Inspector General
Texas Health and Human Services

20D0108

OIG
Quarterly Report

Quarter 2, Fiscal Year 2020

Table of Contents

Executive Summary

I am pleased to present the second quarterly report for fiscal year 2020, summarizing the excellent work this office has performed during this period, to Governor Greg Abbott, Acting Executive Commissioner Phil Wilson, the Texas Legislature and the citizens of Texas.

During this quarter, the OIG recovered nearly $97.2 million. In addition, another $47.3 million was identified for potential future recoveries, and just more than $29.7 million was achieved in cost avoidance by deterring potentially questionable spending before it occurs. This continues the OIG's high level of performance, born of a strong commitment to ensuring the integrity of state health and human services by the OIG staff.

As this quarter ended, the COVID-19 pandemic was just beginning. When Governor Abbott declared on March 13 a state of disaster for all counties in Texas, the OIG took steps to ensure that we continue our work while prioritizing the health and safety of our employees, as well as help our stakeholders in this time of uncertainty. The OIG is open, and staff is working from home to ensure their safety. We adjusted reporting deadlines for providers and managed care organizations to help them focus on Medicaid patients. The OIG has temporarily suspended on-site nursing home visits and will not initiate new audits or inspections through at least mid-April. In addition, we have added a website page (oig.hhsc.tx.gov/covid-19) that outlines all steps we are taking in response to the pandemic. It will be updated as developments warrant.

The OIG is committed to collaborating with our state and federal partners to ensure that funds dedicated to providing services to those who need them are spent only for their intended purpose. While we do not know how long this situation will last or its effect on state services, we will continue to protect taxpayer resources. We are guided by our core values of Accountability, Integrity, Collaboration and Excellence. The OIG team is committed to our mission and embodies those values every day. I am honored to work with them.

Respectfully,
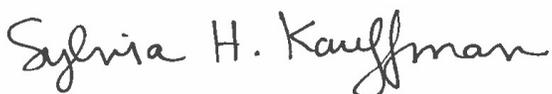
Sylvia Hernandez Kauffman
Inspector General

Quarter 2 Results

Dollars recovered

Audit

Collections	$165,482

Inspections

WIC collections	$212

Benefits Program Integrity

Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC)	
	$4,943,583
Voluntary repayments by beneficiaries	$57,101

Medicaid Program Integrity

Provider overpayments	$10,052,352
Acute care provider overpayments	$2,185,830
Hospital overpayments	$5,331,924
Nursing facility overpayments	$125,958
Recovery Audit Contractor recoveries	$16,177,209

Third Party Recoveries

TPR recoveries	$58,062,728

Peace Officers

EBT Trafficking retailer overpayments	$73,718
Total dollars recovered	**$97,176,097**

Dollars identified for recovery

Audit

Provider overpayments	$772,573

Inspections

WIC vendor monitoring	$4,802

Benefits Program Integrity

Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, WIC)	$13,566,268

Medicaid Program Integrity

MCO identified overpayments	$4,154,871
Acute care provider overpayments	$2,305,064
Hospital overpayments	$5,063,771
Nursing facility overpayments	$562,346
Recovery Audit Contractor identified	$19,077,902

Peace Officers

EBT trafficking	$1,813,421
Total dollars identified for recovery	**$47,321,018**

Cost avoidance

Inspections

WIC vendor monitoring	$259,572

Benefits Program Integrity

Client disqualifications	$1,892,350

Medicaid Program Integrity

Medicaid provider exclusions	$1,707,973

Medical Reviews

Pharmacy Lock-In	$691,888

Third Party Recoveries

Front-end claims denials	$25,074,440

Peace Officers

Disability determination services	$93,120
Total cost avoidance	**$29,719,343**

Liquidated damages

Dollars recovered	$42,750

How we measure results

An investigation, audit, inspection or review that is performed, managed or coordinated by the OIG can result in:

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

Dollars identified for recovery: This is a measure of the total potential overpayments resulting from activities of the Office of Inspector General. 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.

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.

Trends

Medicaid Program Integrity

Personal care attendant calls continued as a high percentage of the OIG Fraud Hotline calls in the second quarter. OIG Litigation excluded 13 attendant care workers from participation in Texas Medicaid this quarter. The investigation determined that identified attendants clocked in and out as though working for clients, when the clients were hospitalized or services were not provided as billed.

Data analysis continues to play a proactive role in detecting potential fraud, waste and abuse. MPI identified a pattern of duplicate billing and billing over the allowable amount for private duty nursing services. The Data and Technology (DAT) team analyzed data which identified multiple providers across the state who were reimbursed more than the allowable amount per member per date of service. These findings are part of an ongoing fraud, waste and abuse detection initiative.

A sample of case results for MPI settled by Litigation for this quarter include:

- **Settlements reached following hospital self-reports.** The OIG entered into seven settlements with hospital providers in Central Texas. Following self-reports from the hospitals, the investigative findings identified that the hospitals billed and were paid separately for injections/infusions when the same services were already covered by another billing code paid on the same dates of service. The hospitals will repay $1,201,752.

- **Durable medical equipment settlement.** The OIG settled a case against a durable medical equipment (DME) provider in South Texas. The investigation found that the provider lacked the required documentation and received reimbursement for more items than were supplied. The DME provider will repay $47,018.

Types of allegations received by MPI

Attendants	53%
Physician (individual/group/clinic)	13%
Home health agency	11%
Hospital	5%
Dental	4%
Pharmacy	4%
Durable medical equipment	3%
Nursing facility	2%
Therapy (counseling)	1%
11 other categories at less than 1%	

Types of MPI field provider investigations

Physician (individual/group/clinic)	29%
Home health agency	28%
Hospital	10%
Durable medical equipment	10%
Pharmacy	8%
Dental	8%
Adult day care	4%
Ambulance	3%

Referrals to MPI

MCO/DMO referrals	98
OIG Fraud Hotline referrals	128

Benefits Program Integrity

The Benefits Program Integrity (BPI) division completed 3,777 investigations involving some form of benefit recipient overpayment or fraud allegation. Eighty-five percent of all investigations completed involved unreported income (22%) or an issue with the reported household composition (63%). 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 the household to receive more benefits than they are

eligible for.

BPI completed 295 investigations where fraud was determined. BPI referred 28 investigations for prosecution and 267 for an Administrative Disqualification Hearing. Ninety-eight percent of fraud investigations completed involve either unreported income (54%) or an issue with the reported household composition (43%).

A sample of cases worked by BPI this quarter include:

- **Whistleblower leads to disqualification.** BPI received a United States Department of Agriculture whistleblower complaint alleging an apartment manager in Bexar County was purchasing SNAP benefits from tenants at 50 cents on the dollar. During the investigation, the apartment manager, who was also a SNAP recipient, admitted she had been involved in SNAP trafficking. In December, the client signed a Waiver of Disqualification Hearing, and received a lifetime disqualification from SNAP.

- **Falsifying SNAP application.** In December, BPI resolved a case in Dallas County involving a client who fraudulently obtained $16,303 in SNAP benefits. The client falsified benefit applications by identifying a family member as her cousin when he was in fact the father of her youngest child, lived in the same household and had unreported income. BPI referred the case to the Dallas County District Attorney's Office for prosecution. The client signed a one-year disqualification agreement for SNAP and was placed on a plan to repay $16,303.

- **Failing to report income.** BPI investigated a client in Young County who failed to report the father of her children, and his earned income, as part of the household on her benefits applications. The client submitted fraudulent applications from June 2016 through April 2019, which resulted in a SNAP overpayment of $20,873 and a Medicaid overpayment of $14,027. The client was charged with a third-

degree felony. The client was sentenced to 10 years deferred adjudication probation, a 12-month SNAP disqualification and ordered to pay $34,900 in restitution.

Electronic Benefits Transfer Trafficking

This quarter, the Electronic Benefits Transfer (EBT) trafficking unit completed 70 investigations and presented another 34 investigations for either administrative disqualification hearings (30) or prosecution (4).

Trends identified by the unit include:

- **Indirect SNAP trafficking.** The EBT Trafficking Unit continues to identify the trend of indirect trafficking by business owners who are not authorized SNAP retailers buying SNAP benefits to stock their businesses. The store or restaurant owner buys the benefits from a SNAP recipient at the typically reduced amount of 50 cents for every dollar, thereby lowering the cost to stock their business.

- **Personal SNAP information.** The EBT Trafficking Unit is evaluating a trend involving mobile vendors that are illegally acquiring personal information from people who use SNAP. The scheme involves business owners creating a credit account for a recipient by acquiring an individual's SNAP benefit account information and personal pin numbers. Possession of this information is a vendor violation and could result in SNAP benefits being used improperly, such as accessing and removing benefits without the knowledge of the client/recipient or withdrawing more benefits than the actual cost of the food items.

- **Law enforcement collaboration.** The EBT Trafficking Unit is experiencing an increase in requests for assistance by law enforcement agencies throughout the state. These requests range from assisting in locating fugitives with arrest warrants, persons involved in criminal activity and request for assistance with cases that involve SNAP trafficking.

A sample of a case worked by EBT this quarter include:

- **Restaurant owners purchasing SNAP.** The OIG's EBT Trafficking Unit and the Beeville Police Department collaborated on a case that led to the felony arrests in February of the owners of a pizza shop. The investigation determined that the business owners purchased SNAP benefits from people in the Beeville community for cash. The owners would then travel to a retailer in San Antonio to purchase dry goods and groceries for the pizza shop. The owners admitted to purchasing EBT cards and fraudulently using the benefits to obtain inventory. The total dollar amount of fraud has yet to be determined.

Internal Affairs

Internal Affairs (IA) worked 66 active investigations in the second quarter involving fraud, waste and abuse in the delivery of health and human services and other issues. Fifty-three investigations were closed by quarter's end. IA processed 39 referrals this quarter and investigated 24 of those referrals. The remaining were forwarded to the appropriate business areas, including the Office of the Independent Ombudsman for State Supported Living Centers, DFPS Office of Consumer Relations and HHS Complaint and Incident Intake.

Trends identified by IA include:

- **Falsifying information/documents.** The number of falsifying information/documents allegations associated with Child Protective Services (CPS) caseworkers remained relatively consistent from the previous quarter. IA provides investigative support to the Department of Family and Protective Services (DFPS) Office of Consumer Relations in matters related to or associated with criminal or gross misconduct of its employees.

- **Employee misconduct.** IA has not seen any significant increase or decrease in cases involving HHS, DFPS or Department of State Health Services employee misconduct this quarter. IA routinely investigates allegations

Open IA cases by type

Falsifying information/documents	30%
Unprofessional conduct	14%
Vital records fraud	7%
Theft	6%
Contract fraud	5%
Unauthorized release of information	4%
Retaliation	4%
Benefits fraud	3%
Conflict of interest	3%
Privacy incident/breach	3%
Travel fraud	3%
Other	18%

related to the delivery of health and human services or criminal/gross misconduct.

Sample of cases concluded by IA this quarter:

- **CPS child death.** IA investigated the death of a child whose family had a prior history with Child Protective Services (CPS). The investigation analyzed whether DFPS personnel followed their policies and procedures for the investigation and in providing CPS services to the child and family. IA determined that CPS staff followed their investigative and conservatorship policies.

- **Privacy breach.** In collaboration with HHS, IA investigated a privacy breach involving an HHS employee and determined the employee transmitted work-related, personally identifiable client information via his personal email account and a third-party website. However, HHS concluded that the employee did not misuse the information. All documents were sent to authorized individuals using encrypted services.

State Centers Investigations Team

The OIG's State Center Investigations Team (SCIT) opened 69 investigations and completed 185 investigations in the second quarter, with an average completion time of 20 days. This compares to 194 opened investigations and 209

completed investigations in the first quarter of fiscal year 2020.

A recent SCIT case involved allegations that a client at the North Texas State Hospital was assaulted by an employee. The client suffered minor facial injuries. Subsequent interviews and a review of video by the SCIT investigator confirmed

the allegation. The case was referred to the Wilbarger County district attorney for prosecution. In December, the court accepted a guilty plea for injury to a child, a second degree felony. As part of the plea agreement, the accused received three years deferred adjudication with court costs and fines imposed.

Rule Proposals

Administrative enforcement

Proposed amendments to 1 TAC §371.1603 and §371.1715 were published in the Texas Register for formal public comment from December 13, 2019 through January 13, 2020. The proposed rules clarify the factors that the agency applies when determining the seriousness, prevalence of error, harm or potential harm of a violation, as required by statute. The amendments add examples of mitigating factors and clarify that a person potentially subject to an enforcement action may introduce such mitigating factors in any contested case, as well as during the agency's informal resolution process. The rule amendments also clarify that the agency assesses penalties in accordance with relevant law, particularly Texas Human Resource Code Section 32.039. OIG received comments from six stakeholders during the formal comment period and is reviewing those comments.

MCO audit coordination

Proposed amendments to 1 TAC §371.37 related to MCO Audit Coordination, along with the HHS companion rule 1 TAC §353.6, were presented at the Medical Care Advisory Committee meeting on February 13, 2020. The Medical Care Advisory Committee voted to move the proposed rules forward for posting in the Texas Register. The proposed rules were also presented at the HHS Executive Council meeting on February 20, 2020. No public comments were received at either meeting. The rule amendments clarify OIG and HHS Medicaid and CHIP Services Department roles and jurisdiction related to audits of MCOs. The amendment to 1 TAC §371.37 adds new detail that describes the coordination - in planning and performance - between OIG and HHS when OIG plans and conducts MCO audits. The proposed rules are expected to be published in the Texas Register for formal public comment in March 2020.

Policy Recommendations

Improve medical transportation claim-processing and reduce administrative burden on medical transportation providers

The OIG completed a series of reports on non-emergency medical transportation services in managed transportation organizations (MTOs). As result of this series of audits, the MTOs have already taken corrective actions to address the findings identified in the audit reports. Other

corrective actions are in progress.

Demand Response transportation services are provided by MTOs when public transportation is not an option. Individual Transport Participant services are provided by individuals and their personal vehicles through individual agreements with an MTO. Detailed standardized forms are required when submitting claims for either service, although much of the same data is captured by an MTO's transportation management system. Transportation providers

may refrain from participating or providing future services if their claims are delayed or denied due to incomplete information on the detailed forms. MTOs may incur additional administrative costs and inefficiencies when ensuring all standardized forms are filled out completely, particularly if the MTO's transportation management system already captures most of the required data.

The OIG recommended that HHS evaluate the information required to support claims and determine whether to continue using the two forms.

Improve the Medical Transportation Program complaints process

The audit of non-emergency medical transportation services in MTOs also focused on addressing client complaints. HHS requires MTOs to forward complaint calls to the HHS Medical Transportation Program (MTP) call center. MTP enters received complaints into a tracking system and emails them back to the appropriate MTO. MTOs conduct investigations to categorize complaints as substantiated, unsubstantiated, unable to substantiate or any other designation they deem appropriate. Each MTO processes the complaints and responds to MTP with the results of its reviews and any actions to be taken. MTOs are prohibited from contacting the complainants, which can hinder their ability to determine appropriate complaint resolutions.

The OIG recommended that HHS evaluate the complaint process for improvements in data accuracy and complaints management to include

(a) establishing a single system of complaint records that both the MTOs and HHS use to better manage complaints and transportation provider performance and (b) determining whether allowing the MTOs to contact the complainant would improve the complaint process and result in a more efficient resolution of a complaint.

Strengthen security controls for confidential HHS system information

The OIG completed an audit of the design and effectiveness of selected security controls over confidential HHS System information stored and processed by Children's Medical Center Health Plan (CMC), as well as business continuity and disaster recovery plans for processing and storing confidential information. Audit results indicated that CMC complied with HHS information security requirements related to workforce training, business continuity and disaster recovery planning, information system monitoring and physical security. However, improvements are needed in CMC's user account management and risk management control areas to adequately protect confidential HHS System information.

Auditors offered recommendations to MCS which, if implemented, will result in CMC implementing control processes to disable inactive and terminated user accounts; consistently enforcing an effective process for provisioning user accounts; conducting and maintaining an annual internal risk assessment; and improving control activities for documenting baseline configurations for servers and other network devices that store and process confidential HHS System information.

Agency Highlights

Doctor convicted in $325 million health care fraud scheme

A federal jury found a South Texas doctor guilty for a scheme in which he falsely diagnosed patients with lifelong illnesses. The doctor from Mission was convicted in January of numerous counts including health care fraud. The case was investigated by the Rio Grande Valley Health Care Fraud Task Force, which includes the OIG, FBI and Texas Attorney General's Medicaid Fraud Control Unit. The U.S. Department of Justice prosecuted the case in front of a federal judge.

The doctor was accused of falsely diagnosing patients with rheumatoid arthritis, an incurable disease. Evidence presented at trial showed that patients received chemotherapy injections and other unnecessary medical procedures. The doctor operated medical practices throughout South Texas and San Antonio. A judge will sentence the provider in late March.

Settlement agreements reached in 12 self-report cases

The OIG entered into settlement agreements with twelve different providers during the quarter. In each instance, the provider discovered their mistakes and reported them to the OIG, along with supporting documentation.

Five separate cases involved employees falsifying documents at occupational rehabilitation facilities in the Dallas area and at pediatric home care providers in Mount Pleasant and Houston. The self-reported behaviors included falsifying or fabricating patient records when services were either not performed or not for the amount of time represented. The employees who falsified the records were terminated and referred to their respective boards by their providers.

The other seven cases covered conduct that ranged from employing an individual from the Medicaid exclusions list to including non-covered expenses on a cost report. The combined

Quarter 2 performance

Audit reports issued	11
Audits in progress	24
Inspections reports issued	0
Inspections in progress	7
Investigations completed (BPI, IA, Peace Officer)	4,085
Investigations opened	4,383
Medicaid provider investigations completed	
Preliminary	425
Full-scale	45
MPI cases transferred to full-scale investigation	76
MPI cases referred to Medicaid Fraud Control Unit	153
Hospital claims reviewed	4,959
Nursing facility reviews conducted	81
Medicaid and CHIP provider enrollment screenings performed	23,110
Medicaid providers excluded	54
Fraud hotline calls answered	6,354

settlements totaled $2,923,378.

Settlement agreement reached with Arlington dental practice

The OIG entered into a settlement agreement in January with an Arlington dental practice for $405,107. The investigation found that between May 1, 2016 and May 31, 2018, the provider billed for specific dental codes that were either inappropriate or out of compliance with Medicaid policy. In addition, the investigation found that the provider engaged in illegal solicitation by using marketers who offered cash incentives to potential patients. Under the terms of the agreement, the provider will pay the overpayment and penalties over six years, along with deferred interest.

Settlement agreement reached with Plano dentist and dental practice

The OIG entered into a settlement agreement in December with a dentist and dental practice with offices in Dallas and Plano for $10,000 in penalties and an agreed four-year exclusion from Medicaid beginning February 2020. The investigation found that between January 1, 2012 through August 30, 2018, the provider billed for specific dental codes when the services were either not rendered, inappropriate or out of compliance with Medicaid policy. In addition, the investigation found that the provider engaged in prohibited marketing and solicitation that included improper transportation and offered cash payments to potential patients.

MPI investigates possible fraud in EEG services

MPI opened six cases based on the identification of providers potentially inappropriately billing for certain electroencephalographic (EEG) services. Neurologists and other clinicians are billing for an EEG service that requires observation by a clinician who can intervene in the monitoring and/or patient care as needed. The OIG initiative focused on two service codes to identify providers who are equipping patients with mobile EEG units and sending them home for overnight monitoring without the presence of a clinician who can intervene. As a result, the providers may have inappropriately received a higher reimbursement amount.

Medicaid Program Integrity is also analyzing results from a separate fraud detection operation (FDO) focused on claims billed and paid for EEG testing. An FDO is a data-driven investigative operation designed to review providers who appear as statistical outliers among their peers and determine whether this outlier status is attributable to fraud, waste or abuse or other program violations. FDOs are an advanced data analytics method of identifying issues that may or may not lead to a full-scale investigation. In February, DAT identified pediatric medical providers in the Houston and Dallas regions who exhibited patterns of potential FWA related to EEG

testing. The preliminary investigative findings are currently pending.

OIG dental team collaborates with federal and state investigators

The OIG dental team partnered with the federal and state investigators in a case from Laredo. In January, the OIG dental team traveled to perform on-site clinical examinations on Medicaid clients from a local provider. OIG Chief Dental Officer Dr. Janice Reardon and OIG Senior Dental Analyst Sherry Jenkins aided the FBI and the Medicaid Fraud Control Unit of the Texas Attorney General's Office in this case. The examinations revealed that the provider engaged in unusual treatment patterns. The case remains under investigation.

ENT provider remains on pre-payment review

The OIG placed an ear, nose and throat (ENT) provider in Pasadena on pre-payment review (PPR) for billing related to allergy testing. PPR is a provider-specific program integrity tool to ensure reimbursement for services is reasonably and objectively based on medical necessity. PPR aims to prevent excessive, low quality or other wasteful and abusive billing by reviewing claims and documentation prior to reimbursement. As part of the PPR process, providers are required to send supporting documentation for each claim submission covered by the PPR. In this case, data analytics identified the provider as an outlier among his peer group for two allergy testing codes. Since the ENT provider was placed on PPR in April 2019, more than $22,000 in billed services has been denied. The provider remains on PPR as the majority of documentation submitted by the provider does not support services billed.

WIC activities across the state

The Women, Infants and Children (WIC) Vendor Monitoring Unit (VMU) conducted 153 compliance buys across the state for this quarter. A compliance buy is a covert in-store inspection. An OIG inspector poses as a WIC client and uses a WIC Electronic Benefits Transfer food card to make purchases to ensure vendors are following WIC

rules. The team also completed 15 invoice audits across the state. An invoice audit is a comparison of a vendor's paid claims and their purchase invoices for WIC food items. The purpose of the invoice audit is to determine if the vendor had a sufficient inventory of WIC food items to justify their submitted claims. The team also conducted 8 on-site store reviews. The review is an overt in-store assessment where 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. The combined total for dollars recovered, civil monetary penalties (CMP) imposed, and dollars identified for recovery for this quarter was $5,015. Cost avoidance associated with vendor disqualifications was $259,572.

Data analytics improves NFUR's fiscal year work plan

OIG's Data and Technology Team (DAT) worked with the Nursing Facility Utilization Review (NFUR) team to revamp the analytical framework for their risk assessment process. The process helps produce NFUR's fiscal year work plan, which involves hundreds of nursing facility reviews in Texas. The NFUR team evaluates whether facilities correctly assessed residents' needs, provided the appropriate level of care and maintained the required documentation.

Historically, NFUR built its work plan manually. DAT worked with the NFUR team to integrate the historical risk factors with newly created risk factors and overlaid a risk score algorithm. DAT's process achieves faster and more comprehensive results. The new framework better highlights facilities that scored high on several risk factors, allowing NFUR to better prioritize their work.

BPI collaborating with HHS to enhance investigations

The Benefits Program Integrity (BPI) division is collaborating with HHS's Access and Eligibility Services (AES) to ensure the integrity of state health and human services programs. Both teams work with the same population and share many common goals. BPI partnered with AES to build

an improved process of checks and balances to reduce the time it takes to terminate benefits for recipients incarcerated for more than 30 days.

OIG educating future investigators

The OIG signed a memorandum of understanding with the University of Texas at San Antonio to start a new internship program. The internship program will allow UTSA Criminal Justice student interns an opportunity to gain skills from the investigative work within Benefits Program Integrity and learn how the OIG protects taxpayer resources. This internship program will be an ongoing partnership with UTSA for five years and incurs no cost to either agency. The OIG expects to welcome its first interns this summer.

EBT enhancing professional rigor

EBT Trafficking Unit held its first quarterly conference of fiscal year 2020 in December. During the conference in San Antonio, the staff from across the state came together to create an action plan to achieve fiscal year goals. EBT staff members were also trained on personal accountability, emphasizing the importance of follow through to ensure effective team work.

MPI collaboration with Centers for Medicare and Medicaid Services

MPI met with the Centers for Medicare and Medicaid Services (CMS) Unified Program Integrity Contractor, Qlarant, to discuss collaborative projects. CMS selected Qlarant to perform data analysis and investigative functions to detect, prevent and deter program integrity risks in the Medicare and Medicaid programs. This collaboration allows MPI to augment current MPI investigative activities and maximize program integrity efforts in multiple areas. Qlarant contributes to OIG's intake and full-scale investigations, Fraud Detection Operations and MPI initiatives. In addition, Qlarant performs data analysis and trend research to identify potential MPI topics of interest. These topics range from Medicaid Program vulnerabilities, areas of highest risk and new emerging schemes. These topics are presented to MPI as potential investigative projects to pursue.

Completed Reports

Audit

Audits of Texas Medicaid Medical Transportation Organizations. This summary report is the last in a series of reports on non-emergency medical transportation (NEMT) services in managed transportation organizations (MTOs). The four MTO audit reports detailed the OIG Audit Division's conclusions regarding the compliance of Demand Response, Individual Transportation Participant (ITP), and complaint, accident and incident contract requirements at American Medical Response, Inc., Medical Transportation Management, Inc., Project Amistad and LogistiCare Solutions. The objective of the audits was to determine whether the MTOs' performance in selected areas was in accordance with contract requirements.

As result of this series of audits, the MTOs have already taken corrective actions to address the findings identified in the audit reports, and other corrective actions are in progress. The audit report includes issues identified as systemic and recommendations for improvement, which can be addressed by HHS.

The OIG observed that, in general, MTOs:

- Provided transportation services to members for selected transportation encounters.

- Did not always use the standard Driver's Log or ITP Service Record forms that had complete information.

- Encountered challenges in efficiently and effectively managing complaints, accidents and incidents, and monitoring of transportation providers.

The OIG made recommendations to MCS that, if implemented, may result in improving efficiencies in processing transportation claims, reducing administrative burden to transportation providers and MTOs, and improving MCS and MTOs' ability to accurately and effectively monitor transportation provider performance and related

corrective action plans.

Security Controls over Confidential HHS System Information – Children's Medical Center Health Plan. The OIG completed an audit of Children's Medical Center Health Plan (CMC). The objectives of the audit were to assess the design and effectiveness of selected security controls over confidential HHS System information stored and processed by CMC, as well as business continuity and disaster recovery plans for operations relating to the processing and storage of confidential HHS System information by CMC.

Audit results indicated that CMC complied with HHS Information Security requirements related to workforce training, business continuity and disaster recovery planning, information system monitoring and physical security. However, improvements are needed in CMC's user account management and risk management control areas to adequately protect confidential HHS System information.

Auditors offered recommendations to MCS which, if implemented, will result in CMC strengthening its user account management and risk management control areas. MCS concurred with the audit recommendations and will coordinate with HHS IT and require CMC to address the audit issues.

DentaQuest USA Insurance Company – A Texas Medicaid and CHIP Dental Maintenance Organization. The OIG completed an audit of DentaQuest USA Insurance Company, Inc. (DentaQuest), a Texas Medicaid and CHIP Dental Maintenance Organization. The audit objective was to evaluate the effectiveness of DentaQuest's performance in complying with selected contract requirements, achieving related contract outcomes, and reporting financial and performance results to HHS.

Audit results indicated that DentaQuest's 2017 Administrative Expenses financial statistical report (FSR) included unsupported, overstated or

unallowable expenses. In addition, DentaQuest did not routinely review, monitor and remove unnecessary accounts that have access to Texas HHS agency sensitive or confidential information. DentaQuest adjudicated paid dental claims selected for review in accordance with requirements, and reasonably processed and resolved selected provider complaints.

Auditors offered recommendations to MCS which, if implemented, will address unallowable, unsupported or overstated expenses reported on DentaQuest's Administrative Expenses FSR for 2017 and other years, and strengthen access controls to financial systems used to process and report financial information.

City Drug Company – A Texas Vendor Drug Program Provider. The OIG completed an audit of City Drug Company (City Drug), a Texas Vendor Drug Program (VDP) provider. The audit objectives were to determine whether City Drug properly billed the VDP for Medicaid claims submitted, and whether City Drug complied with selected contractual and Texas Administrative Code (TAC) requirements.

Audit results indicated that there were exceptions related to claims validity and national drug code (NDC) usage. Of the 229 claims tested, there were six unsupported claims with six exceptions totaling $2,385. The unsupported claims represent overpayments to City Drug. OIG determined that the exceptions represented an overpayment for the population of $11,192. Auditors offered recommendations to City Drug which, if implemented, will correct deficiencies in compliance with contractual and Texas Administrative Code requirements.

Easter Seals Rio Grande Valley. The OIG completed an audit of Easter Seals Rio Grande Valley. The audit objectives were to determine whether controls over certain contract funds were in place and effective, and data reported to the Department of Family and Protective Services (DFPS) was accurate, supported, and in accordance with applicable contractual terms.

The audit scope included the DFPS contracts for

both the Healthy Outcomes through Prevention and Early Support (HOPES) and Maternal Infant Early Childhood Home Visiting (MIECHV) programs in effect September 1, 2017 through August 31, 2019. No significant reportable issues were identified during the audit.

STAR+PLUS Waiver Program Assessments and Services Delivered. The OIG completed an audit of the Home and Community-Based Services (HCBS) State of Texas Access Reform PLUS (STAR+PLUS) Waiver program for Medicaid managed care members served by Amerigroup Insurance Company (Amerigroup) in the Medicaid Rural Service Area West. The HCBS Waiver is designed to provide a cost-effective alternative to living in a nursing facility. The audit objectives were to determine whether Amerigroup HCBS Waiver members (a) were timely assessed, (b) were assessed at least one institutional level of care need, and (c) timely received planned services.

The tested Amerigroup members enrolled in the HCBS Waiver program during 2017 and had an institutional level of care need documented. However, audit results indicated (a) Amerigroup did not pay waiver services claims in 2017 for 41 members, (b) assessments or service plans were not completed or submitted timely, and (c) records were incomplete.

The absence of any waiver services paid claims indicates that Amerigroup might not have been (a) assisting members in receiving timely access to providers and covered services or (b) monitoring members' claim history to confirm all services identified were being delivered.

Auditors offered recommendations to Amerigroup, which if implemented, will increase service coordinator contact with HCBS Waiver members and improve coordination of planned services delivery, improve timely completion and submission of assessments and service plans to HHS, and reduce instances of missing or incomplete documentation.

Collin County MHMR Center – Local Intellectual and Developmental Disability Authority Performance Contract. The OIG completed an

audit of the Collin County Mental Health and Mental Retardation (MHMR) Center. Collin County MHMR Center operates as a local intellectual and developmental disability authority (LIDDA) under a contract with HHSC. The audit objective was to determine whether Collin County MHMR Center performed in accordance with selected contract requirements.

Audit results indicated that a service coordinator was assigned to each of the 214 individuals in the sample and there were no reportable issues identified during the review of general revenue-funded services. However, there were issues noted with the required written plans of services,

person-directed plans and the required face-to-face contacts.

Auditors offered recommendation to Collin County MHMR Center which, if implemented, may ensure documentation of individual service needs and preferences is developed and retained in a written plan of service using the person-directed planning process for general revenue-funded services; signature pages with all individuals that participated in the person-directed planning process are retained and signed; and all required face-to-face contacts are performed in accordance with Texas Administrative Code requirements.

Stakeholder Outreach

OIG enhances collaboration with MFCU

The OIG and the Texas Office of Attorney General Medicaid Fraud Control Unit (MFCU) share responsibility in addressing Medicaid fraud, overpayments and ensuring the welfare of Medicaid clients residing in nursing facilities. A concerted effort by leadership in both offices in the second quarter has enhanced collaborative efforts. The OIG's Medicaid Program Integrity (MPI) leadership traveled to Houston in December 2019 and met with MFCU staff and an assistant U.S. attorney to discuss health care fraud schemes and potential referrals for prosecution.

A Dallas OIG MPI regional manager met with representatives from the Centers for Medicare and Medicaid Services and the Office of Inspector General, U.S. Department of Health and Human Services, to learn successful education and enforcement efforts from other states. In February, the Houston MFCU field office hosted a meeting of the region's OIG investigative staff where the teams discussed how to enhance working together on cases. The Austin MFCU office also hosted the OIG Austin investigators for a similar meeting. MPI has been invited to give presentations to educate MFCU staff.

OIG publishes educational articles for providers

In December, OIG Chief Pharmacy Officer Catherine Coney, R. Ph. collaborated with the OIG Communications Team and Audit Division to publish an article in Texas Pharmacy, the official magazine for the Texas Pharmacy Association. The article, "What to Expect from an Office of Inspector General Audit," describes the audit process for pharmacies. The article describes provider selection for an audit; planning and fieldwork; provider documentation collection and interviews; and audit reporting and outcomes.

In the January issue of Texas Dental Association's TDA Today, OIG Chief Dental Officer Dr. Janice Reardon collaborated with OIG Communications Team to publish "How to Submit Diagnostic Dental X-rays to the Office of Inspector General." This article is a continuation of the spring 2019 issue that explains the guidelines for providers to send diagnostic dental x-rays to the OIG for review.

OIG hosts public-private partnership learning session

In January, the OIG hosted the Healthcare Fraud Prevention Partnership-Regional Information Sharing Session (HFPP-RISS) in Austin with more than 90 participants. The HFPP is a public-private

partnership between federal government, state agencies, law enforcement, private health insurance plans and healthcare anti-fraud associations. Through data and information sharing, the HFPP fosters a collaborative and proactive approach to combat health care fraud. The Medicaid Program Integrity Division's chief, Steve Johnson, presented an overview of the OIG's work and recent results. OIG employees from different areas participated in the sharing session presentation and workshop. A sharing session debrief was held internally among OIG participants to discuss findings and considerations.

Medical Services meets with stakeholders

The Nursing Facility Utilization Review (NFUR) unit held its quarterly stakeholder meeting in December. Discussion included reviewing the oxygen administration process, Resident Assessment Instrument and care planning measurable objectives, and the documentation requirement letter that HHS sent to nursing facility providers in August.

The Hospital Utilization Review (HUR) unit held its quarterly stakeholder meeting in January. Discussion included reviewing HUR coding trends, emergency room/outpatient claims associated with inpatient stays, and updates for SharePoint, review samples, and MCOs.

Third Party Recoveries meets with other state Medicaid programs

In January, staff members from Third Party Recoveries (TPR) attended a training conference with professionals from other state Medicaid Third Party Liability (TPL) programs. The Medicaid Integrity Institute at the National Advocacy Center provided an opportunity to collaborate and learn how other states implement and manage TPL activities to ensure Medicaid is the payor of last resort. The conference focused on topics such as TPL in managed care, Medicaid estate recovery, and vendor contracting. One specific example of the shared best practices was the state of Michigan's MCO TPL Risk Mitigation forms. TPR will use these forms to explore new ways to identify and mitigate potential TPL risk in Texas MCOs.

Conferences and Presentations

- IG Kauffman attended a conference in February organized by Health Care Compliance Association. IG Kauffman gave a presentation to compliance experts about the OIG's role in ensuring the integrity of health and human services.

- IG Kauffman, Chief of Medicaid Program Integrity Steve Johnson, Chief of Strategy Juliet Charron and members of the Policy team attended the 2020 Texas State of Reform Health Policy Conference in February in Austin. The conference of health care executives and policy leaders focused on the challenges and opportunities within the intricate changes taking place across health care in Texas.

- In January, OIG Senior Dental Analyst Sherry Jenkins presented "Risk Management, Record Keeping, Medicaid & The Children's Health Insurance Program" training to dental hygienist students at Concorde Career College in Dallas. This training gave an overview of these topics as they relate to dental providers.

- The OIG Lock-In team in January delivered Lock-In Program training to the MCOs. This training provided an overview of the lock-in program including key definitions, legal references, lock-in criteria, supporting documentation and how the OIG receives referrals. The Lock-In Program is used to restrict the overuse of medications and medical services.

- In December, a staff member from the Acute Care Surveillance team attended the Medicaid Integrity Institute's HCPro's Evaluation and

Training summary

Trainings conducted this quarter 40

Management Boot Camp. This boot camp covered the fundamentals and intricacies of coding and how to perform effective audits.

- OIG Chief Dental Officer Dr. Janice Reardon and OIG Senior Dental Analyst Sherry Jenkins in February attended the Star of the South Dental Conference in Houston, which offered continuing education for dentists and their staff, as well as up-to-date information in dentistry.

- Medical Services Assistant Deputy Inspector General Judy Knobloch and a staff member attended in February the Texas Hospital Association Conference and Expo in San Antonio that brings together health care leaders from across Texas. The conference featured sessions designed for clinical, policy, legal, technology and governance positions.

- The OIG's El Paso Benefits Program Integrity team gave a presentation to HHS Access and Eligibility Services (AES) team. The purpose of the presentation was to educate staff in the AES El Paso regional office about how the OIG ensures the integrity of health and human services in Texas. OIG staff discussed the importance of properly using verification sources and documentation. The presentation also demonstrated to AES staff members how to submit a referral to the OIG.

Program Integrity Spotlight

Data supports pharmacy invoice initiative

Data analytics continues to be a driving force in the OIG's work. It improves the agency's accuracy and efficiency, uncovering potential fraud, waste and abuse across the health care delivery system.

About Fraud Detection Operations

Data played a key role in a recent initiative to uncover questionable pharmacy practices. The Medicaid Program Integrity Division (MPI) conducted a Fraud Detection Operation (FDO) into potentially fraudulent billing practices around prescription drugs, namely billing for an expensive drug while dispensing a cheaper version.

An FDO reviews volumes of data to uncover providers who appear as statistical outliers among their peers. Throughout the operation, investigators evaluate additional records, invoices and information to determine whether an outlier's status is attributable to possible fraud, waste, or abuse or other program violations. This advanced data analytics method of investigating issues reveals potential candidates for an audit or full-scale investigation.

How it's done

The individual National Drug Code (NDC) numbers that identify drugs and their associated costs provide a clear picture of pharmacy activities. The OIG's Data and Technology Team (DAT) developed algorithms to identify pharmacies across Texas exhibiting behavior that can be associated with fraudulent billing. Variables examined included:

- A spike in dollars per claim

- Script exhaustion or filling prescriptions past their validity date

- A high quantity/supply ratio per NDC that may indicate premature refills for reimbursement

- Filling odd quantities – which point to incorrect claim details

- Consistently high refill rates that may suggest auto-refilling.

DAT analyzed 100 million claims statewide, covering a five-year period. The FDO included a review of 2,000 pharmacies.

After identifying outlier pharmacies who exhibited unusual billing patterns, investigators requested invoices to compare NDCs purchased with NDCs billed.

The graph on page 17 plots the number of refills against the dollar amounts at risk. While our algorithms detected suspicious billing patterns on multiple providers, degrees of risk are taken into account as the OIG decides whom to audit or investigate.

For example, the pharmacies in green are identified as outliers in terms of their behavior patterns but generally have low at-risk amounts, possibly due to explainable anomalies or low-frequency transgressions. However, the pharmacies whose behavior could pose a larger risk to the program (seen in red) are where we consider investigating. DAT ultimately identified four pharmacy providers in the Houston region who exhibited patterns of potential wrongdoing. MPI opened investigations on two of the pharmacies; those investigations are still in progress.

Additional data analysis performed for this initiative revealed potential weaknesses in MCO systems to flag payment on questionable pharmacy practices. Those findings are being shared with MCOs to help prevent future overpayments.

Moving forward

One of the OIG's priorities this year is to advance its data analytics maturity. This is a multi-year pursuit that will implement several projects, including implementing more efficient data extraction processes, increasing the use of data

visualization to enable the identification of concerning patterns, acquiring new data sources to incorporate into new types of analysis, and automating existing algorithms.

Dedicated staffers across OIG divisions analyze data and apply their experience and expertise to agency initiatives. This evolving approach to fraud detection and prevention is one way the OIG fulfills its mission to protect taxpayer dollars.
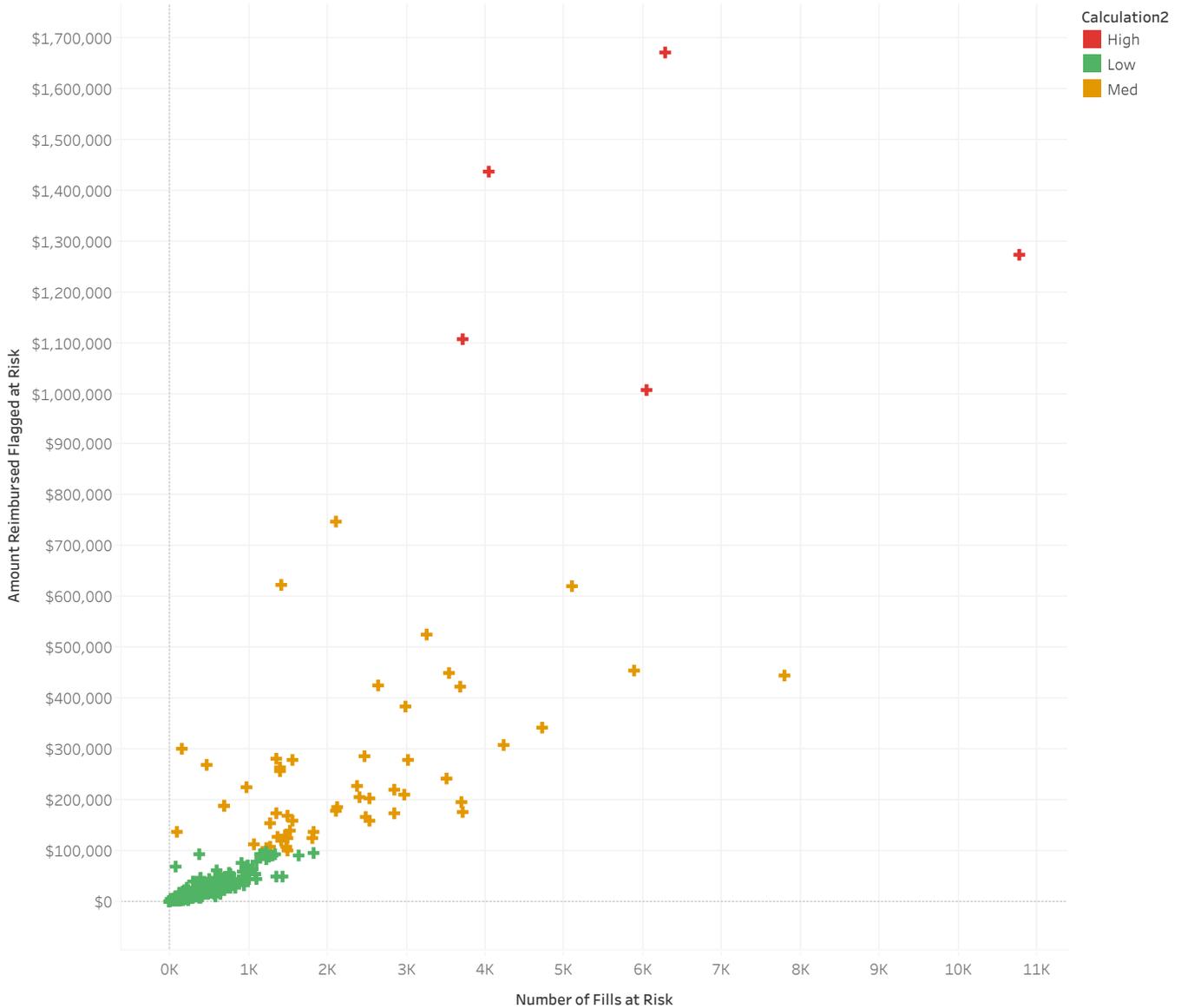
Sum of Number of Records vs. sum of Amt Pd. Color shows details about Calculation2. Details are shown for Pharm NPI. The view is filtered on Exclusions (Calculation2,Pharm NPI), which keeps 353 members.

Division Performance

Inspections and Investigations

Inspections conducts inspections of HHS programs, systems and functions. Inspections also oversees the state's Women, Infants and Children (WIC) Vendor Monitoring Unit. This unit conducts in-store evaluations, compliance buys, and invoice audits to monitor vendors participating in the WIC program.

Investigations includes commissioned peace officers and non-commissioned personnel. It has three units:

- State Centers Investigations Team conducts criminal investigations of allegations of abuse, neglect and exploitation at state supported living centers and state hospitals.

- Cooperative Disability Investigations investigates statements and activities that raise suspicion of disability fraud.

- Electronic Benefit Transfer Trafficking conducts criminal investigations related to trafficking of Supplemental Nutrition Assistance Program (SNAP) benefits.

Benefits Program Integrity investigates allegations of overpayments to health and human services program clients enrolled in WIC; SNAP; the Temporary Assistance for Needy Families program; Medicaid; and the Children's Health Insurance Program.

EBT Trafficking Unit performance

Overpayments recovered	$73,718
Cases opened	186
Cases completed	255

State Centers Team performance

Overpayments recovered	$0
Cases opened	169
Cases completed	185

Peace Officers performance

Cost avoidance	$93,120

Inspections report issued

- None

Inspections in progress

- Member Complaints Received by Texas Medicaid Managed Care Organizations - Series III: Inspection of Member Complaint Appeals

- Molina Quality Living Program

- Child and Adolescent Needs and Strengths Assessment in Community-Based Care

- Local Mental Health Authorities

- Overlapping Long-Term Care Claims During Hospital Stays

- Mental Health Targeted Case Management and Rehabilitative Services in Managed Care

- State Supported Living Centers' Background Checks and Training Processes

Inspections performance

Overpayments recovered	$212
Overpayments identified	$259,572

Benefits Program Integrity performance

Overpayments recovered	$5,000,683
Cases completed	3,777
Cases opened	4,164
Cases referred for prosecution	37
Cases referred for Administrative Disqualification Hearings	219

Medicaid Program Integrity

Medicaid Program Integrity Division includes four units:

- The Provider Investigations unit investigates and reviews allegations of fraud, waste and abuse committed by Medicaid providers who may be subject to a range of administrative enforcement actions including education, prepayment review of claims, penalties, required repayment of Medicaid overpayments, and/or exclusion from the Medicaid program. Some referrals come through the OIG Fraud Hotline or complaints from the OIG's online Waste, Abuse and Fraud Electronic Referral System. Referrals are also received from managed care organizations throughout the state. When criminal Medicaid fraud is detected, MPI refers the matter to the Attorney General's Medicaid Fraud Control Unit. The two work together on joint investigations by sharing resources and information that will lead to successful administrative disposition or criminal prosecution.

- The Medical Services unit conducts claims and medical record reviews on a variety of health and human services, including acute care utilization, hospital utilization, nursing facility utilization, research and detection, and pharmacy lock-in. Medical Services also provides clinical consultation to the Benefits Program Integrity and Audit units, and the Inspections and Investigations Division on dental, medical, nursing and pharmacy services.

- The Program Integrity Development and Support unit provides support and process improvements to other MPI units. Responsibilities include developing projects to improve MPI investigative outcomes, reporting MPI statistics, acting as the Managed Care Organization Special Investigative Unit liaison, planning and conducting Investigative Initiatives and Fraud Detection Operations, and acting as the lead on open records requests.

Medicaid Program Integrity performance

Preliminary investigations opened	526
Preliminary investigations completed	425
Full-scale investigations completed	45
Cases transferred to full-scale investigation	76
Cases referred to AG's Medicaid Fraud Control Unit	153
Open/active full-scale cases at end of quarter	154

Medical Services performance

Acute care provider recoveries	$2,185,830
ACS identified MCO overpayments	$2,305,064
Hospital and nursing home UR recoveries	$5,457,882
Hospital UR claims reviewed	4,959
Nursing facility reviews conducted	81
Average number of Lock-in Program clients	2,087

PEIS performance

Provider enrollment inventory (applications and informal desk reviews) processed	8,196
Individual screenings processed	23,110

- The Provider Enrollment Integrity Screenings (PEIS) unit is responsible for conducting certain federal- and state-required screening activities for providers seeking to enroll in Medicaid, CHIP and other state health care programs. The screenings and reviews conducted by PEIS promote compliance with federal provider enrollment program integrity requirements; increase accountability for the appropriate use of taxpayer resources by helping to prevent fraud, waste and abuse; and protect the health and safety of Texans.

Audit

The Audit Division conducts risk-based audits related to the accuracy of medical provider payments; the performance of HHS agency contractors; and programs, functions, processes and systems within the HHS system. Protocols of provider audits are periodically published on the Resources page on the OIG's website. Audit also coordinates all federal government audits of the HHS system.

Audits reports issued

- Summary of Results – Audits of Texas Medicaid Medical Transportation Organizations
- Security Controls over Confidential HHS System Information and Business Continuity and Disaster Recovery Plans – Children's Medical Center Health Plan
- DentaQuest USA Insurance Company – A Texas Medicaid and CHIP Dental Maintenance Organization
- City Drug Company – A Texas Vendor Drug Program Provider
- STAR+PLUS Waiver Program Assessments and Services Delivered
- Medicaid STAR+PLUS Nursing Facility Risk Groups: Reporting Errors Caused Incorrect Risk Group Assignments
- Collin County MHMR Center – Local Intellectual and Developmental Disability Authority Performance Contract

Audit performance

Overpayments recovered	$165,482
Overpayments identified	$772,573
Audit reports issued by contractors	4

Audits in progress

The Audit Division had 24 audits in progress this quarter on the topics listed below. A list of audits in progress and audit topics the OIG plans to initiate can be found in the two-year rolling audit plan located on the OIG's website (https://oig.hhsc.texas.gov/audit).

- Summary of Results – Audits of Texas Medicaid Medical Transportation Organizations
- Security Controls over Confidential HHS System Information and Business Continuity and Disaster Recovery Plans – Children's Medical Center Health Plan
- DentaQuest USA Insurance Company – A Texas Medicaid and CHIP Dental Maintenance Organization
- City Drug Company – A Texas Vendor Drug Program Provider
- STAR+PLUS Waiver Program Assessments and Services Delivered
- Medicaid STAR+PLUS Nursing Facility Risk Groups: Reporting Errors Caused Incorrect Risk Group Assignments
- Collin County MHMR Center – Local Intellectual and Developmental Disability Authority Performance Contract

Chief Counsel

The Office of Chief Counsel Division provides legal counsel and is comprised of the following:

- General Law provides legal support for audits, investigations, inspections and reviews. Furthermore, General Law supports OIG operations, including researching termination/ exclusion issues, reviewing federal share obligations, analyzing extrapolation processes, contracting and assisting with rule and statute changes affecting the agency.

- Litigation handles the appeal of investigations

Internal Affairs performance

Investigations completed	53
Cases with sustained allegations	7

and audits that determined providers received Medicaid funds to which they were not entitled.

- Internal Affairs investigates employee misconduct in the provision of health and human services, including contract fraud within the HHS system.

Strategy and Data and Technology

The Strategy Division includes the Data and Technology (DAT) and the Policy, Development and Innovation units.

- DAT implements tools and innovative data analytic techniques that streamline OIG operations and increase the identification of fraud, waste, and abuse. DAT assesses trends and patterns regarding behavior of providers, clients and retailers participating in Texas Health and Human Services (HHS) programs. DAT consists of four units: Fraud Analytics, Data Research & Analysis, Statistical Analysis, and Data Operations.

- Policy, Development and Innovation serves as the

Data and Technology performance

Data requests received	275
Data requests completed	249
Algorithms executed	41
New algorithms developed	18

health care policy subject matter expert and liaison between HHS and the OIG. The unit conducts analysis of program policies and coordinates and ensures timely and effective communication with a variety of stakeholders.

Operations

The Operations Division is comprised of five core functions:

- Operations Support includes OIG purchasing, contract management and the OIG Fraud Hotline. The Fraud Hotline receives allegations of fraud, waste and abuse and refers them for further investigation or action as appropriate.

- Finance and Budget oversees the OIG budget, tracks recoveries, reports Legislative Budget Board performance measures and works closely with HHSC Central Budget on the agency's LAR/Exceptional Items.

- Workforce Operations and Professional Development promotes OIG training services and internal policy development.

Operations performance

Fraud hotline calls answered	6,354

Third Party Recoveries performance

Dollars recovered	$58,062,728
Cost avoidance	$25,074,440

- Third Party Recoveries works to ensure that Medicaid is the payor of last resort, oversees the Recovery Audit Contract and operates the Medicaid Estate Recovery Program.

- The Ombudsman provides an independent and neutral process for OIG employees to address concerns and work towards resolution.

External Relations

The External Relations Division focuses on engaging and ensuring a timely response to OIG critical stakeholders:

- Communications manages press relations, maintains the OIG website and social media platforms, publishes the agency's external facing reports and work products, and facilitates communication between the Inspector General and various stakeholders.

- Government Relations serves as the primary point of contact for the executive and legislative

External Relations performance

Website page views	75,263
Communications materials produced	90

branches of government and state policy makers. Government Relations also analyzes legislation to understand the impact to OIG operations.

- Strategic Initiatives leads OIG-wide initiatives and special projects.

Texas Health and Human Services Office of Inspector General

Sylvia Hernandez Kauffman, Inspector General

Mailing address: P.O. Box 85200, Austin, TX 78708

Main phone number: 512-491-2000

Email: OIGCommunications@hhsc.state.tx.us

To report fraud, waste or abuse

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

Website: ReportTexasFraud.com

OIG on Twitter: @TexasOIG

OIG on Facebook: TxOIG

Produced by OIG Communications: Andres Araiza, manager; Emily Hummel and Art Moore, staff