Texas Association for Home Care & Hospice
Leading ★ Advancing ★ Advocating

Winter Conference
Wednesday, February 18, 2026
11:45am-12:45pm

2c. Protecting the Integrity of Home Care and Hospice Services

Presented by:

Inspector General Raymond Charles Winter, Texas HHS
Principal Deputy Inspector General Susan Biles, Texas HHS

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Protecting the Integrity of Home Care and Hospice Services

February 18, 2026

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Section 1

The OIG

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Mission

Texas Government Code § 544.0103

The [Health and Human Services] Commission's Office of Inspector General is responsible for the prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services in the state, including services through any state-administered health or human services program that is wholly or partly federally funded or services provided by the Department of Family and Protective Services, and the enforcement of state law relating to the provision of those services.

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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 or abuse every year.

Texas appropriates $50 billion annually, meaning that up to **$5 billion** is siphoned away from its intended purpose each year.

Every dollar not spent as intended by the legislature is a dollar lost to taxpayers and not delivered to Texas HHS clients.

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Administrative Enforcement

Statutory remedies

- Case closed (no wrongdoing).
- Education.
- Prepayment review of future claims.
- Recoupment of overpayment.
- Recovery of amount paid due to a violation plus additional penalties.
- Exclusion (for a term or permanent).

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Section 2

Interacting with the OIG: Enrollment

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OIG Screening

- Enrollment and revalidation are performed by HHSC and the Texas Medicaid Healthcare Partnership (TMHP).
- Federal law requires that certain providers be screened before enrolling in or when revalidating for Medicaid and other programs.
- OIG conducts the required screening as part of the enrollment/revalidation process based on the CMS assigned provider risk level.
- OIG completes the required screening, makes an enrollment recommendation and returns the application to TMHP.

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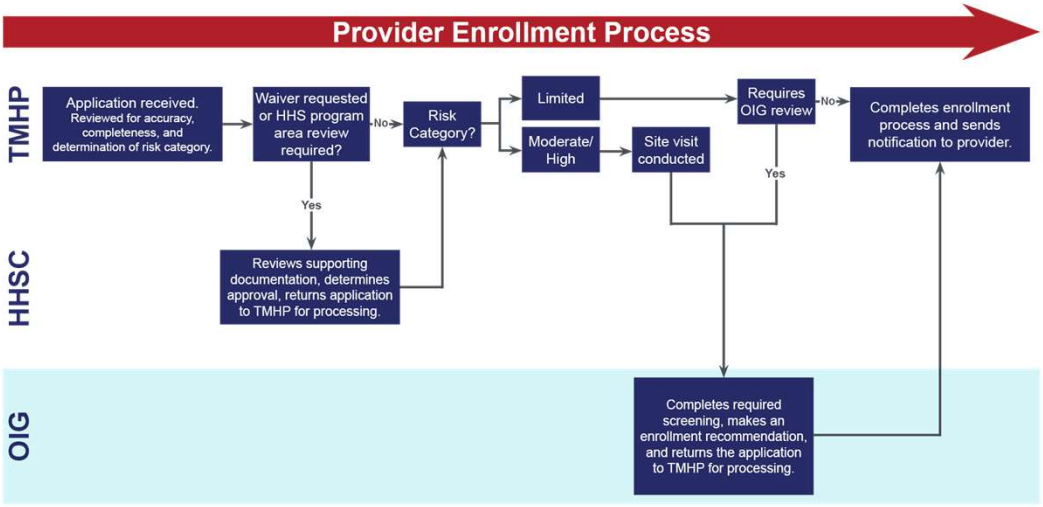
Enrollment and Revalidation Process



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Common Revalidation Deficiencies

Missing and incomplete disclosures:

- **Criminal history**.
- License actions.
- Managing employees and subcontractors.

Convictions	Also reportable
All convictions, other than traffic offenses, must be disclosed, regardless of: • When the event occurred. • Whether there is a post-trial motion or appeal. • The conviction has been expunged or removed.	A federal, state or local court has made a finding of guilt. A federal, state or local court has accepted a plea of guilty or nolo contendere. Participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.

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Common Revalidation Deficiencies

Missing and incomplete disclosures:

- Criminal history.
- **License actions.**
- Managing employees and subcontractors.

License actions	Applies to
All actions against a professional health care license: • Disciplinary. • Non-disciplinary.	Enrolling provider. Any individual or entity that is required to be disclosed on the application that has ever held a professional health care license. • Applies regardless of current license status.

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Common Revalidation Deficiencies

Missing and incomplete disclosures:

- Criminal history.
- License actions.
- **Managing employees and subcontractors.**

Examples of managing employees	Examples of subcontractors
Executive staff (e.g., president, vice president, CEO, CFO, COO). Directors, board members or trustees. Directors or alternate directors of nursing. Medical directors. Hospice or skilled nursing facility administrators. Directors and managers of operations or operational areas (e.g., billing administrator, facilities manager).	Management companies contracted to perform services related to Medicaid participation. Agencies or individuals providing goods, services or medical care under contract. Vendors or contractors with lease or service agreements tied to Medicaid operations.

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Keys to Successful Revalidation

For timely processing, ensure your application is complete and includes all disclosures.

- **Start early:** Starting the revalidation process as early as possible once your revalidation window opens will help prevent gaps in enrollment and payment denials.
- **Double-check disclosures and managing employees:** Missing disclosures and managing employees can result in deficiencies, which can also result in enrollment delays.
- **Verify individual details:** Ensure that the identifiers and contact information for all listed individuals are accurate. If fingerprints are required, confirm that proof is uploaded to the application.

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Enrollment and Revalidation Resources

- OIG provider enrollment webpage: https://oig.hhs.texas.gov/resources/providers/provider-enrollment.
- TMHP provider enrollment webpage: https://www.tmhp.com/topics/provider-enrollment.
- Helpful Texas Administrative Code (TAC) sections:
  - 1 TAC § 371.1 (Definitions).
  - 1 TAC § 371.1005 (Disclosure requirements).
  - 1 TAC § 371.1011 (Recommendation criteria).
  - 1 TAC § 371.1013 (Provider enrollment recommendations).
- Helpful Code of Federal Regulations (CFR) sections:
  - 42 CFR § 455.101 (managing employees).
  - 42 CFR § 455.104 (disclosure of ownership and control).

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Section 3

Interacting with the OIG: Audits and Investigations

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Carrying Out the Mission

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

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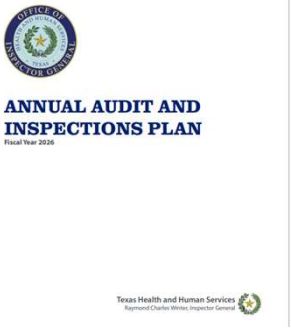
Audits and Inspections

Audits examine the performance of contractors, providers and HHS programs.

Potential topics are available in the Annual Audit and Inspections Plan.

- Audit of pediatric hospice provider.



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Recordkeeping

- Thorough recordkeeping is vital.
  - **Records that support claims:** Records must fully disclose services provided and support claims for payment. If a provider cannot demonstrate to the OIG that services were provided as billed, they may be required to repay the State.
  - **Compliance with HHSC and federal guidelines:** Providers must comply with HHSC manuals such as the Texas Medicaid Provider Procedures Manual (TMPPM) and follow state and federal record requirements. Meticulously following record requirements for each patient and each encounter will prevent potential audit findings and overpayment liabilities.
  - **Retention periods:** Retention periods can vary, so it is vital to know and follow the records retention requirements for the specific program so you can support your billing in the event of an OIG inquiry.

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Investigations

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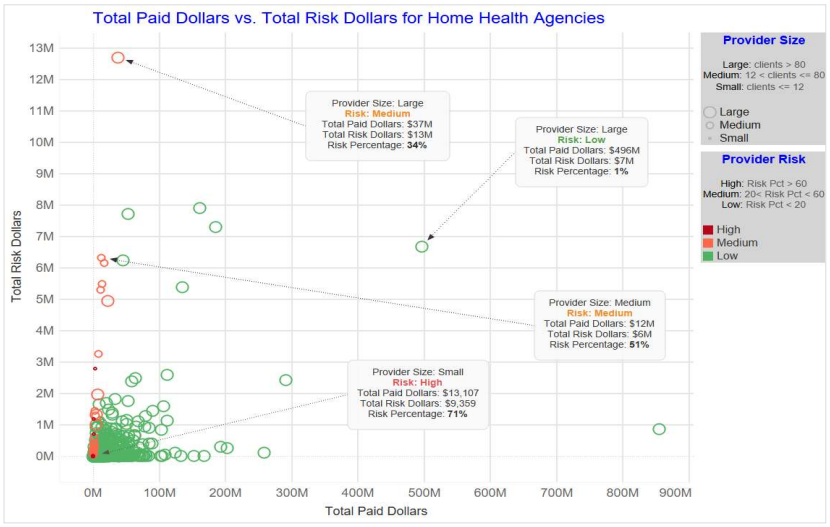
Fraud Detection



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Considerations from Investigations

FY 2025 home care and hospice agency investigations included:

- Billing for an excluded provider.
- Billing for codes that cannot be billed together per NCCI guidelines.
- Billing for services not rendered.
- Medical records do not support services billed.
- Duplicate billing.
- Failure to complete background check.
- Failure to produce requested records.
- Falsifying a provider application.
- Provider-attendant collusion.
- Regulatory or contract violations (e.g., agency not paying staff).
- Solicitation or marketing violations.
- Using an incorrect modifier for higher reimbursement (e.g., UA modifier without the required diagnosis code; RN instead of LVN).

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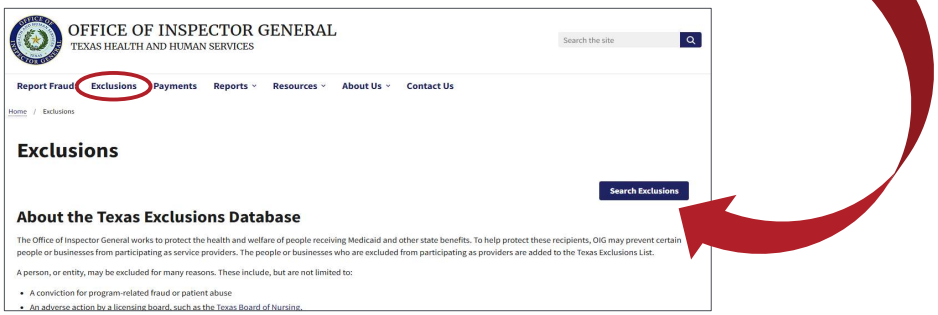
Exclusion Lists

- Medicaid providers are prohibited by federal regulations from employing individuals excluded from program participation.
- Providers should check the state and federal exclusion lists monthly and before hiring.



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Correct Coding Initiative

OIG's Correct Coding Initiative identified several common errors that home health providers should consider:

- **Span billing:** NCCI edits rely on the date of service. Span billing can cause the appearance of an edit violation.
- **Rendering/performing provider information:** It is critical to include the NPI and name of the rendering provider on the claim detail, so it is clear who provided the service. Especially for therapy, this allows the OIG to validate that the modifier was performed by a provider of the appropriate specialty.
- **Modifiers:** Include applicable modifiers to differentiate between distinct services or services provided by a separate provider/specialty.

The OIG will educate providers who were flagged with potential overpayments due to these issues, but for whom, upon further review, medical records determined the services were separate.

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Services while Hospitalized

- OIG data review assessed personal care services billed while clients were hospitalized.
- Recurring initiative.
- 292 providers and almost $300,000 overpayments identified.
- To prevent billing for services not rendered:
  - **Do:** Promote accurate record keeping.
  - **Avoid:** Auto-billing.

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Solicitation

- Solicitation is the act of offering or accepting any form of payment or benefit, either directly or indirectly, in exchange for obtaining or referring patients to or from a licensed health care provider.
- Solicitation is governed by federal statute as well as Texas Occupations Code, Ch. 102, 1 TAC § 371.27 and 1 TAC § 371.1669.
- This includes:
  - Cash, cash equivalents or gift cards in any amount.
  - Free or discounted services to influence care decisions.
  - Transportation, unless properly arranged with the client's managed care organization or HHSC.
  - Goods or services, except low-cost, non-cash items valued under $15.

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Solicitation in Home Health & Hospice

- Offering a higher pay rate is not solicitation.
- Solicitation is a concern if:
  - That higher pay is specifically offered in return for bringing clients with the attendant as a quid pro quo.
  - If the attendant is receiving a sign-on bonus. (U.S. HHS-OIG Advisory Opinion No. 25-12)
  - The higher pay is only for attendants of Medicaid clients.

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Self-Disclosure of Errors

Mitigate Your Risk

Working with providers to resolve overpayments or other issues (intentional or unintentional) can potentially reduce legal and financial exposure, resulting in better outcomes than with a full investigation.

- Self-disclosures in FY 2025:
  - 99 settlements.
  - $34.1 million recovered.

Learn more at:
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Reporting Fraud, Waste and Abuse

Visit **ReportTexasFraud.com** to make a referral.

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Thank you!

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