OFFICE OF INSPECTOR GENERAL
HEALTH AND HUMAN SERVICES
TEXAS

# QUARTERLY REPORT








## Quarter 2, Fiscal Year 2024

OIG
2004 - 2024
20 YEARS

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# EXECUTIVE SUMMARY

I am pleased to present to Governor Greg Abbott, Executive Commissioner Cecile Young, the Texas Legislature and the citizens of Texas the second quarterly report for fiscal year (FY) 2024, summarizing the excellent work the office performed during this period.

From December 1, 2023, to February 29, 2024, the Texas Health and Human Services Office of Inspector General (OIG) recovered more than $100 million. In addition, we identified more than $324 million in potential future recoveries and achieved more than $42 million in cost avoidance.

As we mark the halfway point of the current fiscal year, we are also continuing the commemoration of our 20th anniversary.

When the OIG began operations in 2004, the world was still three years away from the first iPhone, the term "cloud" still referred to the weather, and the Texas Legislature still recorded their proceedings on cassette tapes. Much has changed in the 20 years since. One thing that has not is the enduring dedication of our OIG employees. The means and methods may have evolved, but their commitment to the OIG mission has never wavered and they remain the primary reason for our success.

Of the OIG's approximately 600 current employees, 12 joined the office in its first year of operations. Many more followed, but these 12 individuals were among the first to lay the foundation we continue to build upon 20 years later.

Following the many stories of success in this report, you will find the OIG in Focus column on page 19. I invite you to read, in their own words, the thoughts of these longest-serving employees as we continue to celebrate the OIG's 20th anniversary.

Raymond Charles Winter
Inspector General

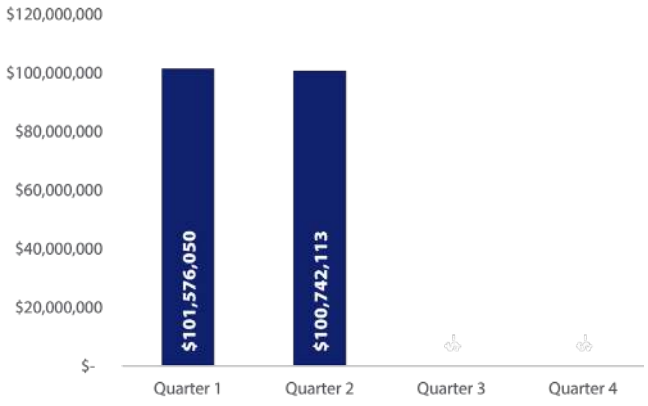
# QUARTERLY METRICS

## DOLLARS RECOVERED

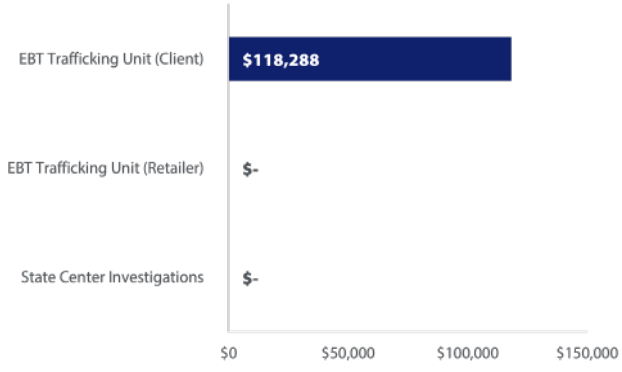
Dollars recovered are overpayments collected based on the results of an investigation, audit, inspection or review.

| TOTAL DOLLARS RECOVERED | $100,742,113 |
|---|---|
| **PROVIDERS AND MANAGED CARE ORGANIZATIONS** | **$95,603,338** |
| Audit and inspection overpayments | $638,251 |
| OIG and MCO investigation overpayments | $5,582,233 |
| Targeted queries overpayments | $2,457,531 |
| Acute care review overpayments | $214,145 |
| Hospital utilization review overpayments | $3,589,123 |
| Nursing facility utilization review overpayments | $453,177 |
| FFS Recovery Audit Contractor recoveries | $20,656,219 |
| Third Party Recoveries | $62,012,659 |
| **CLIENTS** | **$5,138,775** |
| Beneficiary overpayments (SNAP, TANF, Medicaid, CHIP, WIC) | $5,000,738 |
| Voluntary repayments by beneficiaries | $19,749 |
| Electronic Benefits Transfer trafficking beneficiary overpayments ★ | $118,288 |
| **RETAILERS** | **$0** |
| Electronic Benefits Transfer trafficking retailer recoveries ★ | $0 |
| WIC collections | $0 |
| **HHS EMPLOYEES AND CONTRACTORS** | **$0** |
| State Centers Investigations Team recoveries ★ | $0 |

## TOTAL RECOVERIES BY QUARTER




## ★PEACE OFFICER RECOVERIES



## DOLLARS IDENTIFIED FOR RECOVERY

Dollars identified for recovery is a measure of the total potential overpayments found through OIG audits, inspections, investigations and reviews. 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 | $324,169,765 |
|---|---|
| **PROVIDERS AND MANAGED CARE ORGANIZATIONS** | **$299,595,613** |
| Audit and inspection overpayments | $0 |
| OIG and MCO investigation overpayments | $7,243,750 |
| Targeted queries overpayments | $1,764,424 |
| Acute care review overpayments | $322,383 |
| Hospital utilization review overpayments | $6,716,491 |
| Nursing facility utilization review overpayments | $1,170,188 |
| FFS Recovery Audit Contractor recoveries | $20,266,602 |
| Third Party Recoveries | $262,111,776 |
| **CLIENTS** | **$24,574,150** |
| Beneficiary overpayments (SNAP, TANF, Medicaid, CHIP, WIC) | $24,169,686 |
| Voluntary repayments by beneficiaries | $0 |
| Electronic Benefits Transfer trafficking beneficiary overpayments ★ | $404,464 |
| **RETAILERS** | **$2** |
| Electronic Benefits Transfer trafficking retailer recoveries ★ | $2 |
| 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 | $42,743,131 |
|---|---|
| **PROVIDERS AND MANAGED CARE ORGANIZATIONS** | **$38,324,219** |
| Medicaid provider exclusions | $0 |
| Fee-for-service front-end claims denial | $38,324,220 |
| **CLIENTS** | **$4,418,911** |
| Client disqualifications | $2,450,443 |
| Pharmacy Lock-In | $1,733,292 |
| Disqualification of Electronic Benefits Transfer recipients ★ | $235,176 |
| **RETAILERS** | **$0** |
| WIC vendor monitoring | $0 |

# PROVIDER INTEGRITY

## TRENDS

The OIG Intake and Resolution Unit (IRU) continues to receive complaints against dentists and endodontists alleging substandard and unnecessary procedures, which potentially impact patient care. The OIG is investigating these providers and recommending administrative actions based on findings.

IRU has also received complaints related to case management services, which must be performed by either a licensed social worker or registered nurse, that allege duplicate billing, services performed by uncredentialed or unlicensed providers and records not supporting the services billed.

### Provider Investigations Performance

| | |
|---|---|
| **383** | Preliminary investigations opened |
| **378** | Preliminary investigations completed |
| **69** | Cases transferred to full-scale investigation |
| **47** | Full-scale investigations completed |
| **91** | Cases referred to OAG Medicaid Fraud Control Unit |
| **110** | Open/active full-scale cases at end of quarter |

## CASE HIGHLIGHTS

**OIG settles with several hospitals for improper injection and infusion claims**

A North Texas hospital incorrectly billed for injections and infusions and was also paid for emergency room service charges for the same patient on the same day as observation service charges, resulting in the hospital receiving reimbursement for both services when only one or the other is allowed. The provider worked with the OIG to resolve these issues, and the OIG agreed to a settlement of $810,258.

A Central Texas hospital also billed incorrectly for the administration of injections or infusions and observation services. In addition, the hospital also received reimbursement for critical care services (which are payable to the physician who rendered the service but are not payable to an outpatient hospital facility in Texas Medicaid), and it billed incorrectly for both observation room service charges and treatment room service charges when only one charge or the other is allowed. The provider agreed to a settlement of $360,280.

Another Central Texas hospital incorrectly billed several emergency department services. In addition to incorrectly billing for injections and infusions and receiving payment for emergency room service charges for the same patient on the same day as observation service charges, the hospital inappropriately received reimbursement for physician time-based codes that are payable only to physician providers, not hospitals. The hospital also billed and was paid for duplicate emergency room services charges for the same patient on the same date of service. The provider worked with the OIG to resolve these issues, and the OIG agreed to a settlement of $173,953.

An outpatient hospital facility also in North Texas was overpaid for injection and infusion claims in an emergency department setting and agreed to a lump sum settlement of $379,543.

**OIG reaches settlement with national independent laboratory**

In December 2023, the OIG entered into a settlement agreement with a privately owned independent laboratory in California. An OIG investigation found that from September 2017 through August 2021, the laboratory billed and received payment for providing genetic testing services to Texas Medicaid clients, despite the client records not including a signed and dated physician's order and an approved prior authorization, both of which are required for genetic testing services. The laboratory also billed and received payment for genetic testing not covered under the Texas Medicaid program. The conduct reviewed was specifically limited to 149 claim details that were examined by the OIG. The laboratory settled for $317,171.

**OIG settles with multiple pediatric practices over hearing tests**

The OIG entered into settlement agreements with three pediatric practices, totaling $206,614. The OIG investigations found that from September 2018 to August 2022, the providers billed and were paid for pure-tone audiometry services on the same dates of service as a Texas HealthSteps (THSteps) medical check-up for the same clients. Standard hearing screenings are a required component of and are reimbursed as part of THSteps medical check-ups, meaning they should not be separately billed and reimbursed in addition to a THSteps medical check-up. A provider analysis was performed, highlighting any instance in which the pure-tone audiometry code was billed on the same date of service as a THSteps medical check-up for the same client. The providers, two in Brownsville and one in Azle, agreed to settlements of $91,480, $51,408, and $63,725, respectively.

**Consumer Directed Services employer excluded for 20 years**

A Consumer Directed Services (CDS) employer in Lubbock County was excluded from Texas Medicaid for 20 years following an OIG investigation. CDS lets individuals hire and manage the people who provide their HHS services. The investigation determined the individual, who failed to produce records to the OIG upon request, submitted claims for services that were not rendered, failed to manage personal care attendants' services and failed to carry out the responsibilities of a CDS employer from April 2015 through September 2021. The exclusion took effect in January 2024.

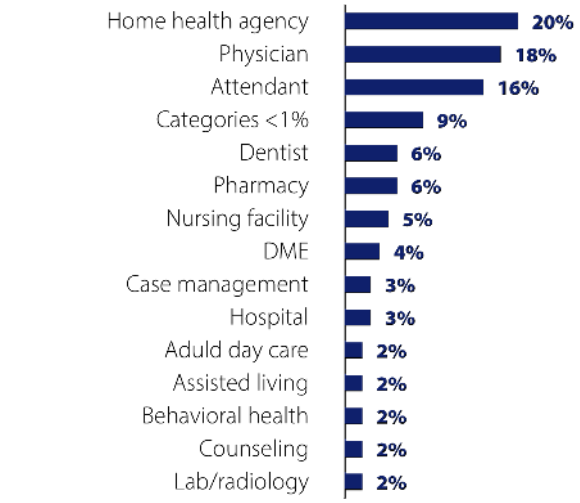
**OIG settles case with Houston home health agency**

In December, the OIG settled with a home health provider whose medical records did not support the use of the UA modifier billed for some clients. The UA modifier provides additional reimbursement for patients who are ventilator-dependent or have a tracheostomy. The provider worked with the OIG to resolve these issues, and the OIG agreed to a settlement of $147,291.

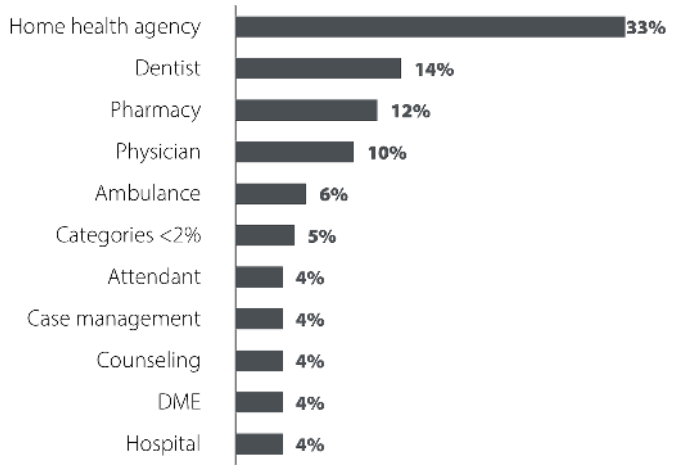
**OIG settles audit investigation with two Houston pharmacies**

The OIG settled two audit cases with Houston pharmacies in the second quarter of FY 2024. Both final audit reports were issued in August 2023 and showed that the pharmacies improperly submitted

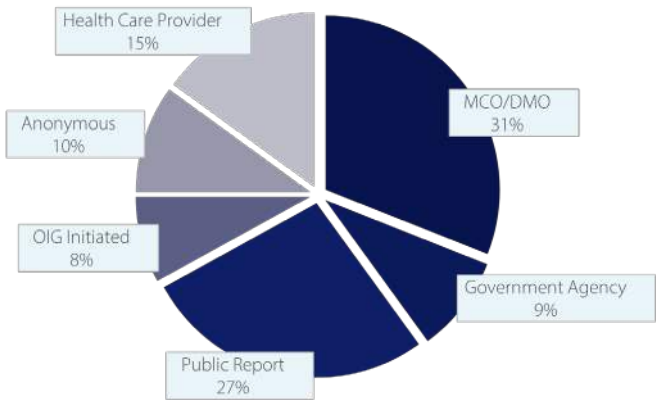
## Preliminary Provider Investigations
(by type)




## Full-Scale Provider Investigations
(by type)




## Investigation Referral Sources



claims to the Texas Medicaid program. One pharmacy was found to have failed to identify the correct prescriber on a majority of the reviewed prescriptions and contained incomplete directions for use on one prescription. For the second pharmacy, the audit determined that provider did not consistently comply with certain requirements for dosage directions, medication strength, maintaining records, signing or dating written prescriptions, and dispensed opioid and Schedule II prescriptions received by fax, which is not allowed. The pharmacies worked with the OIG to resolve the issues and agreed to settlements of $12,683 and $18,675, respectively.

### Surveillance Utilization Review

| | |
|---|---|
| **$214,145** | Acute care provider recoveries |
| **$322,383** | Acute care services identified overpayments |
| **133** | Acute care services cases closed |
| **$3,669,215** | Hospital and nursing home (UR) recoveries |
| **6,086** | Hospital (UR) claims reviewed |
| **46** | Nursing facility reviews completed |
| **2,681** | Average number of Lock-in Program clients |

### Provider Enrollment and Exclusions

| | |
|---|---|
| **6,060** | Provider enrollment applications processed |
| **20,442** | Individual screenings processed |
| **49** | Medicaid providers excluded |

**OIG settles audit investigation with Houston area behavioral health services provider**
The OIG settled another audit case in December with a behavioral health services provider in Webster, near Houston. The final audit report, issued in August 2023, found that the provider improperly submitted claims to the Texas Medicaid program for teleservices provided from June 2021 through December 2021. Specifically, the audit found that provider received reimbursement for teleservices delivered by providers who were not enrolled in Texas Medicaid. Further, the provider did not separately identify evaluation and management and add-on psychotherapy services for the majority of behavioral health claims tested, and medical records did not distinctly identify the amount of time it spent providing add-on psychotherapy services to its patients. The provider agreed to a settlement of $54,087.

**OIG reaches settlement with ambulance provider**
The OIG settled a case in January where a ground ambulance corporation self-disclosed that they had employed an excluded individual. The provider reported that an emergency medical technician they employed was excluded under her maiden name, and the exclusion was missed when searching the employee's current married name. Once the exclusion was discovered, the provider disclosed the error to the OIG and reported the employee's services billed from September 2022 through June 2023. The case resulted in a settlement of $30,939.

**OIG settles case with Austin home health agency**
An OIG investigation discovered that the agency reported to have provided home health care attendant services to a client at the same time the client was hospitalized and in a nursing home. The provider worked with the OIG to resolve the issue and agreed in February to a settlement of $10,587.

## AGENCY HIGHLIGHTS

**Pharmacy prescription services fraud detection operation**
Fraud detection operations (FDOs) are data-driven investigative operations that identify providers who are statistical outliers amongst their peers and assess whether they are outliers because of fraud, waste, 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 FDO conducted in November 2023 was focused on pharmacy prescription services where data showed a significant spike in claims, potential prescription brokering or a lack of previous relationship between

### Fraud Analytics and Data Operations

| | |
|---|---|
| **182** | Data requests received |
| **163** | Data requests completed |
| **97** | Algorithms executed |
| **0** | Algorithms developed |

the prescriber and client. A review of records is currently in progress and will be used to determine if full-scale investigations are warranted. Full-scale investigations could include additional interviews and reviews of more client clinical records to gain a broader understanding of the provider's operations.

**Algorithm audits**
The OIG's Fraud Analytics team develops algorithms to flag providers exhibiting billing behaviors that indicate potential fraud, waste or abuse. These algorithms are designed to analyze Medicaid fee-for-service claims and managed care organization (MCO) encounter data to identify outliers and potential noncompliance with Medicaid policy. OIG Fraud Analytics and OIG Audit are working closely on algorithms selected for an audit. The OIG Audit Division released two algorithm audits in February with a focus on electroencephalogram (EEG) services. The team reviewed a sample of providers and tested claims and encounters to validate whether the algorithms were flagging the billing behavior as designed. Fraud Analytics used the validation to modify the algorithms to improve their effectiveness, as needed. The audit team anticipates releasing future algorithm-based audits in May that will better inform the OIG of risk across the Medicaid program.

**Fraud Analytics to launch provider dashboards**
The OIG is adopting analytical tools to help identify potential indicators of fraud, waste and abuse within Texas health and human services programs. The Fraud Analytics team is customizing comprehensive dashboards that showcase billing, rendering, referring and prescribing trends and patterns for medical, dental and pharmacy providers, along with peer comparisons. The dashboards will facilitate further user reviews and analyses on providers of interest. Tools like the new dashboards help protect the integrity of the programs and better identify potential fraud, waste and abuse.

**Fraud Analytics analyzes Electronic Visit Verification**
The 21st Century Cures Act passed by Congress in 2016 required states to document and verify service delivery information for certain Medicaid services that require home visits using a computer-based Electronic Visit Verification (EVV) system. EVV helps prevent fraud, waste and abuse while making sure Medicaid recipients receive their authorized care. The OIG Fraud Analytics team conducted a complex analysis of EVV data and related personal care services claims and encounters to identify claims and encounters without a corresponding visit and visits with missing data. The analysis identified providers and claims for closer review, which is currently being undertaken by OIG investigators.

**Productivity increases within the Targeted Query Team**
The Targeted Queries (TQ) Team closed 543 cases in the second quarter of fiscal year 2024, exceeding the number of cases closed in the first quarter by 303 cases, a 126% increase. The case closures recovered inappropriate Medicaid payments identified by various TQs focused on the review of inpatient, laboratory, outpatient hospital, physician and personal care service claims.

**Texas State Auditor's Office Statewide Single Audit includes the Texas Medicaid Recovery Audit Contractor**
For the first time, the Texas Medicaid Recovery Audit Contractor (RAC) was included in the Texas State Auditor's Office (SAO) Statewide Single Audit for FY 2023. RAC staff met with auditors, responded to multiple information requests, and provided documentation for testing and review. The SAO audit did not identify any issues or adverse findings during the RAC program review.

**Provider Enrollment Integrity Screenings team tackles workload increase**
The Provider Enrollment Integrity Screenings (PEIS) team screens certain Medicaid provider applications to proactively safeguard client well-being and Medicaid program integrity. Since National Provider Identifier based enrollment was deployed in Texas in 2021, the volume of provider enrollment applications going through the OIG's PEIS team for review increased substantially. The end of the COVID-19 public health emergency in May 2023 also added to PEIS's workload as providers whose enrollment in Texas Medicaid was extended are now required to revalidate their enrollment. Thanks to the efforts of PEIS personnel and three new full-time positions granted by the Texas Legislature, the team is completing more than 98% of screenings within the required 10 business days.

## AUDIT REPORTS COMPLETED

**Electroencephalogram Services in Texas Medicaid: Cook Children's Medical Center**
Cook Children's Medical Center's (Cook Children's) claims submitted for 30 ambulatory electroencephalogram (EEG) service encounters complied with selected Texas Medicaid Provider Procedures Manual (TMPPM) regulations.

The audit selected 30 encounters from a risk-based sample of ambulatory EEG encounters between November 2020 and August 2021, for which no charges for a set-up procedure were included on the claim for the date of the EEG test in the sample. Testing showed that Cook Children's performed set-up for all sampled EEGs. In the instances in which Cook Children's did not submit claims for set-up, medical records showed that technicians performed set-up for a routine EEG within a day prior to the ambulatory test, which covered set-up for both EEGs. As such, the audit identified no issues or opportunities for improvement.

**Electroencephalogram Services in Texas Medicaid: Memorial Hermann Health System**
Providers must submit claims for ambulatory EEGs with specific procedure codes and diagnosis codes to be reimbursable under Texas Medicaid. Procedure codes identify services provided, while diagnosis codes help identify the reason the service was provided.

Memorial Hermann did not include an allowable diagnosis code on the Medicaid claim for 15 of 30 (50%) ambulatory EEG encounters tested, as required. Memorial Hermann did have supporting documentation that it performed the ambulatory EEG tests and submitted the claims with allowable procedure codes.

However, Memorial Hermann made coding errors on its claims for Medicaid reimbursement. While its medical records supported services rendered, it did not always include the allowable diagnosis codes in the claims it submitted. MCOs should deny claims without allowable diagnosis codes, which could otherwise result in an overpayment to the provider. Memorial Hermann should develop a process to validate claims submitted for payment comply with the TMPPM and include allowable diagnosis codes.

**Follow-Up Assessment on Previously Issued Audit Recommendations: Co-Treatment Therapy Billing at Rebound Sports and Physical Therapy**
The OIG conducted a follow-up assessment of the previously issued audit report titled "Co-Treatment Therapy Billing: Rebound Sports and Physical Therapy" to determine the implementation status of an audit recommendation previously issued.

### Audit Performance

**$638,251** Overpayments recovered

**$0** Overpayments identified

### Audits Issued (3)

- Electroencephalogram (EEG) Services in Texas Medicaid: Cook Children's Medical Center (February 14, 2024)
- Electroencephalogram (EEG) Services in Texas Medicaid: Memorial Hermann Health System (February 29, 2024)
- Follow-Up Assessment on Previously Issued Audit Recommendations: Co-Treatment Therapy Billing at Rebound Sports and Physical Therapy (February 29, 2024)

### Audits In Progress (22)

- Selected Telehealth Providers
- Managed Care Pharmacy Benefits Management Services
- DMO and MCO Financial Reporting
- Selected Local Mental Health Authorities
- Selected Pharmacy Providers
- Selected Prescribed Pediatric Extended Care Centers
- MCO IT Security Controls and Business Continuity
- Selected Long-Term Care Discharges
- Selected Day Care Providers
- Selected Durable Medical Equipment Providers
- Selected Substance Use Disorder Treatment Providers

In lieu of implementing the audit recommendation, Rebound Sports and Physical Therapy (Rebound) elected to discontinue co-treatment for all therapies and performed all needed therapies separately for each patient. This alternate action allowed Rebound to continue providing care to its patients without directly addressing the recommendation. Rebound successfully implemented changes that resolved the recommendation using a process, system or policy. As a result, the OIG did not reissue the recommendation from the previous audit.

## INSPECTION REPORTS COMPLETED

### Inspections Issued (3)

Ambulance Claims Oversight: Non-Medically Necessary Ambulance Claims (January 9, 2024)

Follow-Up Assessment on Previously Issued Inspections Recommendation: Nursing Facility Staffing Hours Verification-Mira Vista Court (January 12, 2024)

Mental Health Private Psychiatric Bed Funds: Tropical Texas Behavioral Health (February 15, 2024)

### Inspections In Progress (4)

Follow-Ups of Nursing Facility Staffing Hours Verification Inspections

**Ambulance Claims Oversight: Non-Medically Necessary Ambulance Claims**

The OIG conducted a review of non-medically necessary ambulance encounters for all Texas Medicaid–contracted MCOs from April 2022 through April 2023. Texas Medicaid ambulance services include both non-emergency and emergency transports. An emergency transport service is a Medicaid benefit when the client has an emergency medical or behavioral health condition. A non-emergency ambulance transport is a Medicaid benefit for clients to or from scheduled medical appointments or licensed treatment facilities, or to the client's home after discharge from a hospital when the client has a medical condition for which an ambulance is the only acceptable means of transportation.

The encounter data showed six MCOs had one or more ambulance encounters with a paid status and a GY modifier, which indicates no medical necessity. MCOs should automatically deny a claim with a GY modifier. Inspectors sent these claims to each MCO for further review to identify the reason the MCOs paid the claims in error.

The MCOs have stated they have adjusted or are currently working to adjust and deny the identified claims. The OIG's work was limited to evaluating documentation provided by certain MCOs and did not include follow-up testing to verify MCO assertions regarding new controls implemented or other statements.

**Follow-Up Assessment on Previously Issued Inspections Recommendation: Nursing Facility Staffing Hours Verification-Mira Vista Court**

The OIG conducted a follow-up assessment of the previously issued inspection report titled "Nursing Facility Staffing Hours Verification: Mira Vista Court" to determine whether the previously issued recommendation from August 16, 2022, was implemented. The objective of the original inspection was to determine whether the direct care licensed nursing hours recorded at Mira Vista Court supported the hours reported to the U.S. Centers for Medicare and Medicaid Services (CMS) in compliance with federal requirements. The OIG found that Mira Vista Court fully implemented the recommendation and has no additional recommendations.

**Mental Health Private Psychiatric Bed Funds: Tropical Texas Behavioral Health**

The OIG conducted an inspection of Tropical Texas Behavioral Health's (Tropical) use and oversight of funds provided to subcontracted entities for inpatient mental health services to eligible patients.

For the months tested, Tropical paid for client hospitalizations with mental health private psychiatric bed funds. Tropical accurately paid all tested invoices, totaling $424,375. Tropical subcontracted with three local mental health authorities (LMHAs) to arrange 32 hospitalizations and three private psychiatric hospitals to provide 89 inpatient mental health services.

Tropical grants an initial authorization of three days when approving hospital admissions. If it is anticipated that the client will need more than three days of hospitalization, the hospital must submit a continued stay request to Tropical for authorization. Of the 89 tested hospitalizations with the private psychiatric hospitals, Tropical paid $41,875 for 28 continued stays where requests were not documented as required by its contracts with the hospitals. Tropical did not establish controls to document evidence of advance approval of continued stay authorization requests that Tropical's utilization manager for the hospital made in real time. Not requiring its contractors to follow its authorization process could result in Tropical not having enough funds to pay for services provided.

Tropical paid $163,125 for 32 tested hospitalizations arranged by contracted LMHAs without receiving all the documentation required by its contracts. Tropical asserted it waived the supporting documentation requirement to increase the efficiency and effectiveness of service provision.

While not a finding of noncompliance, Tropical also paid for services at a private psychiatric hospital without a fully executed contract with one hospital for the scope period. The OIG noted this as an opportunity for improvement.

# CLIENT ACCOUNTABILITY

## TRENDS

The Benefits Program Integrity (BPI) Unit investigates allegations of overpayments to health and human services program clients. This quarter the unit completed 5,147 investigations involving benefit recipient overpayments or fraud allegations.

Concerns involving a client's household composition made up 50% of all completed BPI investigations, with an additional 15% 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 20 investigations for prosecution and 249 investigations for administrative disqualification.

**Benefits Program Integrity Performance**

**$5,000,738**
Overpayments recovered

**3,925**
Cases opened

**5,147**
Cases completed

**20**
Cases referred for prosecution

**249**
Cases referred for administrative disqualification

## CASE HIGHLIGHTS

**Abilene SNAP client pleads guilty to felony charges**

As a result of an OIG investigation, an Abilene woman pleaded guilty in district court to felony charges of tampering with a governmental record. She applied to receive SNAP and Medicaid benefits but failed to report a required household member. OIG investigators found evidence the unreported individual 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 $14,531 in SNAP and Medicaid benefits she was not entitled to receive. On December 15, 2023, the defendant was sentenced to five years deferred adjudiction community supervision and ordered to pay $14,531 in restitution to Texas Health and Human Services.

**Lubbock County SNAP beneficiary agrees to disqualification**
A Lubbock County woman voluntarily agreed to be disqualified from the SNAP program and to pay full restitution following an OIG investigation. The individual concealed her earned income when she applied to receive SNAP benefits. The subject received $31,096 in SNAP benefits she was not entitled to, which she was ordered to repay in full, in addition to being disqualified from SNAP for 12 months.

**Tarrant County SNAP beneficiary disqualified and ordered to repay stolen benefits**
In an administrative hearing following an OIG investigation, a Tarrant County woman was found to have committed violations. The individual concealed her income, including unemployment income, when she applied to receive SNAP benefits. In total, the subject received $14,572 in SNAP benefits she was not entitled to. The subject was ordered to repay all $14,572 to Texas Health and Human Services. This was the individual's second program violation, so, in accordance with federal policy, she was disqualified from SNAP for 24 months.

## AGENCY HIGHLIGHTS

**Benefits Program Integrity partners with HHS Access and Eligibility Services**
The BPI team has entered into a workgroup with HHS Access and Eligibility Services (AES) to gain insight into AES's fraud prevention efforts. The workgroup explores opportunities where the two entities can work together to achieve the shared goals of identifying and preventing fraud, waste and abuse in benefit programs.

Recent meetings have been focused on EBT fraud schemes and the methods of client education related to fraud prevention that AES has found to be most effective. AES policy experts provided insight on policy issues and needs, such as clarifying "household composition" and who is a "required household member" on a benefits application. BPI shares the fraud trends OIG investigators are seeing and provides information on what eligibility workers should be looking for, how to refer those cases to OIG and what constitutes an actionable referral.

# RETAILER MONITORING

## TRENDS

**Electronic Benefits Trafficking Unit**
The Electronic Benefits Transfer (EBT) Trafficking Unit is comprised of commissioned law enforcement officers and non-commissioned investigators who conduct criminal investigations into EBT misuse by retailers. This quarter, the EBT Trafficking Unit completed 67 investigations and presented another 44 investigations for either administrative disqualification hearings (43) or prosecution (1).

| Electronic Benefits Transfer Trafficking Unit Performance | |
|---|---|
| **$118,288** | Overpayments recovered |
| **78** | Cases opened |
| **67** | Cases completed |

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

This quarter, the Grand Prairie EBT Trafficking Unit has also seen an increase in reports of EBT fraud at boarding and group homes. The reports indicate some facilities are requiring residents to turn over their EBT cards, and unauthorized purchases are made with the cards. The facilities are also refusing to return the cards upon the clients' requests. EBT investigators are assisting other state and local law enforcement with these investigations.

**WIC Vendor Monitoring Unit**

The Women, Infants, and Children (WIC) Vendor Monitoring Unit (VMU) uses a variety of tools to monitor and ensure the compliance of retailers participating in the WIC program. This quarter, WIC VMU conducted 87 compliance buys across the state. A compliance buy is a covert in-store inspection. An OIG inspector poses as a WIC client and uses a WIC (EBT) food card to make purchases to ensure vendors are following WIC rules. No violations were cited.

**WIC Vendor Monitoring Unit Performance**

| | |
|---|---|
| **87** | Compliance buys |
| **22** | Inventory reviews |
| **43** | On-site store inspections |

The team also completed 22 inventory reviews across the state. An inventory review is a comparison of a vendor's paid claims and purchase invoices for WIC food items. The inventory review determines if the vendor had a sufficient inventory of WIC food items to justify submitted claims. All vendors reviewed this quarter were in compliance.

The WIC VMU also conducted 43 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.

Over the past three years, the WIC Vendor Monitoring Unit conducted compliance activities with a limited scope in response to post-COVID-19 enforcement limitations. At the beginning of FY 2024, all post-COVID-19 policy waivers were lifted, and full enforcement returned. This resulted in an increase of violations being cited during store visits. The WIC VMU's goal is to assist stores in becoming fully compliant with WIC contracts, including getting all stores back up to speed with mandatory program compliance.

## CASE HIGHLIGHTS

**Seafood restaurant owner suspected of $100k EBT fraud**

The EBT Trafficking Unit received information from a large retailer about possible EBT fraud occurring at one of their stores in the Dallas-Fort Worth area. The information stated a store member's account had used approximately 93 different EBT cards for more than $74,000 in purchases. The items purchased were mostly seafood, including 2,000 cases of shrimp. The investigation revealed the suspect owned a seafood restaurant and is not an EBT client. Investigators suspected that he was using EBT cards to stock his restaurant.

Investigators obtained evidence from the retailer that confirmed the allegations and linked the suspect to the purchases. Investigators also met with the suspect and his attorney for an interview and spoke with several witnesses. The total amount of fraud suspected in the case is $128,848. The case will be referred to the district attorney's office for prosecution.

**Retailer caught extending credit to SNAP customers**

The EBT Trafficking Unit investigated a retail business for allegedly running credit accounts through the business. Retailers are prohibited from allowing SNAP recipients to buy items on credit and later use their SNAP benefits to reconcile the accounts. The business, a drive-through convenience store in Alamo, Texas, was submitted to the USDA Food and Nutrition Service (FNS) for consideration of administrative penalties. On February 12, 2024, FNS issued a determination letter to the owner of the drive-through convenience store informing them of a one-year disqualification period.

**OIG takes on cases from USDA Food and Nutrition Service**

The Houston EBT Unit has worked multiple retailer EBT trafficking investigations with FNS. FNS investigators initiated 11 cases where SNAP benefits were exchanged for cash. FNS referred these cases to the OIG's EBT Trafficking Unit, which continued the investigations and conducted undercover operations confirming the allegations. Charges have been filed in eight of the cases. Two cases are pending, and one case was not accepted due to insufficient evidence.

# HHS OVERSIGHT

## Internal Affairs Performance

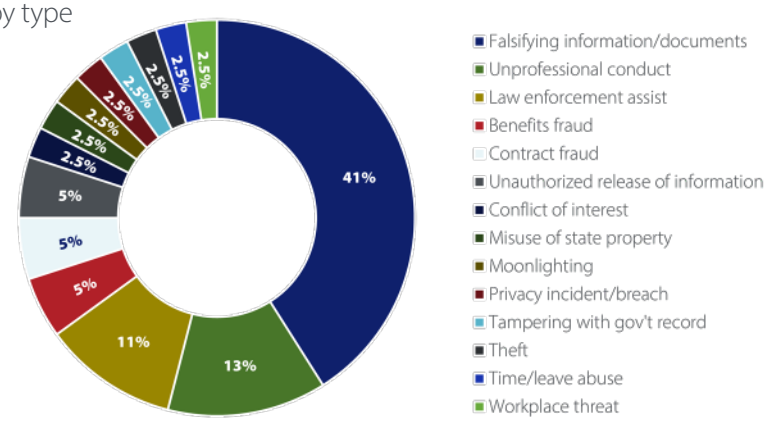
| | |
|---|---|
| **75** | Cases opened |
| **41** | Cases completed |

## State Center Investigations Team Performance

| | |
|---|---|
| **209** | Cases opened |
| **187** | Cases completed |

## Internal Affairs Completed Cases

by type




## TRENDS

**Major Case Unit**

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

**Internal Affairs**

Internal Affairs (IA) processed 120 referrals this quarter. IA worked on 51 active investigations and closed 41 investigations in the same period. The remaining referrals were forwarded to the appropriate business areas, including the Office of the Independent Ombudsman for State Supported Living Centers; the Department of Family and Protective Services (DFPS) Office of Internal Affairs; and HHS Complaint and Incident Intake.

Approximately 26% of Internal Affairs' open cases involve Child Protective Services client or supervisor allegations of DFPS employees falsifying documents. Many referrals also come from outside entities not involved with a state agency or HHS. In the second quarter of FY 2024, IA saw a 12% increase in referrals received, a 13% increase in cases opened, and a 25% decrease in case closure averages.

**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. This quarter, SCIT opened 209 investigations and completed 187 investigations with an average completion time of 20 days. This compares to 176 opened investigations and 232 completed investigations in the prior quarter. In the same quarter of FY 2023, SCIT opened 302 investigations and completed 293 investigations.

## CASE HIGHLIGHTS

**DSHS lab technician investigated**

IA investigated a case involving a lab technician who aggressively grabbed another employee's arm. The employee reported the incident to supervisors and the police but did not pursue charges. Witness interviews established the technician grabbed the employee's shirt and yelled at him. The technician was reassigned and later resigned.

**DFPS employee improperly released information**

IA investigated a now-terminated employee for allegedly directing a subordinate to use an HHS database for information without an official need. The supervisor provided the information to a non-employee. Database audits, witness interviews and the employee's own admission confirmed the allegation.

**Investigation finds HHS supervisor moonlighting**
IA investigated a case involving an HHS supervisor who was allegedly moonlighting while on leave. Employee interviews and a review of social media revealed the employee was operating a business while on medical leave. The investigation determined the employee violated HR policies related to unapproved outside employment. The employee resigned.

**OIG investigates abuse allegations**
Two recent SCIT cases involved allegations of physical abuse at separate state facilities, one at the Brenham State Supported Living Center and the other at the Waco Center for Youth. In both cases, OIG investigators reviewed video evidence and conducted interviews that confirmed the allegations. Both cases were referred to the respective district attorney for criminal prosecution.

## POLICY RECOMMENDATIONS

**OIG provides program integrity feedback on policy changes for durable medical equipment**
In January, HHS requested program integrity feedback from the OIG on a new durable medical equipment (DME) policy. The OIG recommended that the policy clarify that MCOs do not have discretion to determine whether a prior authorization is required. The OIG also recommended that the policy state that MCOs must comply with all applicable state and federal laws, rules, regulations and policies relating to MCO prior authorization reviews and determinations and that an MCO prior authorization of DME and supplies allowed under the exceptional circumstances provision must be prior authorized in compliance with Medicaid program rules, regulations and policies. Finally, the OIG also recommended that the new DME policy specify that services are subject to retrospective review and recoupment if documentation does not support the services billed.

## RULES

**Overpayments identified by inspection**
The OIG is processing new rule 1 TAC §371.1721, concerning the recoupment of overpayments identified by inspections, to describe the OIG's inspections procedures for records requests, inspection processes, notices, final reports and due process. This rule is currently undergoing review and will be posted in the Texas Register in the third quarter of FY 2024 for a 31-day public comment period.

**Medicaid Estate Recovery Program**
The OIG is processing proposed amendments to 1 TAC, Part 15, Chapter 373, Subchapters A, B, and C, concerning the Medicaid Estate Recovery Program (MERP). The revisions will clarify MERP eligibility and rule requirements to ensure proper recovery of Medicaid long-term care costs, update outdated terminology and citations, adjust financial thresholds for inflation, and eliminate ambiguous language. These amendments are currently undergoing review with other HHSC divisions.

**Overpayments identified by retrospective payment review**
The OIG is processing new rule 1 TAC §371.1723, concerning the recoupment of overpayments identified by retrospective payment reviews, to describe the OIG's retrospective payment review procedures for records requests, review processes, notices and due process. This rule was posted in the Texas Register on February 16, 2024, for a 31-day public comment period.

**Third-Party Recoveries**
The OIG processed amendments to several sections in 1 TAC, Part 15, Chapter 354, Subchapter J, concerning Third-Party Recoveries (TPR), as a result of changes to federal rules and legislation passed during the most recent Texas legislative session. The adopted rule was posted in the Texas Register on February 16, 2024, and was effective February 22, 2024.

# STAKEHOLDER ENGAGEMENT

## Fraud Hotline Performance

**7,223** Fraud Hotline contacts handled

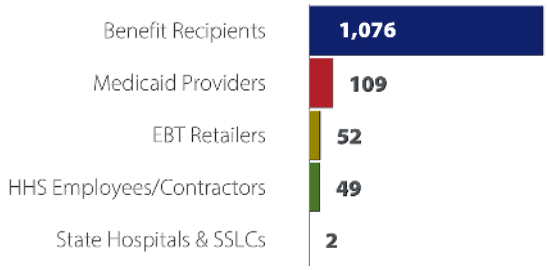
**1,288** Fraud Hotline referrals to OIG units

## External Relations Performance

**83** Communications products

**91,436** OIG web page views

### Fraud Hotline Referrals by Type




## STAKEHOLDER MEETINGS

**Association meetings**

Throughout the second quarter of FY 2024, Inspector General Raymond Charles Winter continued meeting with stakeholder associations to learn more about their organizations, members and priorities. The meetings also allowed Winter to share his vision and goals for the OIG and explore opportunities for future collaboration. This quarter's meetings included the Texas Health Care Association on December 6 and the Texas Dental Association on February 9.

**El Paso stakeholder visit**

On February 1, Inspector General Winter and OIG leaders toured United Medical Center in El Paso and met with leadership from University Medical Center, El Paso Children's Hospital, and El Paso Health to learn how they serve the El Paso region. The team also met with Emergence Health Network in El Paso to better understand how they assist area residents with mental illness, intellectual developmental disabilities and substance abuse issues. At their final stop in El Paso, the OIG leaders met with several independent providers from area. Dr. Ogechika Alozie, M.D.; Dr. Andres Boadella, M.D.; Dr. Lizbeth Holguin, D.D.S. and Dr. Robert Wison, D.D.S. provided insights into their experiences with Medicaid as they serve the health care needs of local El Pasoans. Meetings such as these inform the OIG's work and build the public-private partnerships that are essential to Medicaid.

OIG officials meet with local health care leaders at the University Medical Center El Paso

**Texas Fraud Prevention Partnership leadership meeting**

On February 15, 2024, the OIG held the Texas Fraud Prevention Partnership (TFPP) meeting with OIG leadership and executive leadership from the managed care organizations (MCOs) to discuss current initiatives and combined efforts to prevent, detect and investigate fraud, waste and abuse. More than 40 representatives from MCOs and other interested stakeholders attended the meeting virtually and in person. Discussion topics included information about the expanded requirements for MCO overpayment reporting, updates on information technology security audits and special investigative unit audits, data and trends related to activities and recoveries in investigations and utilization reviews, a reminder about the MCO requirement to verify that beneficiaries received the services that were billed, updates on an OIG emergency department initiative, and updates on OIG amendments to the Texas Administrative Code. The final TFPP MCO leadership meeting of the fiscal year will be June 20.

Inspector General Winter speaks at the February 2024 Texas Fraud Prevention Partnership meeting.

**Texas A&M University Bush School of Government and Public Service**
On February 28, Inspector General Winter and OIG leaders traveled to College Station to meet with students and faculty at the Bush School of Government and Public Service. In addition to informing graduate students about the work of the OIG, Inspector General Winter addressed critical issues for the emerging leaders, such as decision-making, negotiation, and the importance of transparency and program integrity in health care and other public services. The team also met with faculty, exploring opportunities for future collaboration.

OIG leaders and their host by the bust of President George H.W. Bush at the Texas A&M Bush School.

**OIG publishes educational article for providers**
The OIG's continued focus on educating and collaborating with providers helps to prevent waste and wrongdoing from happening in the first place. In the second quarter, OIG Chief Dental Officer Dr. Janice Reardon collaborated with the OIG Communications Team on the article "Common Errors in Sedation and Anesthesia Administration," featured in the Texas Dental Association Today February 2024 newsletter. Designed to support patient safety and accurate Medicaid billing, the article outlined the compliance requirements for administering sedation and anesthesia and shared the typical errors to avoid.

OIG Communications also produced an article for the Texas Association for Home Care and Hospice outlining the updated process for self-disclosing errors to the OIG. Providers are required to self-disclose overpayments received from participation in HHS programs. The article explained the process for doing so and the benefits afforded to the providers who follow it.

An article produced for the Texas Pharmacy Association revealed the pharmacy errors frequently discovered by OIG investigators and auditors. They include problems related to upcoding, unauthorized prescription refilling, and maintaining accurate records to support Medicaid billing.

## CONFERENCES, PRESENTATIONS AND TRAININGS

### Training Overview

**54** Trainings conducted this quarter

**Medicaid Program Integrity Summit**
The OIG's Medicaid Program Integrity team, which is comprised of staff from the Intake Resolution Unit, Provider Field Investigations and Program Integrity Development & Support unit, gathered in Austin in January for the week-long MPI Training Summit. The gathering was designed to help sharpen investigative skills and learn about new and emerging fraud, waste and abuse schemes. The training included a special emphasis on managed care, legal considerations and working jointly and collaboratively with the Texas Office of Attorney General's Medicaid Fraud Control Unit.

The summit also served as a platform for OIG staff to introduce their teams, outline their work, highlight areas of work where there may be overlap between teams, and discuss potential collaboration opportunities. For example, OIG Data Reviews gave presentations on the Data Reviews Division and its Fraud Analytics, Data Operations, and Provider Enrollment Integrity Screenings (PEIS) teams.

The OIG Operations Division provided valuable assistance by coordinating logistics, travel arrangements, and presentation support for the 60 attendees. The OIG Training team also presented on professional development and leadership topics during the event.

Attendees gather for a photo following the 2024 OIG Medicaid Program Integrity Summit.

**Colors of Communication Training**
Surveillance Utilization Review (SUR) participated in the Colors of Communication Training provided by OIG Program Support and Training. All staff studied the different communication styles and were able to determine their personal communication style. This training provided insight to the benefits and challenges of each style to facilitate better collaboration across the team.

# OIG IN FOCUS

## LONGEST-SERVING EMPLOYEES MARK OIG ANNIVERSARY

This year, the Texas Health and Human Service's (HHS) Office of Inspector General (OIG) celebrates 20 years of service to Texas. The OIG was established as an oversight agency by the state legislature in 2003 and began operations in 2004. The OIG replaced the HHS Office of Investigations and Enforcements, consolidating fraud detection activities spanning 12 agencies.

From the outset, the OIG has provided oversight to HHS employees and the providers, clients and contractors who interact with its programs. This work is accomplished through audits, inspections, investigations and reviews to prevent and detect fraud, waste and abuse in Texas Medicaid, SNAP, WIC and others.

**Protecting tax dollars, serving Texans in need**

The OIG's activities make sure the $46 billion now spent each year on HHS programs are used as intended. From day one, the OIG's team members were drawn to that mission and the opportunity to affect the state budget and citizens' wellbeing. The OIG has grown to employ approximately 600 people; 12 current team members have been with the organization since its first year of operations. Their commitment to serving the state has endured two decades. As we celebrate, we wanted to share some of their thoughts in their own words.

As the director of investigations and reviews for Electronic Benefits Transfer (EBT) trafficking and WIC, Andy Abrams well understands the people served by vital HHS programs. "The work that I have been a part of for the last 20 years directly impacts people's lives. Tax dollar oversight is important, as is making sure that the people who are being served are properly served. But the best part about working at the OIG is making a difference in the lives of those who are marginalized and somewhat rejected by the systems."

OIG Benefits Program Integrity (BPI) prosecutes recipients who commit fraud. "BPI's work is essential in the fact that we recover fraud overpayments, and by doing so, often deter fraudulent activity by getting the word out that fraud against the program is a state jail felony, and the agency takes action," says BPI manager Norra Kost-Lambert. "Just as important, our job often times is to determine an individual did not commit a crime or have an overpayment and, therefore, is innocent of the fraud allegations."

The personal results of the work drew many people to the OIG. And it's kept them here. Protecting HHS program integrity helps ensure that assistance is available for the vulnerable families who truly need it.

Medicaid Program Integrity (MPI) management analyst Patricia Nascimento explains, "If the OIG did not exist to do the work we do, there would be no or little accountability for the use of taxpayer dollars and to protect Texas beneficiaries from actions that can cause them harm." "The work we do helps more recipients to receive benefits," adds Maryann Magovern, an administrative assistant in Abilene's regional office.

"In a world that seems to desire instant gratification, even if it means being fraudulent, I think it's important to say being fraudulent is not right," says research specialist Eugene Sánchez with the Targeted Queries team.

**Growing and evolving**

In FY 2023, OIG teams recovered $532 million in misspent tax dollars. Returning billions of tax dollars to the state since 2004 is only part of the agency's track record of success. A continued focus on educating and collaborating with providers has helped to prevent waste and wrongdoing from happening in the first place.

"I have worked for many different Inspectors General and seen a lot of changes, but the overall vision and mission have always been very similar. We work side-by-side with a common goal to ensure our success," explains management analyst Ada Porter, with Recovery Coordination and Program Support. "But the biggest change has been technology; it has changed how we communicate, learn and think."

Since its inception, the OIG has evolved into a data-driven agency, employing top talent to create algorithms, analyze results and successfully complete cases. OIG advancements have improved the early detection of questionable behavior and the identification of industry-wide trends. For example, the OIG's Fraud Analytics team developed a predictive model to identify potential waste and wrongdoing using artificial intelligence. The team trained the supervised machine learning model to identify risky providers using examples of providers that are currently excluded from participating in the Texas Medicaid program. The model helps uncover questionable behavior and highlight claims for closer review. Throughout FY 2024 and beyond, our stakeholders can expect to see continued innovation in Medicaid fraud prevention and detection.

While leveraging the latest technology and tools helps drive the OIG forward, the secret to two decades of continuous improvement lies with the talented employees who put the OIG's values – accountability, integrity, collaboration and excellence – into practice.

BPI investigator Bonny Bryson shares, "The best part of working here is being a member of this team. I've seen OIG evolve and improve, and I'm thankful that I've been part of that."

**Looking ahead**

The OIG is grateful for the collaborative relationships forged over the years with our stakeholders. The continuing commitment of thousands of providers and hundreds of OIG team members across the state helps create a healthier Texas for everyone.

"No one wants to hear from us, but our staff are dedicated and committed," explains training advisor Todd Shaw. "The OIG positively impacts both recipients and providers by being vigilant to abuses in the system. It protects and gives back, usually without fanfare or acclaim, and does so year after year."

# OFFICE OF INSPECTOR GENERAL
# TEXAS HEALTH AND HUMAN SERVICES

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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 Section 531.102 (U)