Worth home health agency. The provider submitted bills for and was paid for more than the maximum allowable amount (96 units or 24 hours/day) of private duty nursing per client. The provider worked collaboratively with OIG Litigation to resolve these issues, and the OIG agreed to a settlement of $95,918.

Agency highlights

OIG prevents fraud, waste and abuse before it happens

In February, the OIG published a detailed report for the Texas Legislature that describes cost avoidance and waste prevention activities employed by managed care organizations (MCOs) and the OIG's efforts to combat fraud, waste and abuse (FWA) in Medicaid managed care.

The OIG surveyed all 20 MCOs and dental maintenance organizations (DMOs) participating in Texas Medicaid and the Children's Health Insurance Program. Respondents were asked about the use and the effectiveness of various cost avoidance activities. In the review the OIG found MCOs implement measures to promote program integrity that fall into three broad categories: prepayment reviews, post-payment reviews and strategies to reduce potentially preventable events:

- Prepayment reviews focus on preventing improper payments to providers by identifying and denying claims that contain billing errors before they are processed by the claims system, reviewing accepted claims before payments are processed and preventing payments for improperly coded heath care services.

- Post-payment reviews occur after a provider has been paid. However, reviewing the activity may prevent future FWA. For example, duplicate payment detection is a data-driven strategy that allows MCOs to recover or even prevent payments to providers claiming the same service for the same patient.
- Post-payment review strategies also include analyzing data and implementing interventions for prospective cost savings.

Potentially preventable events are tracked by MCOs to avoid waste by reducing health care encounters through intervention and prevention strategies. This effort promotes both better care and health outcomes for Medicaid clients, reducing the need for multiple provider visits related to the same issue.

The OIG will continue to collaborate with MCOs when needed through the Cost Avoidance Workgroup, which has included representatives from all Texas MCOs, DMOs, the Texas Association of Health Plans and the Texas Association of Community Health Plans to identify effective ways to protect Texas taxpayer dollars and protect the integrity of Medicaid delivery.

Providers and clients can learn more about the OIG's cost avoidance efforts by reading the report on our website.

Fraud Detection Operation leads to investigations

The OIG Fraud Detection Operation (FDO) team identified three non-local mental health authority (LMHA) behavioral health service providers with claims billed for mental health rehabilitation (MH Rehab) and mental health target case management. The FDO team determined a review of billing from providers of these services was appropriate due to data algorithms flagging the following areas:

- Client diagnoses that appeared to not be appropriate for these services
- Unusual patterns of utilization and billing.

An FDO is the result of multiple OIG units' review and analysis of large volumes of data to identify providers who appear as statistical outliers among their peers. Investigators, through coordinated field work and research, evaluate additional evidence and information to determine whether an outlier's status is attributable to possible fraud, waste, abuse or another explanation. Providers are required to supply records requested by OIG investigators, to make staff available for interviews, and to generally cooperate with OIG investigations.

Medicaid policy requires providers must document and perform the service based on diagnosis, periodic assessment of client need and according to a documented plan of care.

The record reviews for the three FDO-identified providers were completed in December 2021, which resulted in a referral to full investigation on all three providers. Referral to investigations will allow for a broader look at each provider's billing and documentation patterns to determine if a violation of Medicaid policies or rules has occurred.

Completed reports - Audit

Selected Memory Care Facilities: Village Green Alzheimer's Care Home–Cypress

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

Village Green–Cypress complied with most but not all of the selected HHSC health and safety requirements during OIG Audit's unannounced site visit. Most significantly, it advertised as a facility providing specialized services to residents who have Alzheimer's disease when it was not certified to do so. At the time of the audit, Village Green–Cypress was seeking, but had not yet attained, certification as an Alzheimer's facility from HHSC. HHSC certified the facility as an Alzheimer's Care facility on February 24, 2022. It also did not fully comply with all COVID-19 emergency rules or maintain an up-to-date emergency preparedness and response plan.

When applicable in the future, Village Green should not advertise as an Alzheimer's facility or indicate the facility is a freestanding Alzheimer's or dementia facility until certified by HHSC. Additionally, the facility should (a) conduct all required screening for facility visitors in accordance with HHSC guidance and ensure employees are trained to perform infection control procedures, and (b) develop a process to ensure the emergency preparedness and response plan is complete and reviewed annually or after a significant event and updated as needed.

Audits in progress 22

- Selected Home and Community Support Services Agencies
- Medicaid and CHIP Enrollment Broker
- MCO Special Investigation Units
- Psychiatric Care Hospitals
- Selected DSHS Contracts
- MCO Financial Reporting
- MCO IT Security Controls and Business Continuity and Disaster Recovery Processes
- Telemedicine Providers
- Memory Care Centers
- Home and Community-Based Services Oversight
- Deaf-Blind with Multiple Disabilities Program

Audit performance

Overpayments recovered	$382,370
Overpayments identified	$ 0
Audit reports issued by OIG	1
Audit reports issued by contractors	0

Inspections in progress 5

- Selected MCOs' Clinical Laboratory Improvement Amendments (CLIA) Certification
- Nursing Facility Staffing

Completed reports - Inspections

Nursing Facility Staffing Hours Verification: The Villa at Mountain View

OIG Inspections conducted an inspection to determine whether the licensed nursing hours recorded at the Villa at Mountain View, a skilled nursing facility, supported the licensed nursing hours reported to the U.S. Centers for Medicare and Medicaid Services (CMS) in compliance with federal requirements. The OIG compared licensed nursing hours documented in the Villa at Mountain View's payroll records against the licensed nursing hours it submitted to CMS and determined that the Villa at Mountain View submitted accurate and complete licensed nursing hours to CMS for the 1,449 payroll records reviewed as part of this inspection. As a result, no issues or opportunities for improvement were identified for this inspection.

IV. Client Accountability

Trends

The Benefits Program Integrity (BPI) division completed 4,375 investigations involving some form of benefit recipient overpayment or fraud allegation. Ninety-five percent of all investigations completed involved unreported income or an issue with reported household composition. Household composition cases usually deal with an unreported household member who has income or could also include a reported household member who does not actually live in the same residence. Both instances cause a household to receive benefits in excess of what the program allows. For this quarter, BPI referred five investigations for prosecution and 108 investigations for administrative disqualification proceedings.

Benefits Program Integrity performance

Overpayments recovered	$5,604,952
Cases completed	4,375
Cases opened	2,650
Cases referred for prosecution	5
Cases referred for Administrative Disqualification Hearings	108

Case highlights

Hardin County SNAP client disqualified

In January, BPI resolved a case in Hardin County where a client committed fraud by failing to report her children's father as a member of her household when applying for SNAP and Medicaid benefits. From July 2017 to November 2019, the client received a total of $25,406 in excess benefits. To prove the father was a part of the client's household and married to the client, the BPI investigator obtained driver's license records, payroll records, photos of the husband's car at the client's residence, attorney general records, school records, their marriage record and multiple witness statements. After evidence was presented to the Hardin County district attorney, the client was ordered to pay the full $25,406 in restitution and was disqualified from the SNAP program for ten years.

Gonzalez County SNAP client disqualified

BPI investigated a client in Gonzalez County who committed an intentional program violation by concealing the father of her children and his associated income as part of their household from March 2018 to October 2021. During the investigation, the investigator obtained corroborating evidence that proved the father was living in the home, married to the client, and earning a reportable income. The client waived her rights to an administrative hearing to contest the findings. In January, the client was disqualified from SNAP for 12 months and ordered to pay back $31,555 in SNAP benefits.

Authorized representative disqualified from SNAP

In January, BPI presented investigative findings at an Administrative Disqualification Hearing regarding an authorized representative who renewed SNAP benefit applications on behalf of the client and attested that the client resided in their home; however, the client was incarcerated and ineligible to receive benefits. Authorized representatives are designated by a client to sign applications, complete and submit renewal forms, receive notices, designate health plans, and otherwise act on behalf of the client. Authorized representatives are also required to follow program rules and are not permitted to use a client's benefits for themselves. The hearing officer found the authorized representative committed an intentional program violation. The authorized representative

was disqualified from SNAP for 12 months and required to pay $1,720. The investigation was the result of a data match with Texas Department of Criminal Justice records that compares individuals receiving benefits with incarceration records for the purpose of identifying potential fraud, waste and abuse.

Gonzalez County SNAP client disqualified

BPI investigated a client in Gonzalez County who committed an intentional program violation by concealing the father of her children and his associated income as part of their household from March 2018 to October 2021. During the investigation, the investigator obtained corroborating evidence that proved the father was living in the home, married to the client, and earning a reportable income. The client waived her rights to an administrative hearing to contest the findings. In January, the client was disqualified from SNAP for 12 months and ordered to pay back $31,555 in SNAP benefits.

Agency highlights

Technology helping to enhance client investigations

In collaboration with the Fraud, Waste and Abuse Research and Analytics team, BPI completed development of an automated Work in Progress (WIP) board that will better assist unit managers and leads with tracking their high-volume investigative caseloads. The WIP board is a tool that produces visualized data regarding the progress of milestones throughout the investigative lifecycle to help BPI leadership identify barriers and provide assistance when delays exist. It will also help the division gather intelligence on potential opportunities to further streamline investigative processes and allocate resources to the most time- and resource-intensive investigative tasks.

With the help of OIG information technology partners, BPI enhanced its case documentation system to allow investigators to send pre-populated warning letters to Medicaid and SNAP clients where allegations of fraud, waste and abuse appear credible based on investigative research but cannot be proven or further acted upon. Warning letters serve as education and a deterrent – providing an opportunity for BPI to remind clients about eligibility qualifications and guidelines for appropriate use that apply to the benefits they receive, as well as the potential penalties for failure to comply with program requirements.

SNAP data analytics grant

BPI continues to enhance data-informed fraud detection using grant funds awarded by the U.S. Department of Agriculture in September 2020. Since the award, the OIG has executed a contract with ISF, Inc. who, in partnership with Knowli Data Science, is designing a data model using algorithms and visualization tools that will help BPI investigators proactively identify cases with an increased risk of fraud. BPI and its contractor are currently collaborating across HHS – including the OIG's Fraud, Waste and Abuse Research and Analytics team; HHS Information and Technology; the Center for Analytics and Decision Support; and Access and Eligibility Services – to refine the data incorporated in the model, validate and weight potential risk indicators, and secure infrastructure support to promote sustainability.

V. Retailer Monitoring

Trends

The OIG's EBT Trafficking Unit is working with law enforcement in the Houston area on investigations related to mobile vendor retailers. The investigations are the result of a continued high volume of referrals to the unit. Clients are reporting mobile vendors removing benefits from their accounts through unauthorized transactions. The OIG is currently collaborating with district attorneys in Montgomery and Harris counties as several mobile vendor investigations proceed.

Electronic Benefits Transfer Trafficking Unit performance	
Overpayments Recovered	$143,149
Cases opened	57
Cases completed	45

During the second quarter, Women, Infants and Children (WIC) Vendor Monitoring Unit focused on remote inventory reviews. Fiscal year to date, 102 reviews have been completed, and no findings were identified. The remote review process has indicated greater compliance across the vendor population. The team is on track to exceed last year's total of reviews.

Case highlights

Undercover operation in South Texas finds fraud

OIG EBT investigators in Pharr sent a referral to USDA Food and Nutrition Services (FNS) in December to exclude a Kleberg County retailer. OIG undercover investigators purchased beer and cigarettes with an EBT card at the retailer and exchanged some SNAP benefits for cash with the retail owner. In January, FNS permanently disqualified this retailer from participation in the SNAP program.

Joint investigation uncovers EBT fraud

The OIG's EBT Trafficking Unit in Grand Prairie conducted a joint investigation with the Smith County Sheriff's Office. Individuals who were recently released from prison were found to be living in unsafe conditions and were performing unpaid work for the director of a recovery residence for parolees. The house director required all new residents to apply for SNAP benefits and would then confiscate the new resident's SNAP card. The director would change the pin when the EBT card arrived and would use the EBT card for the director's personal use. The case remains under investigation.

EBT investigators help catch murder suspect

The EBT Trafficking Unit in Grand Prairie provided information that directly resulted in the capture and arrest of a homicide suspect. The Plano Police Department was investigating the homicide of a 22-year-old Dallas resident who was shot and later died. Police identified a suspect and asked Grand Prairie EBT Trafficking to identify and locate the suspect, who was believed to be a SNAP client. EBT trafficking conducted searches and provided information that directly resulted in the suspect's apprehension.

VI. HHS Oversight

Trends

Internal Affairs (IA) worked 47 active investigations and closed 32 investigations in the second quarter. IA processed 74 referrals this quarter and investigated 36 of those referrals. The remaining were forwarded to the appropriate business areas, including the Office of the Independent Ombudsman for State Supported Living Centers, Department of Family and Protective Services (DFPS), Office of Consumer Relations, and HHS Complaint and Incident Intake.

The majority of IA's open cases involve referrals from DFPS. Many of the cases relate to allegations of falsifying documents. This is possibly the result of DFPS management establishing quality assurance processes to identify misconduct by employees and reporting these cases to IA, as well as a greater number of clients alleging caseworker misconduct.

Internal Affairs performance

Investigations opened	36
Investigations completed	32

Open Internal Affairs cases by type

Falsifying information/documents	36%
Tampering with governmental record	22%
Conflict of interest	6%
Unauthorized release of information	6%
Unprofessional conduct	6%
Other	24%

State Centers Investigations Team performance

Cases opened	164
Cases completed	148

The OIG's State Center Investigations Team (SCIT) opened 165 investigations and completed 148 investigations in the second quarter, with an average completion time of 18 days. This compares to 110 opened investigations and 125 completed investigations in the second quarter of fiscal year 2021.

Case highlights

HHS employee accused of benefits fraud

Upon completion of an OIG Benefits Program Integrity (BPI) investigation, a referral was made to IA regarding a Texas Works supervisor who was not included as a household member during a determination of benefits. As a result, the subject's child qualified for benefits it would have otherwise been ineligible to receive. During the IA investigation, the employee acknowledged lying to BPI investigators and falsifying IRS tax documents. The employee was subsequently terminated.

Tampering with government record

A DFPS employee in Houston was accused of failing to accurately enter time off in the CAPPS employee timekeeping database. The investigation discovered the employee falsified leave time for 108 hours and received $2,376 in unearned salary. The case was sustained for the criminal offenses of tampering with a governmental record and theft. The case was referred to the Harris County District Attorney's Office for prosecutorial review. The individual no longer works for the agency.

Patient injured at state hospital

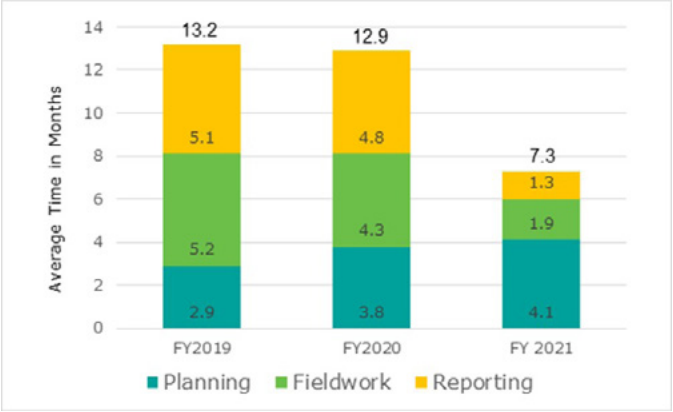
A recent SCIT case in February involved an injury to a patient at the Terrell State Hospital. An employee was accused of striking a patient multiple times, which resulted in injuries. The case was referred to the Kaufman County district attorney for prosecution.

HHS employee accused of moonlighting

A recently promoted state hospital supervisor contacted the OIG regarding an employee who was allegedly falsifying their HHS time sheets to moonlight during scheduled work hours. The employee was exonerated after the investigation established the employee was working under the guidelines established by their previous supervisor. However, the IA investigation did show a sustained violation of HHS policy when it was determined the employee held a second job without submitting the the proper human resources form.

Agency highlights

OIG improves audit efficiency



Over the past fiscal year, the OIG audit team has dedicated resources to improve the planning phase of the agency's audits, as well as streamline other processes. This has reduced the overall time it takes to complete an audit. In partnership with the OIG's Centralized Risk Review team, the audit division has focused on doing preliminary research and identifying potential auditees even before audit teams start planning. Additionally, the division is continuing to develop predefined step-by-step processes based on topics or types of audits for teams to follow to achieve objectives more efficiently. As shown in the figure above, by taking a little more time on initial planning and research, the team has significantly decreased fieldwork and reporting time. The team has reduced the time to complete an audit from approximately 13 months to just over seven months.

OIG expands data analytics by engaging external vendor

The OIG has contracted with SAS, a vendor that works in both the government and private sectors, to develop more advanced analytical tools to help identify potential indicators of fraud, waste and abuse throughout state health and human services.

The work-based contract allows the OIG to identify important opportunities to leverage SAS expertise to perform complex and advanced data analytics. SAS staff will partner with the OIG's Fraud, Waste and Abuse Research and Analytics team to enhance the agency's ability to perform highly complex work, and to leverage the unique skill sets of both our in-house data analysts and vendor team.

MCO contract manual changes take effect

The OIG recommended changes to the Texas Medicaid and CHIP Uniform Managed Care Manual, to better enhance the security of confidential information. The changes include instructions for MCOs to complete security measures used to determine whether a user is human before uploading a report to the OIG's web portal. The OIG recommended these changes to enhance the web portal's security as MCOs submit confidential data.

Third Party Recoveries implements amendments to Texas Medicaid state plan

OIG Third Party Recoveries (TPR) received approval from the Centers for Medicare & Medicaid Services (CMS) in February for amendments related to third party liability (TPL) requirements in Texas Medicaid. The TPL amendments, effective December 1, 2021, ensure Texas Medicaid is in compliance with the Bipartisan Budget Act (BBA) of 2018 and Medicaid Services Investment and Accountability Act (MSIAA) of 2019, affecting the BBA of 2013, modifying TPL requirements related to special treatment of certain types of care and payment.

Although the BBA and MSIAA changes were already in place, CMS directed states to include the amended language related to the special treatment of certain types of care and payment in their plans. OIG TPR took this opportunity to implement additional amendments that more accurately describe current TPL processes.

Federal law and regulations require states to ensure Medicaid recipients use all other resources available to them to pay for all or part of their medical care before billing Medicaid. TPL activities reduce Medicaid expenditures by shifting claims expenses to third-party payers, ensuring Medicaid is the payer of last resort.

Policy recommendations

OIG recommends update to private duty nursing policy

The OIG submitted formal comments to HHS Medicaid CHIP Services on their draft revisions to the Texas Medicaid Medical Policy Manual section on private duty nursing. The OIG provided comments related to the UA claims modifier, which is used for additional reimbursement for clients with a tracheostomy or who are ventilator dependent.

VII. Stakeholder Engagement

Texas Fraud Prevention Partnership update

The Texas Fraud Prevention Partnership (TFPP) continues to be an important OIG forum for strengthening the Medicaid and CHIP programs in Texas. TFPP MCO Leadership meetings encourage discussions and collaboration among OIG and Texas Medicaid and CHIP MCO leadership. These meetings provide an opportunity to discuss current initiatives and the combined efforts to prevent, detect and investigate fraud, waste and abuse.

In January, the TFPP MCO Leadership Meeting included discussions related to ongoing and upcoming OIG audits and inspections; nursing facility utilization review recoveries; fraud, waste and abuse trends; MCO cost avoidance; and an OIG data initiatives project. The next meeting will be in May.

Fraud Hotline performance

Fraud Hotline contacts handled	5,995
Fraud Hotline referrals within OIG	
Benefit recipients	1,298
Medicaid provider	102
HHS employee/contractor	27
EBT retailer	50
State Supported Living Center/State Hospital	1

Training summary

Trainings conducted this quarter	39

External Relations performance

Communication products produced	68
Website page views	85,590*

*Technical error excluded website page views from February 2022

A Texas Fraud Prevention Partnership Special Investigative Unit (SIU) meeting held in February included SIU staff from MCOs and DMOs, along with the Texas Office of Attorney General Medicaid Fraud Control Unit. The OIG Benefits Program Integrity unit shared information on client fraud, waste and abuse investigations. OIG Chief of Investigations and Reviews Steve Johnson presented on data initiatives for provider investigations.

Building partnerships to improve fraud prevention

The OIG Communications Team produced educational articles for a variety of health care association magazines and newsletters in the second quarter. An article for the Texas Dental Association's TDA Today highlighted the collaboration between the OIG's Policy and Strategic Initiatives unit and the Texas Department of State Health

Services. The project shared information about illegal dental solicitation with dentists who participate in Texas Health Steps, which provides free dental and medical checkups to children with Medicaid. The TDA article included prohibited behavior and its potential consequences for dental practices.
The Texas Medical Association published an article outlining the process for providers to self-report billing irregularities to the OIG; it included the potential benefits to health care professionals who voluntarily disclose payment errors and potentially avoid a full investigation.

An article produced for the Texas Pharmacy Association outlined common violations found in pharmacy audits and investigations. Educating providers about the typical errors found in the course of the OIG's work helps prevent fraud, waste and abuse and assists the providers in avoiding costly mistakes.

Surveillance Utilization Review meets with stakeholders

Surveillance Utilization Review continues to educate and inform stakeholders of utilization review activities and updates. The unit held a virtual quarterly meeting in December for Nursing Facility Utilization Reviews (NFUR). NFUR discussions included updates on quality control monitoring, fiscal year 2021 onsite review common errors and trends and fiscal year 2022 onsite review updates. The most common errors and trends in fiscal year 2021 included: 1) billing for conducting mental status and mood interviews after the assessment date; 2) missing, incorrect or blank activities on daily living forms; and 3) missing or incomplete physician orders.

Medicaid Lock-In Program meets with MCOs

The OIG's Medicaid Lock-In Program restricts or locks a Medicaid member to a designated pharmacy or provider if it finds 1) the member used Medicaid services, including drugs, at a frequency or amount that is duplicative, excessive or conflicting or 2) the member's actions indicate abuse, misuse or fraud. The program is both a means to help fight prescription drug abuse and save taxpayer resources.

Members of the OIG's Lock-In Program held a virtual meeting with MCOs in December. Topics included reviewing Lock-In staff updates, lockable diagnosis codes, referral form accuracy, pharmacy changes and continued lock-in reviews. Lock-In Program training for MCOs is available upon request.

OIG educating future investigators

From August to December 2021, the BPI San Antonio Office hosted its first group of interns from the University of Texas at San Antonio (UTSA). The interns completed research that assisted in the investigation of more than 50 allegations of fraud, waste and abuse by individuals receiving HHS services. Their internship provided them a hands-on opportunity to apply the knowledge gained through their secondary education and expand their investigative skills and understanding of state government processes and procedures. BPI welcomed a new set of UTSA interns in early February, and the team is excited to enrich their educational experience while also benefitting from the exchange of ideas related to the techniques and tools that their recent educational experiences afford.

In conjunction with BPI's ongoing partnership with the University of Texas System, a memorandum of agreement was finalized in February between the University of Texas Rio Grande Valley (UTRGV) and the OIG, establishing an internship program over the next three years. The internship program will provide UTRGV Criminal Justice student interns the opportunity to learn investigative processes and evidentiary standards associated with benefit fraud investigations.

Conferences, Presentations and Trainings

The integrity of OIG's staff is the most important asset the agency has in preventing fraud, waste and abuse. OIG completed its third year of Ethics in the Workplace and Zero Tolerance for Harassment training. These trainings by the HHS chief ethics officer are in-depth discussions of issues impacting workplace integrity. The mandatory employee training brings awareness to consider professionalism in all actions toward staff and stakeholders.

As part of its strategy to prevent fraud, waste and abuse (FWA) from happening in the first place, the OIG continues to offer training opportunities to new and expanded audiences. OIG staff provided training to HHS regulatory staff in February on the role of the OIG and how to report FWA. The training took place during the Long-Term Care Regulatory Regional Director Meeting. The training included guidance on how to spot FWA and how to report it to the OIG. The OIG will continue to look for new avenues to educate HHS staff about FWA.

VIII. OIG in Focus

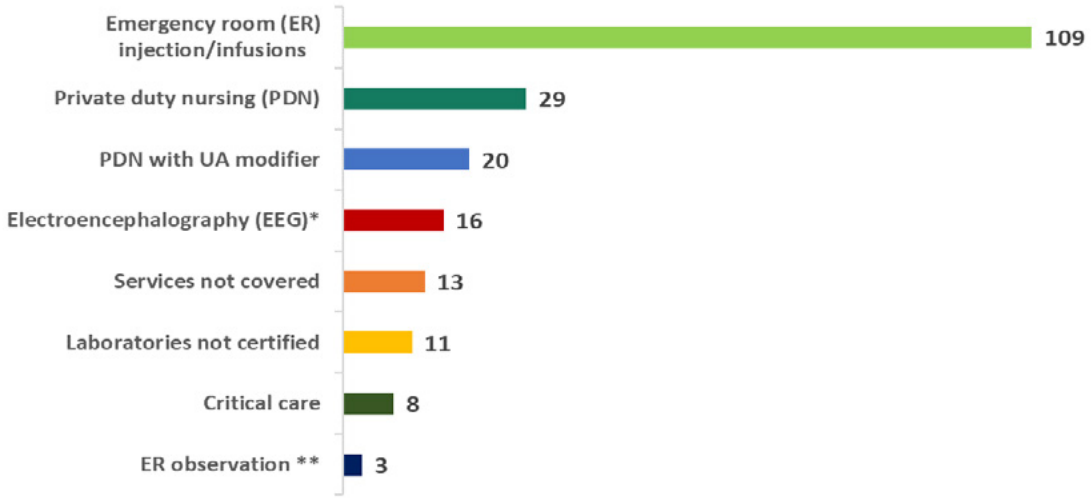
OIG Data Initiative Team reporting record recoveries

The OIG continues to broaden its use of data analysis to help uncover fraud, waste and abuse (FWA) trends in the health care system by assessing potentially problematic behavior patterns of providers, clients and retailers participating in Texas Health and Human Services (HHS) programs. The OIG's Data Initiative Project Team (DIPT) is using data to streamline operations while driving collaboration across the agency's divisions to produce multi-million-dollar recoveries from Medicaid providers. DIPT focuses its data analysis on providers who may be receiving Medicaid payments that they should not have received. When OIG staff see an issue or a problem arises with one provider, DIPT can analyze data from across the Texas health care system to determine whether similar issues are occurring with other providers who participate in Medicaid.

Opening investigations

Whenever DIPT identifies a behavior that may indicate FWA, it partners with the OIG's data team to initiate a sophisticated data analysis that can spot the same behavior occurring across the state. Chart 1 describes the types of cases that DIPT has opened between April 17, 2017 and February 23, 2022. The top allegation involves emergency room injection and infusion cases. These cases deal with providers who have double billed for injections and infusions in the emergency department, when the charges were already covered by the payment of an emergency room evaluation and management charge.

Chart 1. Total of Cases Opened by Allegation

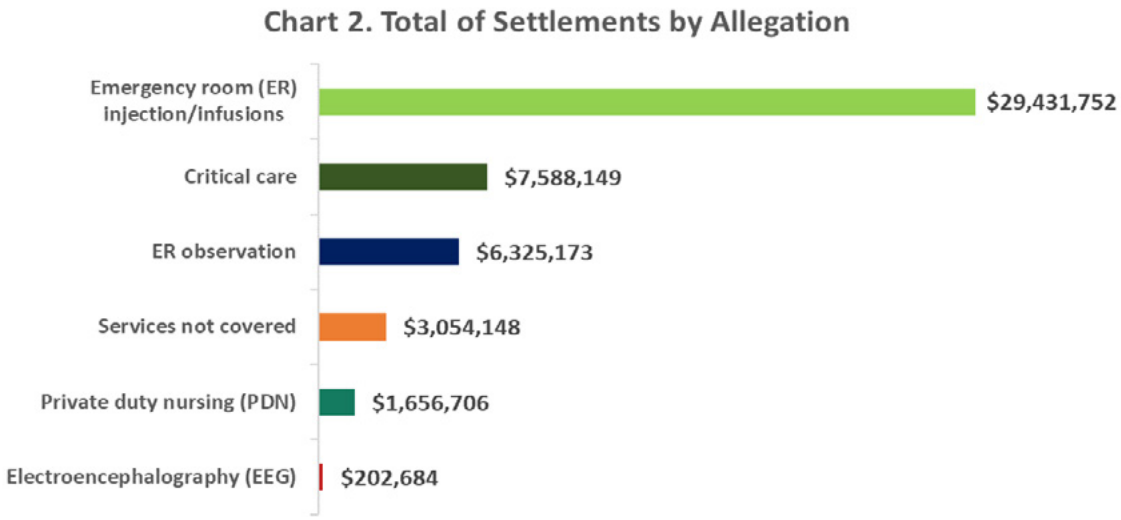


The team recently completed the investigation on three cases and referred them to the OIG's Litigation Team. The potential value of the overpayment, based on certified paid claims, for those three cases is over $15.5 million.

Working with providers, DIPT recently identified, analyzed and investigated a new scenario where providers are improperly using a billing modifier to obtain additional Medicaid funds when the patients do not have the appropriate medical condition or diagnoses for the provider to bill for the extra dollar amount. The team opened 20 new cases involving UA modifiers for private duty nursing. A UA modifier is a billing code for private duty nursing patients with a tracheostomy or ventilator dependent. The providers were using the UA billing code when the patients did not have a tracheostomy or were not dependent on a ventilator. DIPT worked collaboratively with the providers, their compliance departments and their legal counsel to reach an understanding that certain, specific patients did not have the appropriate diagnosis code and should not have received the extra payment for the modifier.

Case settlements

By harnessing the power of data analytics and the expertise of OIG staff, investigators and attorneys, DIPT can handle cases in a more efficient manner from the moment a case is initiated to final resolution. Chart 2 describes settlements by allegation type between April 17, 2017 and February 23, 2022, totaling more than $48 million.



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To report fraud, waste or abuse

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

Website: ReportTexasFraud.com

OIG on LinkedIn: hhsc-office-of-inspector-general

OIG on Twitter: @TexasOIG

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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)