Protecting Taxpayer Funds in HHS Programs

May 5, 2026

Texas Health and Human Services
Raymond Charles Winter, Inspector General

Agenda

- OIG at a Glance
- Governor Abbott's Request
- Common Schemes in Medicaid and SNAP
- Provider Enrollment and Revalidation
- Policy Considerations in Program Design
- Recommendations

Dealing with the Government

“Men must turn square corners when they deal with the Government.”

- Supreme Court Justice Oliver Wendell Holmes, Rock Island, Ark. & LA RR Co. v. United States, 1920

“There is no kind of dishonesty into which otherwise good people more easily and frequently fall than that of defrauding the government.”

- Benjamin Franklin, 1767

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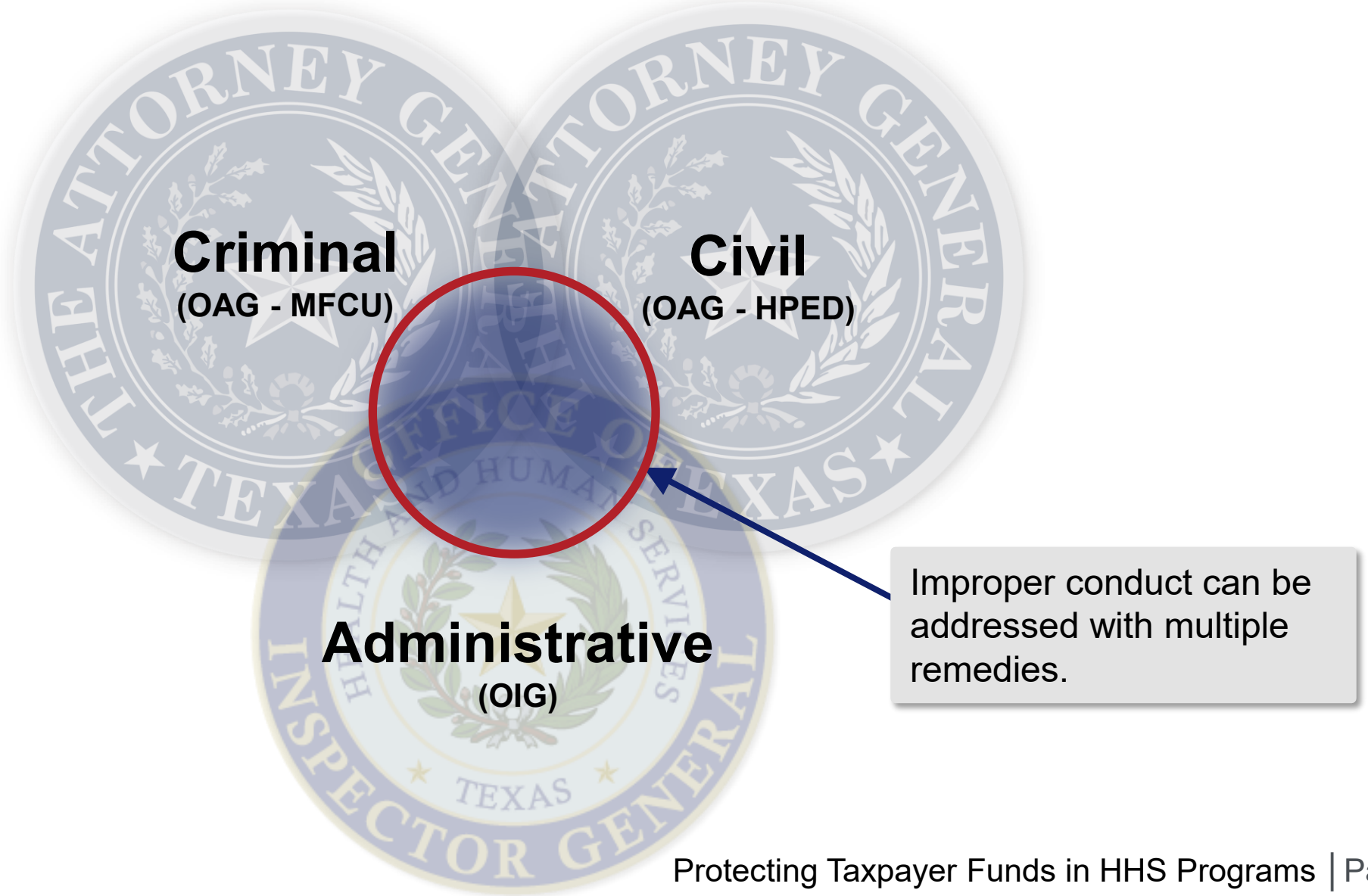
The Toll of Fraud, Waste and Abuse

The National Health Care Anti-Fraud Association estimates that up to **10%** of total health care expenditures are lost to fraud, waste and abuse each year. Meaning that in Texas with **$53 billion** spent on HHS services, over **$5 billion** are siphoned away from their intended purpose.

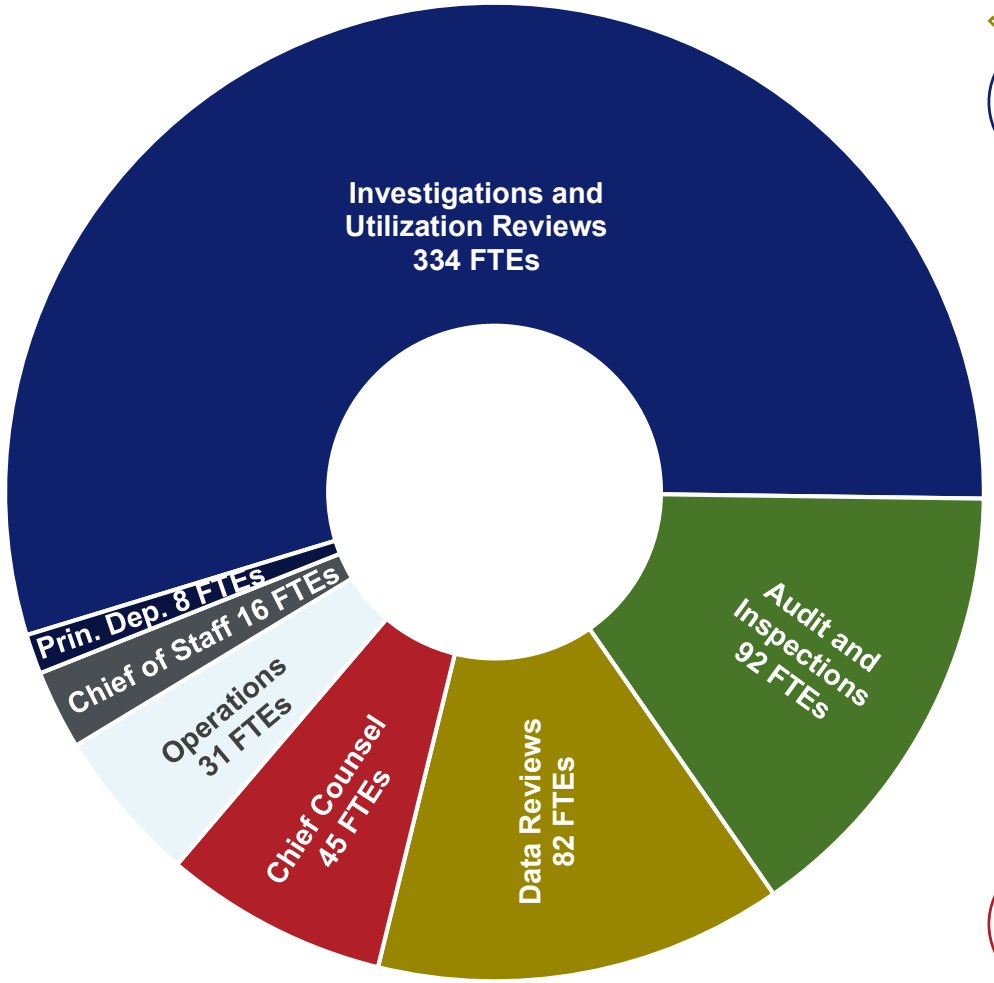
Every dollar not spent as intended by the Legislature is a dollar lost to taxpayers and not available to serve Texas HHS clients.

State Agency Collaboration



OIG's Toolbox

FY 2026



- Investigations
- Reviews
- Audits
- Inspections
- Data Analysis
- Litigation

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FY 2025 Performance

Category	FY 2025
Recoveries	$465,691,516
Investigations	22,746
Audit Reports	34
Fraud Hotline Contacts	32,249
MFCU Referrals	270
Provider Screenings	91,991
Exclusions	364
Return on Investment	$4.21

Governor's Request

- Expand reviews of high-risk Medicaid services and focus OIG resources on suspected FWA.
- Ensure that MCOs Special Investigations Units (SIUs) are fully staffed and are meeting statutory requirements.
- Provide additional training to strengthen SIU FWA detection and prevention.
- Promote the online fraud reporting portal and hotline.

Common Medicaid FWA Conduct

- **Upcoding** occurs when providers submit inaccurate CPT codes to receive higher reimbursements than the treatment or services actually provided and documented in the patient records.
- **Unbundling** refers to using multiple CPT codes for the individual parts of a procedure or service rather than a more appropriate code that encompasses all parts of the procedure or service.
- **Double billing** occurs when a provider seeks payment more than once for the same service.
- **Adding modifiers** to CPT codes to allow more than one procedure or service to be paid when it is not medically appropriate to do so.
- **Billing for procedures or services not covered** by Texas Medicaid or other Texas health care programs, such as age-restricted services billed for clients who don't meet the age requirement.
- **Failing to implement NCCI requirements** that either prohibit the payment of two procedures together or impose quantity limitations for certain procedures or services.

Allegations by Provider Type

Provider type	Related allegations
Ambulance	Upcoding from basic to advanced life support. Staff misconduct. Documentation does not support the services billed. Failure to produce records. Billed for services not provided. Billed for mileage for services not provided. Did not obtain required prior authorizations.
Attendants	Attendant not providing services. Quality of care. Overlapping schedules of clients/attendant with multiple clients. Attendant/Client Collusion. Exploitation. Forged or altered documentation. Misappropriation of benefits. CDS Program–Parent retaining funds.
Behavioral Health	Provider not enrolled in Medicaid. Duplicate billing. Documentation does not support codes billed. Billing for services not rendered. Performing provider is uncredentialed/not licensed. Provider billing for unallowable services.
Case Management	Solicitation. Marketing violations. Failure to produce records. Billing for services not rendered. Failure to coordinate services.
Durable Medical Equipment	Forging/Altering authorization forms. Billing for equipment not provided. Documentation does not support the services billed. Billing non-reimbursable procedure code(s). Billing without required prior authorization.
Home and Community Based Services	Quality of care. Exploitation of client. Billing for services not rendered. Forged documentation. Program non-compliance due to employee with felony background. Documentation does not meet service claim requirements or billing guidelines.

Allegations by Provider Type

Provider type	Related allegations
Home Health Agency	Documentation does not support services billed. No background check completed. Duplicate billing. Provider/Attendant collusion. Failure to produce requested records. Billing above the allowable amount. Upcoding for a higher level of care than rendered. Billing for services not rendered. Billing for a provider excluded from Medicaid. Falsifying a provider application. Billing for codes that are not allowed to be billed together. Using incorrect modifier for higher reimbursement.
Nursing Facility	Billing for a provider excluded from Medicaid. Upcoding. Billing for services not rendered. No documentation to support resident assessment. Documentation not signed by a physician. Documentation is insufficient to substantiate the services provided for intravenous medication or IV fluids.
Physician (Individual, Group or Clinic)	Provider not enrolled in Medicaid. Billing for unnecessary services. Duplicate billing. Documentation does not support the services billed. Upcoding. Quality of care. Billing for services not rendered. Billing a code that is not payable in Medicaid. Billing for a provider excluded from Medicaid. Including the wrong modifier/not indicating modifier. Performing provider is uncredentialed and/or not licensed. Provider billing for services unallowable per policy. Failure to produce requested records. Billing for unnecessary services. Billing after employment ended. Billing for services not licensed or certified to provide. Billing for services under the incorrect provider name, NPI and/or location.

SNAP Fraud

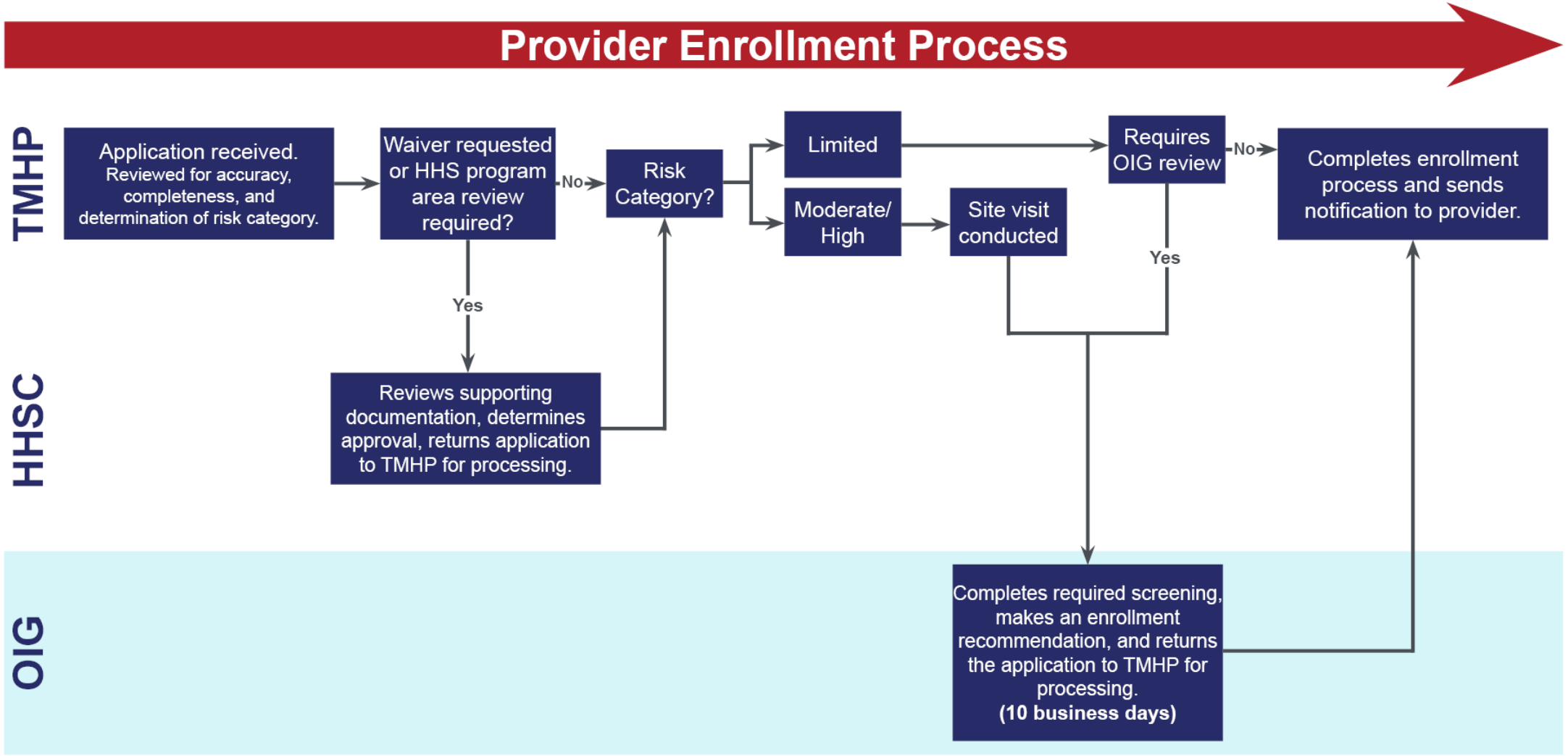
Primary Categories

Client Fraud
Providing false information to obtain benefits

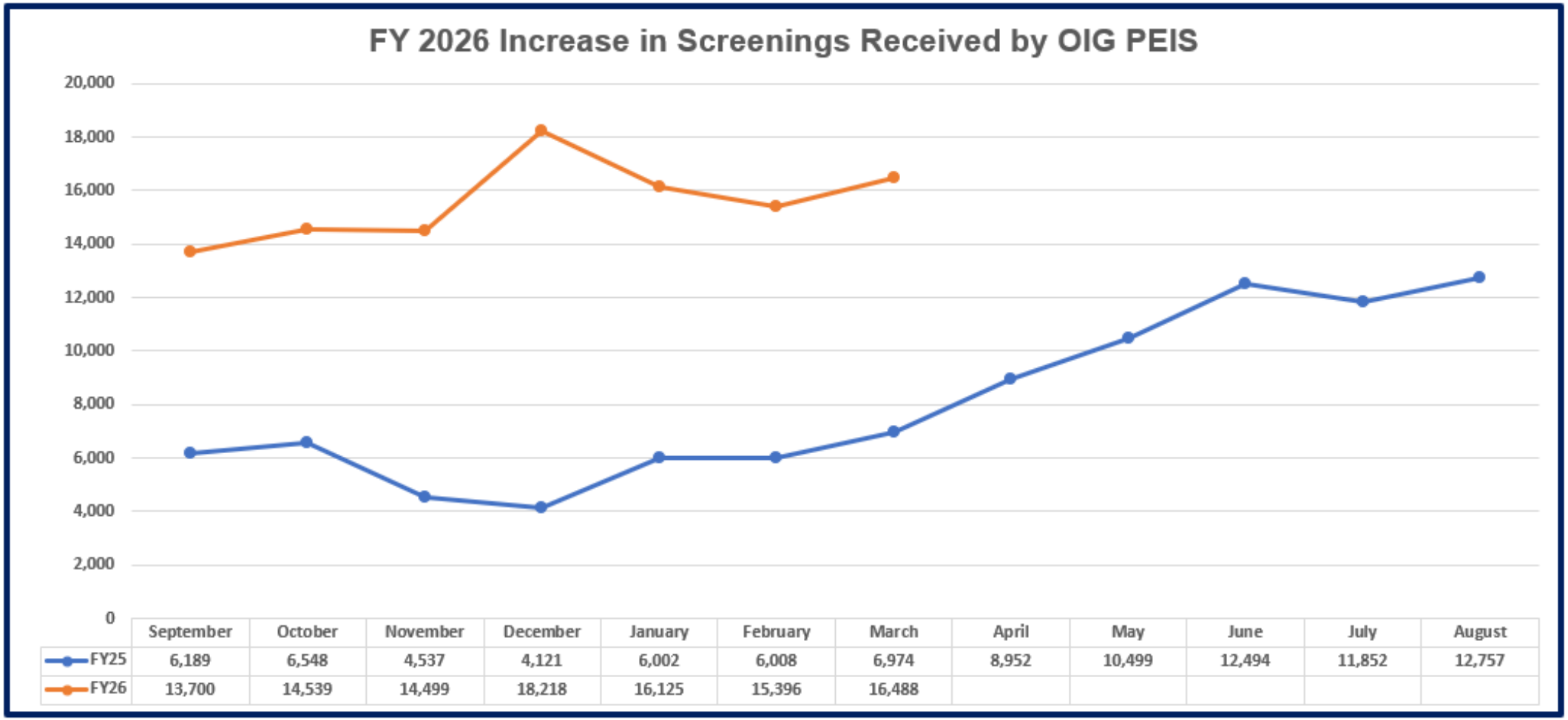
Trafficking
Exchanging benefits for cash

Benefits Theft
Skimming, hacking, or account takeover

Provider Enrollment and Revalidation



Provider Enrollment and Revalidation



	September	October	November	December	January	February	March	April	May	June	July	August
FY25	6,189	6,548	4,537	4,121	6,002	6,008	6,974	8,952	10,499	12,494	11,852	12,757
FY26	13,700	14,539	14,499	18,218	16,125	15,396	16,488					

Policy Considerations

Integrity through policy

- **Prior Authorization:** Controls access to high-cost or high-risk services.
- **Benefit limits:** Defined covered units, duration, and components to prevent unbundling and duplicate billing.
- **Place of service:** Ensure services are delivered in the most appropriate and cost-effective setting.
- **Provider Requirements:** Specify eligible provider types, delegation limits, and conflict-of interest restrictions.
- **Documentation & Claims Controls:** Require clear records and federally compliant billing.
- **Oversight & Safeguards:** Include licensure, enrollment, surety bonds, telehealth limits for high-risk providers.

Recommendations

- Consider implementing a 1:1 relationship between enrolling and billing entity
- Create a personal care attendant registry
- Improve verification of certain kinds of identification for client enrollment
- Add chips to SNAP cards and enable multi-factor authentication
- Improved access to data & information sharing

Thank you!

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