Audit Report

Community First Health Plans, Inc.
Special Investigative Unit

A Texas Medicaid Managed Care Organization

April 28, 2022
OIG Report No. AUD-22-008

Inspector General

Texas Health and Human Services

Community First Health Plans, Inc. Special Investigative Unit

A Texas Medicaid Managed Care Organization

Results in Brief

Why OIG Conducted This Audit

The Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division (OIG Audit) conducted an audit of SIU activities at Community First Health Plans, Inc. (Community First), a Medicaid and Children's Health Insurance Program (CHIP) managed care organization (MCO).

Community First's 2019 total enrolled member months was 1,385,589 for Medicaid and 208,698 for CHIP. In 2020, Community First's total enrolled member months was 1,410,769 for Medicaid and 186,461 for CHIP.

Summary of Review

The audit objective was to determine whether Community First complied with selected state and contractual requirements related to (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to the Texas Health and Human Services Commission (HHSC).

The audit scope covered SIU activities in state fiscal year 2020. The scope also included a review of significant controls and control components within the context of the audit objectives including the prevention, detection, investigation, recovery (as applicable), and reporting of fraud, waste, and abuse allegations through the end of fieldwork in February 2022.

Conclusion

Community First Health Plans, Inc. (Community First) did not consistently comply with certain state and contractual requirements related to (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on special investigative unit (SIU) activities, results, and recoveries to the Texas Health and Human Services Commission (HHSC).

During the audit period, Community First met certain requirements related to staffing the SIU, training, monitoring service patterns, and remitting funds recovered.

Key Results

Community First has opportunities to improve the timing and documentation of its SIU efforts in both preliminary and extensive investigations, reporting to OIG, and its fraud, waste, and abuse training. Specifically, Community First did not consistently:

- Ensure preliminary investigations contained required elements and met required timelines. Eight of the 23 (35 percent) preliminary investigations were not completed within the 15-working-day requirement. Those 8 preliminary investigations were closed, on average, 73 working days from when the allegation was reported to Community First. Furthermore, 22 investigations were missing at least one required element including those Community First indicated it had completed on time. Conducting timely preliminary investigations and performing all required elements helps ensure Community First timely identifies potential fraud, waste, and abuse, Medicaid overpayments, and appropriately reports SIU activities.
- Include the date of the allegation on its log of incidences of suspected fraud, waste, and abuse. Community First stated it used the date the case was opened as the date the allegation was received in its incident log, regardless of whether the investigation was opened immediately. Not documenting when the allegation was received could impede Community First's ability to complete preliminary investigations within the required timeframe.

Background

HHSC requires MCOs to have an SIU to investigate potential fraud, waste, or abuse by members and health care service providers.

Recommendations

Community First should implement processes, when applicable, to ensure it:

- Timely completes and sufficiently documents all required elements of preliminary investigations.
- Records the date the allegation of fraud, waste, or abuse is received.
- Selects at least the minimum sample sizes of members or claims required for investigations.
- Meets and adequately documents the required timelines for elements of extensive investigations.
- Logs all cases and ensures it reports all opened investigations to OIG.
- (a) ensures all possible fraud, waste, and abuse findings are referred to OIG as required, and remit half of the money collected from such referrals, (b) documents its rationale when it determines that the results of an investigation do not indicate possible fraud, waste, and abuse, (c) re-audits providers given education as the result of an extensive investigation, and (d) submits referrals within 30 working days.
- Provides fraud, waste, and abuse training to employees and subcontractors directly involved with any aspect of Medicaid or CHIP within 90 days of employment and annually.

Management Response

Community First agreed with the audit recommendations and indicated corrective actions would be implemented by June 2022.

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- Ensure sample sizes for extensive investigations met requirements. Texas Administrative Code requires Community First to select certain minimum sample sizes to review. Limiting sample sizes can prevent Community First from identifying claim patterns and may impede detection of potential fraud, waste, and abuse committed by the provider.
- Meet or sufficiently document all timeline requirements for extensive investigations. Community First has required timeframes after completion of a preliminary investigation to select a sample of claims for review, request records and encounter data, and review the records and encounter data. When fraud, waste, or abuse is suspected, delays can impair Community First's ability to mitigate fraud, waste, and abuse within the Medicaid and CHIP programs.
- Include all opened investigations on the Monthly Open Case List Report submitted to OIG. Community First conducted 28 SIU investigations in 2020 that it did not report to OIG on the monthly report. In addition, a case that OIG referred to Community First was neither assigned a case number nor added to the report. OIG uses information provided by MCOs to analyze potential fraud, waste, and abuse trends. Inconsistent reporting by MCOs impairs OIG's ability to effectively analyze, detect, and pursue fraud, waste, and abuse.
- Refer all extensive investigations and remit half of recovered amounts of possible acts of fraud, waste, or abuse to OIG, as required, or document why those extensive investigations with findings and recoveries were not referred to OIG. Not consistently referring all possible fraud, waste, or abuse also limits OIG's ability to effectively investigate potential fraud, waste, and abuse across the state's Medicaid programs.
- Submit referrals for possible acts of fraud, waste, or abuse to OIG within the required timeframe. During the audit period, Community First referred a total of three cases to OIG. Two of the three cases were referred after 36 and 39 working days, respectively, rather than within 30 working days, as required. Not reporting referrals timely limits OIG's ability to coordinate and oversee efforts to prevent fraud, waste, and abuse throughout Texas HHS programs.
- Ensure staff and a subcontractor completed fraud, waste, and abuse training within the required timeframes. One employee did not receive fraud, waste, and abuse training within 90 days of hire, and another employee hired prior to the audit scope did not receive annual training in state fiscal year 2020, as required. In addition, Community first did not verify that one subcontractor provided its employees with required training. Not ensuring all employees and subcontractors receive required training may decrease the likelihood of detecting potential fraud, waste, and abuse.

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Audit Overview

Overall Conclusion

Community First Health Plans, Inc. (Community First) did not consistently comply with certain state and contractual requirements related to (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on special investigative unit (SIU) activities, results, and recoveries to the Texas Health and Human Services Commission (HHSC).

Objective

The audit objective was to determine whether Community First complied with selected state and contractual requirements related to (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to the Texas Health and Human Services Commission (HHSC).

Scope

The audit scope covered SIU activities in state fiscal year 2020. The scope also included a review of significant controls and control components within the context of the audit objectives including the prevention, detection, investigation, recovery (as applicable), and reporting of fraud, waste, and abuse allegations through the end of fieldwork in February 2022.

Key Audit Results

The Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division (OIG Audit) conducted an audit of SIU activities at Community First, a Medicaid and Children's Health Insurance Program (CHIP) managed care organization (MCO).

During the audit period, Community First met certain requirements related to staffing the SIU, training, monitoring service patterns, and remitting funds recovered.

However, Community First has opportunities to improve the timing and documentation of its SIU efforts in both preliminary and extensive investigations, reporting to OIG, and its fraud, waste, and abuse training. Specifically, Community First did not consistently:

- Ensure preliminary investigations contained required elements and met required timelines.
- Include the date of the allegation on its log of incidences of suspected fraud, waste, and abuse.

- Ensure sample sizes for extensive investigations met requirements.
- Meet or sufficiently document all timeline requirements for extensive investigations.
- Include all opened investigations on the Monthly Open Case List Report.
- Refer all extensive investigations of possible acts of fraud, waste, or abuse to OIG, or document why those extensive investigations with findings and recoveries were not referred to OIG.
- Remit to OIG half of all amounts recovered as the result of a fraud and abuse determination.
- Submit referrals for possible acts of fraud, waste, or abuse to OIG within the required timeframe.
- Ensure staff and subcontractors completed fraud, waste, and abuse training within the required timeframes.

Unless otherwise described, any year referenced is the state fiscal year, which covers the period from September 1 through August 31. For state fiscal year 2020, the period is September 1, 2019, through August 31, 2020. The "Detailed Audit Results" section of this report presents additional information about the audit results.

OIG Audit presented preliminary audit results, issues, and recommendations to Community First in a draft report dated April 5, 2022. Community First agreed with the audit recommendations and indicated corrective actions would be implemented by June 2022. Community First's management responses are included in the report following each recommendation.

OIG Audit thanks management and staff at Community First for their cooperation and assistance during this audit.

Key Program Data

HHSC contracts with Community First to coordinate health services in Texas for members enrolled in the Medicaid State of Texas Access Reform (STAR) program, the STAR Kids program, and CHIP.[1] Community First is a licensed MCO that provides Medicaid and CHIP services through its network of providers.

Community First's 2019 total enrolled member months was 1,385,589 for Medicaid and 208,698 for CHIP. In 2020, Community First's total enrolled member months was 1,410,769 for Medicaid and 186,461 for CHIP.[2] Table 1 shows Community First's capitation payments by program.

Table 1: Community First's Capitation Payments by Program[3]

Program	2019	2020	Total
Medicaid	$ 498,472,662	$ 544,401,896	$ 1,042,874,558
CHIP	27,832,482	26,565,216	54,397,698
Total	**$ 526,305,144**	**$ 570,967,112**	**$ 1,097,272,256**

Source: HHSC 2019 334-day and 2020 90-day Financial Statistical Reports

Community First is one of 18 contracted MCOs responsible for administering, on behalf of the state of Texas, $22.7 billion of Medicaid and CHIP health care services in 2019 through its health plans. In 2020, the contracted MCOs provided $23.0 billion in Medicaid and CHIP health care services.[4]

HHSC requires MCOs to establish and maintain an SIU to investigate potential fraud, waste, or abuse by members and health care service providers.[5] While an MCO may contract with an outside organization to perform all or part of the

[1] The managed care contracts relevant to this audit include the Uniform Managed Care Contract and the STAR Kids Contract. The Uniform Managed Care Contract is used for referencing contract requirements for this report.

[2] HHSC 2019 334-day Financial Statistical Report, data through Aug. 31, 2019; and 2020 90-day Financial Statistical Report, data through Aug. 31, 2020.

[3] Amounts reflect only medical and pharmacy capitation payments.

[4] HHSC Financial Statistical Reports; 2019 data through Aug. 31, 2019; 2020 data through Aug. 31, 2020.

[5] Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, v. 2.29 (Sept. 1, 2019) through v. 2.30 (Mar. 1, 2020).

activities associated with the SIU, Community First maintains an internal SIU department.

Auditing Standards

Generally Accepted Government Auditing Standards

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Detailed Audit Results

Community First complied with certain state and contractual requirements related to (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to OIG.

Specifically, Community First:

- Had a full-time SIU manager and one full-time investigator dedicated solely to the Texas Medicaid and CHIP programs.
- Ensured staff fraud, waste, and abuse training included required topics such as the definition of fraud, waste, and abuse, and information on how to report suspected fraud, waste, and abuse.
- Conducted detection activities including random payment reviews, member service verification of billed services, and service pattern monitoring to identify potential fraud, waste, and abuse.
- Maintained a fraud hotline to receive referrals of potential fraud, waste, and abuse.
- Remitted to OIG, when appropriate, half the amounts recovered as the result of SIU investigations that were referred to OIG.

The following sections of this report provide additional detail about the instances of noncompliance identified by OIG Audit. OIG Audit communicated less significant non-reportable issues to Community First in writing.

Preliminary Investigations

MCOs are responsible for investigating possible acts of fraud, waste, and abuse for all services, starting with a preliminary investigation. Community First is required to complete a preliminary investigation within 15 working days of the identification or reporting of suspected or potential fraud, waste, or abuse.[6] Additionally, preliminary investigations must include specific elements, which differ for provider[7] and member[8] investigations.

Chapter 1: Preliminary Investigations Did Not Always Contain Required Elements or Meet Required Timelines

Out of 23 preliminary investigations reviewed, one was a member investigation and the remaining 22 were provider investigations. Community First performed all the required elements for the preliminary member investigation. However, none of the 22 preliminary provider investigations tested included all required elements.

Preliminary provider investigations have these specific required elements:

- Determining if the MCO has received any previous reports of fraud, waste, or abuse or if it has conducted any previous investigations of the provider in question.
- Determining if the provider has received educational training from the MCO regarding the allegation.

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[6] 1 Tex. Admin. Code §§ 353.502 (c)(2)(A) and (c)(4)(A) (July 18, 2019) and 370.502 (c)(2)(A) and (c)(4)(A) (Mar. 1, 2012); Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, v. 2.29 (Sept. 1, 2019) through v. 2.30 (Mar. 1, 2020).

[7] 1 Tex. Admin. Code §§ 353.502 (c)(2)(B) (July 18, 2019) and 370.502 (c)(2)(B) (Mar. 1, 2012); Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, v. 2.29 (Sept. 1, 2019) through v. 2.30 (Mar. 1, 2020).

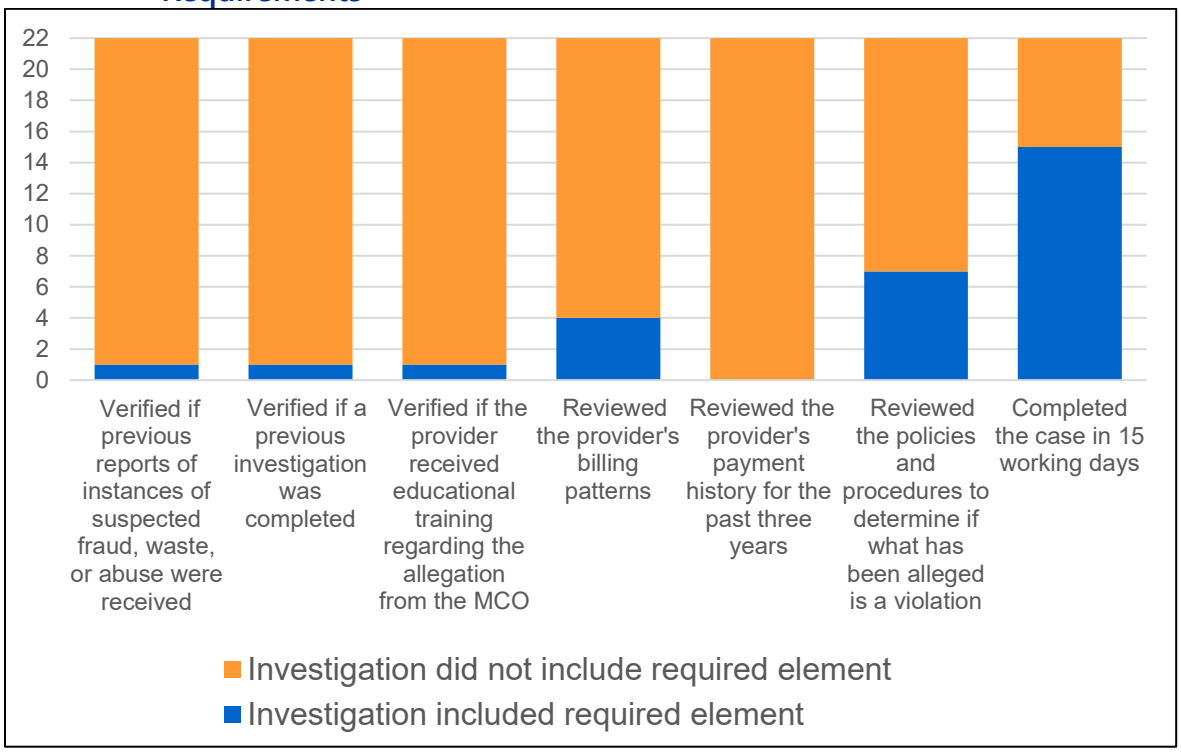
[8] 1 Tex. Admin. Code §§ 353.502 (c)(4)(B) (July 18, 2019) and 370.502 (c)(4)(B) (Mar. 1, 2012); Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, v. 2.29 (Sept. 1, 2019) through v. 2.30 (Mar. 1, 2020).

- Reviewing the provider's billing patterns.
- Reviewing the provider's payment history for the past three years, if available.
- Determining whether the new allegation is a violation of program policy or procedure.

In addition, 8 of the 23 (35 percent) preliminary investigations were not completed within the 15-working-day requirement. Those 8 preliminary investigations were closed, on average, 73 working days from when the allegation was reported to Community First.

Figure 1 summarizes Community First's compliance with requirements for 22 preliminary provider investigations reviewed and how many Community First recorded as closed within 15 working days without including all required elements.

Figure 1: Community First's Compliance with Preliminary Provider Investigation Requirements



Source: OIG Audit

Not reviewing all the required elements during a preliminary investigation limits the effectiveness of the preliminary investigation and may impede detection of

potential fraud, waste, and abuse committed by the provider. Performing the required elements may help determine whether there is a pattern of inappropriate behavior. Additionally, conducting timely preliminary investigations and performing all required elements helps ensure Community First (a) effectively investigates potential fraud, waste, and abuse, (b) timely identifies overpayments and recovers Medicaid funds, and (c) appropriately reports SIU activities and results to OIG.

Review of controls during the audit engagement determined that Community First management performs a supervisory review of investigation documentation. However, Community First's review process did not consistently ensure (a) timely completion of all required elements of a preliminary investigation or (b) sufficient documentation was maintained to support required elements were completed.

Recommendation 1

Community First should implement processes to ensure it (a) completes all required elements of preliminary investigations timely and (b) sufficiently documents the investigation to demonstrate all required elements were completed within 15 workdays of the identification or reporting of suspected fraud, waste, or abuse.

Management Response

Action Plan

1. Several processes were put in place and completed on March 17, 2022. The processes included:

   The creation of a Preliminary Investigation Checklist form to assist SIU staff with ensuring complete documentation for each of the required elements of a preliminary investigation. The form (a) is to be completed within 15 workdays of the identification or reporting of suspected fraud, waste, or abuse and (b) includes:

   - Any previous reports of fraud, waste, and abuse or any previous investigations of the provider in question

- Any previous educational training from the MCO regarding the allegation
- A review of the provider's billing patterns
- A review of the provider's payment history for the past three years
- A determination of whether the new allegation is a violation
- A supervisory review to confirm that required elements have been documented

2. Staff training on documentation of all the required elements of a preliminary investigation in the Preliminary Investigation Checklist form was conducted on March 4, 2022.
3. A job aid will be developed to identify the steps to complete the Preliminary Investigation Checklist form accurately and completely.
4. Revision to the Preliminary Investigation Monitoring tool (Excel), which is used to monitor timely completion of the investigations, is under development.

Responsible Managers

- Director, Audit Services
- SIU Manager

Target Implementation Date

June 30, 2022

Chapter 2: Incident Log Did Not Include Date of Allegation

Community First did not record the date it received allegations in the incident log, as required.

Texas Administrative Code requires Community First to "maintain a log of all incidences of suspected waste, abuse and fraud received by the MCO regardless of the source."[9] The log must contain the subject of the complaint, the source, the allegation, the date the allegation was received, the recipient's or provider's Medicaid or CHIP number, and the status of the investigation.

Community First stated it used the date the case was opened as the date the allegation was received in its incident log, regardless of whether the investigation was opened immediately. Not documenting when the allegation was received could impede Community First's ability to complete preliminary investigations within the required timeframe.

Recommendation 2

Community First should implement processes to ensure it records the date the allegation of fraud, waste, or abuse is received on its log.

Management Response

Action Plan

1. The date of the allegation received was added to the Suspicious Activity Log on February 1, 2022.
2. The staff was retrained regarding the documentation requirement for the date of the allegation on the log and within the Preliminary Investigation Checklist form.
3. As of March 4, 2022, weekly meetings are in place to review the Suspicious Activity Log and current SIU activities, including a quality review of the investigation timeline.

[9] 1 Tex. Admin. Code § 353.502 (d)(2) (July 18, 2019) and 1 Tex. Admin. Code § 370.502 (d)(2) (Mar. 1, 2012).

Responsible Managers

- Director, Audit Services
- SIU Manager

Target Implementation Date

June 30, 2022

Extensive Investigations

Community First is required to perform an extensive investigation if it determines suspicious indicators of possible fraud, waste, or abuse exist during the preliminary provider investigation.[10] An extensive investigation involves additional required elements, including (a) selecting a sample of claims for review, (b) requesting the records, and (c) reviewing the records.

Community First has 15 working days after the completion of a preliminary investigation to select a sample of claims for review. After selecting claims for review, the MCO has 15 working days to request medical or dental records and encounter data.[11] Community First must review the requested records and encounter data within 45 working days of receipt of those records to:

- Validate the sufficiency of service delivery data and to assess utilization and quality of care.
- Ensure that the encounter data submitted by the provider is accurate.
- Evaluate whether the review of other pertinent records is necessary to determine if fraud, waste, or abuse has occurred. If review of additional records is necessary, then conduct such a review.[12]

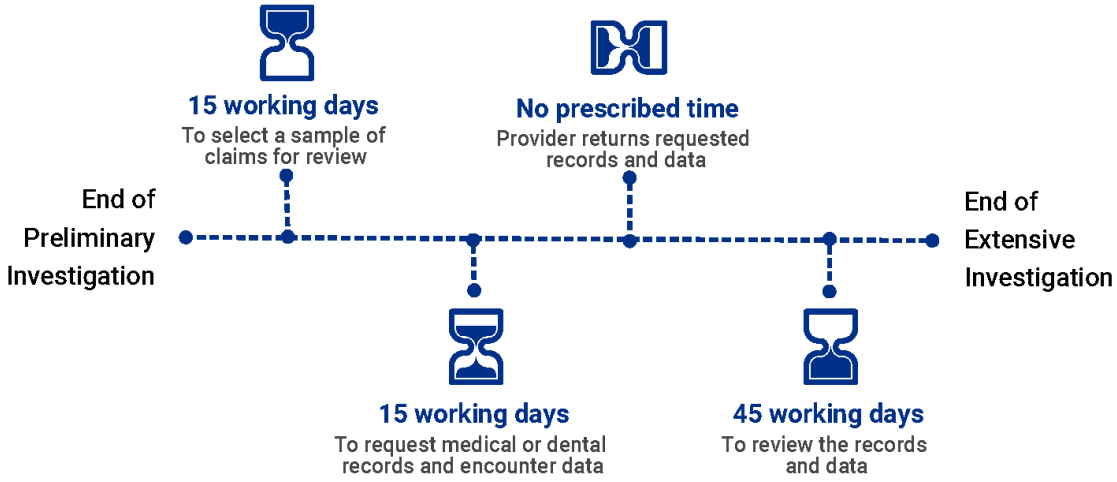
[10] 1 Tex. Admin. Code § 353.502 (c)(2)(C) (July 18, 2019) and 1 Tex. Admin. Code § 370.502 (c)(2)(C) (Mar. 1, 2012); Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, v. 2.29 (Sept. 1, 2019) through v. 2.30 (Mar. 1, 2020).

[11] 1 Tex. Admin. Code § 353.502 (c)(2)(C)(i) (July 18, 2019) and 1 Tex. Admin. Code § 370.502 (c)(2)(C)(i) (Mar. 1, 2012); Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, v. 2.29 (Sept. 1, 2019) through v. 2.30 (Mar. 1, 2020).

[12] 1 Tex. Admin. Code § 353.502 (c)(2)(C)(ii) (July 18, 2019) and 1 Tex. Admin. Code § 370.502 (c)(2)(C)(ii) (Mar. 1, 2012); Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, v. 2.29 (Sept. 1, 2019) through v. 2.30 (Mar. 1, 2020).

Figure 2 details the timelines for each task in an extensive investigation.

Figure 2: Timeline of Tasks in an Extensive Investigation



Source: OIG Audit

Of the 23 preliminary investigations tested, Community First found suspicious indicators of fraud, waste, and abuse in 16, which resulted in an extensive investigation being performed to determine if fraud, waste, or abuse had occurred. The SIU did not perform some required elements, did not always document when some elements were completed, and did not consistently complete elements within the required timelines.

Chapter 3: Extensive Investigation Sample Sizes Did Not Always Meet Requirements

Of the 16 investigations warranting extensive investigations, 15 were for Medicaid providers and one was for a CHIP provider. Community First did not always select the minimum sample size as required. Specifically:

- 10 of 15 (66.7 percent) Medicaid investigations did not meet the required minimum sample size of 30 members.
- One of one (100 percent) CHIP investigations did not meet the required minimum sample size of 50 members.

Community First is required to select a minimum of 30 Medicaid members or 15 percent of a provider's claims related to the suspected fraud, waste, or abuse to review. If Community First selects 15 percent of the claims, they must include claims relating to at least 30 members.[13] For CHIP, Community First is required to select a minimum of 50 members or 15 percent of a provider's claims related to the suspected fraud, waste, or abuse to review, provided, that if Community First selects 15 percent of the claims, it must include claims relating to at least 50 members.[14]

Limiting sample sizes can prevent Community First from identifying claim patterns and may impede detection of potential fraud, waste, and abuse committed by the provider. Reviewing claims for at least 30 Medicaid members or 50 CHIP members may help determine if there is a pattern of inappropriate behavior. Additionally, limited sample sizes may result in incomplete recoveries of Medicaid and CHIP overpayments and could result in Community First not referring possible fraud, waste, or abuse to OIG.

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[13] 1 Tex. Admin. Code § 353.502 (c)(2)(C) (July 18, 2019); Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, v. 2.29 (Sept. 1, 2019) through v. 2.30 (Mar. 1, 2020).

[14] 1 Tex. Admin. Code § 370.502 (c)(2)(C) (Mar. 1, 2012); Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, v. 2.29 (Sept. 1, 2019) through v. 2.30 (Mar. 1, 2020).

Testing of controls during fieldwork indicated that Community First management performs a supervisory review of investigations. However, Community First did not ensure it selected samples according to applicable requirements.

Recommendation 3

Community First should implement processes to ensure it selects at least the minimum sample sizes of members or claims.

Management Response

Action Plan

1. On March 17, 2022, the creation of a Preliminary Investigation Checklist form to assist SIU staff with ensuring the investigation sample size adheres to the required minimum sample size for Medicaid (30 members) and CHIP (50 members) was implemented. A supervisory review to confirm the required sample size is included on the Preliminary Investigation Checklist form.
2. Staff members were retrained on sample size selection requirements on March 4, 2022.
3. As of March 4, 2022, weekly meetings are in place to review current SIU activities, to include assurance that the correct minimum sample size has been selected.
4. A job aid will be developed for the Preliminary Investigation Checklist form, and it will include instructions regarding the selection of the required sample size.

Responsible Managers

- Director, Audit Services
- SIU Manager

Target Implementation Date

June 30, 2022

Chapter 4: Required Extensive Investigations Did Not Always Meet or Sufficiently Document Timeline Requirements

Only one of the extensive investigations documented the date a sample was selected. As a result, for the other 15 extensive investigations, OIG Audit used the dates documented for requesting records to determine if Community First selected samples within 15 working days of the completion of the preliminary investigations.

Community First is required to select a sample of members or claims related to the suspected fraud, waste, or abuse within 15 working days from the conclusion of a preliminary investigation that determined suspicious indicators of Medicaid fraud, waste, or abuse exist.[15,16]

Community First did not consistently complete extensive investigation tasks within required timeframes.

[15] 1 Tex. Admin. Code § 353.502 (c)(2)(C) (July 18, 2019); Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, v. 2.29 (Sept. 1, 2019) through v. 2.30 (Mar. 1, 2020).

[16] 1 Tex. Admin. Code § 370.502 (c)(2)(C) (Mar. 1, 2012); Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, v. 2.29 (Sept. 1, 2019) through v. 2.30 (Mar. 1, 2020).

Table 2 shows the number of timeliness errors by extensive investigation task and the average number of days to complete the selection of claims or members for review, to request records of the selected claims, and to complete the review of requested records.

Table 2: Extensive Review Elements and Timelines

Investigation Task	Required Timeline	# in Sample [17]	# Not Performed Timely	% Not Performed Timely	Average Time to Complete[18]
Records Selected	15 days	16	3	18.75%	39 days
Records Requested	15 days	16	3	18.75%	39 days
Records Reviewed	45 days	13	5	38.46%	77 days

Source: OIG Audit

When fraud, waste, or abuse is suspected, delays can impair Community First's ability to mitigate fraud, waste, and abuse within the Medicaid and CHIP programs and (a) effectively investigate potential fraud, waste, and abuse, (b) timely identify overpayments and recover Medicaid funds, and (c) appropriately report SIU activities and results to OIG.

Testing of controls during fieldwork indicated that Community First management performs a supervisory review of investigations. However, Community First did not ensure that it consistently met and documented required timeframes.

[17] Auditors tested 16 extensive investigations. However, Community First received records for only 13 of the 16 investigations.

[18] For Records Selected and Records Requested, the average time to complete is based on the number of days between when fraud, waste, or abuse was suspected and when Community First requested medical records, because Community First did not document either the date the preliminary investigation was closed or the date the sample was selected.

Recommendation 4

Community First should implement processes to ensure it meets and adequately documents the following timelines:

- Samples of providers' claims related to suspected fraud, waste, or abuse are selected within 15 working days of completing a preliminary investigation that had suspicious indicators of fraud, waste, or abuse.
- Medical records, dental records, and encounter data related to claims selected for review are requested within 15 working days of choosing the sample.
- The review of requested medical records, dental records, and encounter data is completed within 45 working days of receipt.

Management Response

Action Plan

1. On March 17, 2022, the creation of a Preliminary Investigation Checklist form and an Extensive Investigation Checklist form was implemented to assist SIU staff with ensuring documentation of each of the required elements of an extensive investigation. The forms include documentation that:
    - Samples of providers' claims related to suspected fraud, waste, or abuse are selected within 15 working days of completing a preliminary investigation.
    - Medical records from claims selected for review are requested within 15 working days of choosing the sample for an extensive investigation.
    - The review of requested medical records is completed within 45 working days of receipt of medical records for an extensive investigation.

2. Staff members were retrained on documentation of all the required elements of an extensive investigation in the Extensive Investigation Checklist form.

3. A job aid will be developed for the Extensive Investigation Checklist form, and it will include (a) instructions for selection of the required sample size and (b) documentation of the completed medical record review within 45 working days of receipt of medical records.

4. As of March 4, 2022, weekly SIU staff meetings are in place to review current investigations to include the required elements of the extensive investigation to ensure (a) completion of timelines and (b) documentation of required criteria. SIU staff workload, prioritization of data review, records requests, and record reviews are discussed to ensure thorough documentation is completed and completion of investigations is timely.

Responsible Managers

- Director, Audit Services
- SIU Manager

Target Implementation Date

June 30, 2022

Monthly Reporting

The HHSC Uniform Managed Care Manual requires MCOs to submit a monthly report to OIG of all Medicaid fraud, waste, and abuse investigations opened by their SIU and the status of each investigation.[19] This report is called the Monthly Open Case List Report.

Chapter 5: The Monthly Open Case List Report Did Not Always Include Community First–Opened Investigations

Community First did not comply with the HHSC Uniform Managed Care Manual governing SIU functions of MCOs because it did not report all investigations to OIG. Community First provided information to OIG Audit of investigations conducted during 2020, which included 28 SIU investigations not reported to OIG on the Monthly Open Case List Report. In addition, a case that OIG referred to Community First was not (a) assigned a case number or (b) added to the Monthly Open Case List Report, even though a preliminary investigation was completed. Community First did not have a process in place to ensure all SIU investigations were reported to OIG on the Monthly Open Case List Report.

OIG uses information provided by MCOs to analyze potential fraud, waste, and abuse trends. Reporting all investigations through the Monthly Open Case List Report creates a central repository of potential and actual fraud, waste, and abuse. Inconsistent reporting by MCOs impairs OIG's ability to effectively analyze, detect, and pursue fraud, waste, and abuse.

Recommendation 5

Community First should implement processes to consistently log cases and ensure all opened investigations are reported on the Monthly Open Case List Report.

[19] Uniformed Managed Care Manual, Chapter 5.5.1, v. 2.1, (Apr. 26, 2019).

Management Response

Action Plan

1. The Monthly Open Case List Report previously included monitoring and auditing activities, in error. After review and discussion with the OIG MCO-SIU Coordinator on February 28, 2022, the Monthly Open Case List Report was revised to only reflect investigations in process; investigations that resulted in no findings of fraud, waste, or abuse; and investigations with findings of fraud, waste, or abuse. The monitoring and auditing activities were "closed" on the March 2022 Monthly Open Case List Report so that an accurate Monthly Open Case List Report can be initiated for the month of April 2022. Going forward, audits that result in findings of fraud, waste, or abuse will be initiated as an investigation and noted as open on the applicable Monthly Open Case List Report.
2. SIU staff members were educated regarding the Monthly Open Case List Report on March 4, 2022.
3. As of March 4, 2022, weekly SIU staff meetings are in place to review current investigations, to include the accurate submission of the Monthly Open Case List Report.
4. A job aid will be developed for the Monthly Open Case List Report, and it will outline the elements required on the report for investigations.

Responsible Managers

- Director, Audit Services
- SIU Manager

Target Implementation Date

June 30, 2022

OIG Referrals

In addition to reporting opened cases monthly,[20] Community First is required to assign an officer to report all investigations resulting in a finding of possible acts of fraud, waste, or abuse to OIG. The assigned officer must notify and refer these acts to OIG within 30 working days of receiving reports of possible acts of fraud, waste, or abuse identified in an SIU extensive investigation.[21] The referral must contain certain information, such as the investigative report identifying the allegation, statutes or regulations violated or considered, and the results of the investigation.[22,23]

Chapter 6: Possible Acts of Fraud, Waste, and Abuse Were Not Always Referred to OIG or Were Not Referred Within the Required Timeframe

Community First did not report extensive investigations that identified possible fraud, waste, or abuse as required. Specifically, of the 16 extensive investigations in OIG Audit's sample, Community First identified noncompliance in nine investigations. That noncompliance resulted in Community First educating the providers and, in some cases, recouping overpayments. However, Community First did not refer possible fraud, waste, or abuse for any of those nine investigations. In addition, Community First did not document its rationale for (a) determining when noncompliance was an error rather than fraud, waste, or abuse and (b) providing education rather than referring the investigation to OIG.

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[20] Uniformed Managed Care Manual (UMCM), Version 2.1, Chapter 5.5.1 (Apr. 26, 2019).

[21] 1 Tex. Admin. Code § 353.502 (c)(5)(D) (July 18, 2019) and 1 Tex. Admin. Code § 370.502 (c)(5)(D) (Mar. 1, 2012); Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, v. 2.29 (Sept. 1, 2019) through v. 2.30 (Mar. 1, 2020).

[22] 1 Tex. Admin. Code § 353.502 (c)(5)(D)(i) – (x) (July 18, 2019) and 1 Tex. Admin. Code § 370.502 (c)(5)(D) (Mar. 1, 2012); Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, v. 2.29 (Sept. 1, 2019) through v. 2.30 (Mar. 1, 2020).

[23] This requirement applies to all reports of possible acts of fraud, waste, or abuse except an expedited referral.

Figure 3 summarizes the disposition of those extensive investigations.

Figure 3: Errors Community First Identified in Sampled Extensive Investigations

16	Extensive Investigations were sampled
9	Community First identified a billing or processing error that it asserted did not constitute fraud, waste, or abuse
9	Lacked documentation to support why the error was not possible fraud, waste, or abuse
6	Identified overpayments totaling $19,391.47

Source: OIG Audit

MCOs are required to refer all investigations resulting in a finding of possible acts of fraud, waste, or abuse[24] and to remit half of any money recovered from such a referral to the OIG.[25] Community First did not consistently refer all possible acts of fraud, waste, and abuse to OIG; therefore, it also did not consistently remit half of the recouped amounts to OIG, as required. Not consistently referring all possible fraud, waste, or abuse also limits OIG's ability to effectively investigate potential fraud, waste, and abuse across the state's Medicaid programs.

Community First stated that its process for first-time instances determined to be a provider's billing or processing error is to send an education letter to the provider and to conduct an audit in 12 to 18 months. Although it provided education by sending a letter to the nine providers, the list of providers to audit in 12 to 18 months did not contain five of the nine providers with billing or processing errors. The Community First policy does not define the process to conduct audits in 12 to 18 months which may not allow Community First to identify patterns of noncompliant behavior.

[24] 1 Tex. Admin. Code § 353.502 (c)(5)(D) (July 18, 2019) and 1 Tex. Admin. Code § 370.502 (c)(5)(D) (Mar. 1, 2012); Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, v. 2.29 (Sept. 1, 2019) through v. 2.30 (Mar. 1, 2020).

[25] 1 Tex. Admin. Code § 353.505 (c) (July 18, 2019).

In addition, during the audit period, Community First referred a total of three cases to OIG that were not among the 23 investigations tested in the audit sample. However, two of the three cases were referred after 36 and 39 working days, respectively, rather than within 30 working days, as required. Not reporting referrals timely limits OIG's ability to coordinate and oversee efforts to prevent fraud, waste, and abuse throughout Texas HHS programs.

Recommendation 6

Community First should:

- Ensure all possible fraud, waste, and abuse findings are referred to OIG as required, and remit half of the money collected from such referrals.
- Document its rationale when it determines that the results of an investigation do not constitute possible fraud, waste, and abuse.
- Develop a documented process to ensure Community First conducts a follow-up audit of providers who have received education as the result of an extensive investigation.
- Implement processes to ensure the assigned officer submits referrals within 30 working days of receiving the report of possible fraud, waste, or abuse.

Management Response

Action Plan

1. A flowchart and policy are under development to outline the distinction between and specific requirements for (a) monitoring audits and (b) preliminary and extensive investigations.
2. An Audit Checklist form was developed to assist SIU staff with documentation of the source of the audit and the elements of an audit. The form includes:
    - Rationale when a determination is made that the results of an initial audit require provider education and training.

- Assurance that Community First conducts a timely follow-up audit of providers who have received education and training resulting from an initial audit.
- Criteria for when the results of a follow-up audit result in advancement to a preliminary investigation.

3. The creation of a Preliminary Investigation Checklist form was implemented to assist SIU staff with ensuring complete documentation of the source of the preliminary investigation and each of the required elements of a preliminary investigation. The form includes:
   - Rationale when a determination is made that the results of a preliminary investigation do not constitute possible fraud, waste, and abuse.
   - Criteria for when the results of a preliminary investigation result in advancement to an extensive investigation.
4. The creation of an Extensive Investigation Checklist form was implemented on March 17, 2022, to assist SIU staff with ensuring complete documentation for each of the required elements of an extensive investigation. The form includes:
   - Rationale when a determination is made that the results of an extensive investigation do not constitute possible fraud, waste, and abuse.
   - Assurance that the assigned officer submits referrals within 30 working days of receiving the report of possible fraud, waste, or abuse.
   - The Extensive Investigation Checklist form was revised on April 11, 2022, to allow notation of the date when remittance of half of the money collected from recoupments was submitted to OIG.
5. A job aid will be developed for the Audit Checklist form, the Preliminary Investigation Checklist form, and the Extensive Investigation Checklist form. The job aid will provide instructions for SIU staff to document the criteria and required documentation elements for each form.

Responsible Managers

- Director, Audit Services
- SIU Manager

Target Implementation Date

June 30, 2022

Fraud, Waste, and Abuse Training

Community First is required to provide fraud, waste, and abuse training annually to each employee and subcontractor who is directly involved in any aspect of Medicaid or CHIP.[26] Additionally, Community First must provide fraud, waste, and abuse training to all new MCO and subcontractor staff who will be directly involved with any aspect of Medicaid or CHIP within 90 days of their employment date.[27]

Community First is required to maintain a log for all training pertaining to fraud, waste, or abuse in Medicaid or CHIP. The log must include the name and title of the trainer, names of all staff attending the training, and the date and length of the training.[28]

Chapter 7: Staff and Subcontractors Did Not Always Receive Fraud, Waste, and Abuse Training in the Required Timeframes

Community First offered required fraud, waste, and abuse training that included:

- The definition of fraud, waste, and abuse
- How to report suspected fraud, waste, and abuse
- Who should receive the report of suspected fraud, waste, and abuse

However, opportunities exist for Community First to ensure required training is provided timely. Out of thirty employees tested, two employees (6.7 percent) did

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[26] 1 Tex. Admin. Code §§ 353.502 (c)(6)(A) (July 18, 2019) and 370.502 (c)(6)(A) (Mar. 1, 2012); Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, v. 2.29 (Sept. 1, 2019) through v. 2.30 (Mar. 1, 2020).

[27] 1 Tex. Admin. Code §§ 353.502 (c)(6)(D) (July 18, 2019) and 370.502 (c)(6)(D) (Mar. 1, 2012); Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, v. 2.29 (Sept. 1, 2019) through v. 2.30 (Mar. 1, 2020).

[28] 1 Tex. Admin. Code §§ 353.502 (c)(6)(G) (July 18, 2019) and 370.502 (c)(6)(G) (Mar. 1, 2012); Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, v. 2.29 (Sept. 1, 2019) through v. 2.30 (Mar. 1, 2020).

not receive fraud, waste, and abuse training within the required timeframes. Specifically:

- One of the five new employees hired during the audit scope did not receive training within 90 days of their hire date. The new hire received training 226 days after their hire date.
- One of the 25 employees hired prior to the audit scope did not receive the required annual fraud, waste, and abuse training. The employee did not receive training during the scope of this audit, from September 2019 through August 2020. Training for that employee was completed in December 2020.

Community First stated that it made changes in its training system that resulted in the automatic training reminders not being sent for some employees.

In addition, Community First did not verify that one subcontractor provided its employees with the annual fraud, waste, and abuse training. Not ensuring all employees and subcontractors receive fraud, waste, and abuse training may decrease the likelihood of detecting potential fraud, waste, and abuse.

Recommendation 7

Community First should ensure employees and subcontractors directly involved with any aspect of Medicaid or CHIP receive fraud, waste, and abuse training within 90 days of employment and annually.

Management Response

Action Plan

1. The Community First Fraud, Waste and Abuse policy outlines that employee training is completed within 90 days of employment and annually thereafter. Through an enhancement of the Community First electronic learning system, new employees will be identified and assigned the required fraud, waste, and abuse training upon entry into the staff management system. Then, on an annual basis, Community First will deploy the training to all staff members to allow for assurance of timely annual training. Employees who have not completed the

fraud, waste, and abuse training are contacted by email by the SIU Department. If training is not completed, a reminder is again sent to the employee, their supervisor, and the Chief Compliance Officer to alert leadership regarding delinquency.

2. Subcontractors who are directly involved with any aspect of Medicaid or CHIP are audited annually, at a minimum, to ensure the required fraud, waste, and abuse training has been received. The Fraud, Waste and Abuse Plan will be revised to reflect these requirements and will include that (a) subcontractor audit findings are relayed to the health plan Quality Council, which provides oversight for subcontractors, and (b) corrective action plans regarding fraud, waste, and abuse trainings are monitored by Quality Council on a quarterly basis, as appropriate.
3. A job aid will be developed (a) for instructions to access the Community First electronic learning system; (b) to identify the new and current employees assigned to the required 90-day and annual fraud, waste, and abuse trainings; and (c) to include the process for, when training is delinquent, contacting the employee, their supervisor, and the Chief Compliance Officer.

Responsible Managers

- Director, Audit Services
- SIU Manager

Target Implementation Date

June 2022

Appendix A: Objective, Scope, and Criteria

Objective and Scope

The audit objective was to determine whether Community First complied with selected state and contractual requirements related to (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to HHSC.

The audit scope covered SIU activities in 2020. The scope also included a review of significant controls and control components within the context of the audit objectives including the prevention, detection, investigation, recovery (as applicable), and reporting of fraud, waste, and abuse allegations through the end of fieldwork in February 2022.

Criteria

OIG Audit used the following criteria to evaluate the information provided:

- 4 Texas Government Code §§ 531.113 and 531.1131 (2015 and 2019)
- 1 Tex. Admin. Code §§ 353.501 through 505 (2012 and 2019)
- 1 Tex. Admin. Code §§ 370.501 through 505 (2004 and 2012)
- Uniformed Managed Care Manual, Version 2.1, Chapter 5.5.1 (2019)
- Uniform Managed Care Contract, v. 2.29 (2019) and 2.30 (2020)
- Community First Fraud, Waste, and Abuse Compliance Plan (2020)

Appendix B: Detailed Methodology

To accomplish its objectives, OIG Audit collected information for this audit through discussions and interviews with responsible staff at Community First, and through request and review of the following information:

- A description of the SIU function and organizational structure.
- A list of individuals in the SIU function, including their names, titles, and a description of their qualifications.
- Policies and practices associated with prevention, detection, investigation, disposition, and reporting of fraud, waste, and abuse.
- Data and other supporting evidence related to SIU performance, including investigations, recoveries, and referrals in 2020.
- Significant SIU system internal controls, including components of internal control, within context of the audit objectives.[29]
- Processes in place to prevent, detect, and investigate fraud, waste, and abuse and to report reliable information to HHSC.

OIG Audit interviewed responsible SIU personnel regarding their roles in SIU activities, evaluated policies and practices relevant to the SIU function, and reviewed relevant SIU activities related to investigations, including those related to prevention, detection, investigation, disposition, and reporting. OIG Audit determined that the data used in this audit was sufficiently reliable for the purposes of the audit.

[29] For more information on the components of internal control, see the United States Government Accountability Office's "Standards for Internal Control in the Federal Government" (Sept. 2014), https://www.gao.gov/assets/gao-14-704g.pdf (accessed Apr. 16, 2021).

Sampling Methodology

OIG Audit performed audit testing on samples selected based on the following approaches.

Elements of Investigations

OIG Audit examined Community First investigations for the period from September 1, 2019, through August 31, 2020. Community First had a total of 54 cases open during that timeframe. After an initial assessment of risks and associated controls, OIG Audit selected a risked-based sample of 32 cases stratified to include:

- Open cases
- Closed cases
- Cases that were referred to Community First from internal and external sources
- Cases involving Medicaid members
- Cases involving CHIP members
- Preliminary investigations
- Extensive investigations
- Cases involving recoupment of funds under and over $100,000
- Cases which were completed and did not have recoupment

The samples selected from the strata were not always proportionate to the total number of cases within the strata population and the total population of 54 cases and therefore it would not be appropriate to project the findings to the population.

Training

OIG Audit examined Community First's fraud, waste, and abuse training for the period September 1, 2019, to August 31, 2020. After an initial assessment of risks and associated controls, OIG Audit selected a random sample of 30 employees. Five of the employees sampled were new hires during the audit period while 25 of the employees sampled were hired prior to the audit scope. OIG Audit tested the timing of both new hire and annual fraud, waste, and abuse training.

Appendix C: Summary of Recommendations

For all recommendations, the responsible managers are the Director of Audit Services and the SIU Manager and the target implementation date is June 2022.

Table C: Summary of Recommendations to Community First Community Options

No.	Recommendation
1	Community First should implement processes to ensure it completes all required elements of preliminary investigations timely and sufficiently documents to demonstrate all required elements were completed within 15 workdays of the identification or reporting of suspected or potential fraud, waste, or abuse.
2	Community First should implement processes to ensure it records the date the allegation of fraud, waste, or abuse is received on its log.
3	Community First should ensure it selects at least the minimum sample sizes of members or claims.
4	Community First should implement processes to ensure it meets and adequately documents the following timelines: • Samples of providers' claims related to suspected fraud, waste, or abuse are selected within 15 working days of completing a preliminary investigation that had suspicious indicators of fraud, waste, or abuse. • Medical records, dental records, and encounter data related to claims selected for review are requested within 15 working days of choosing the sample. • The review of requested medical records, dental records, and encounter data is completed within 45 working days of receipt.
5	Community First should implement processes to consistently log cases and ensure all opened investigations are reported on the Monthly Open Case List Report.

6	Community First should: • Ensure all possible fraud, waste, and abuse findings are referred to OIG as required, and remit half of the money collected from such referrals. • Document its rationale when it determines that the results of an investigation do not constitute possible fraud, waste, and abuse. • Develop a documented process to ensure Community First conducts a follow-up audit of providers who have received education as the result of an extensive investigation. • Implement processes to ensure the assigned officer submits referrals within 30 working days of receiving the report of possible fraud, waste, or abuse.
7	Community First should ensure employees and subcontractors directly involved with any aspect of Medicaid or CHIP receive fraud, waste, and abuse training within 90 days of employment and annually.

Source: OIG Audit

Appendix D: Related Reports

- Aetna Better Health of Texas: Special Investigative Unit, AUD-21-023, August 18, 2021
- Audit of Medicaid and CHIP MCO Special Investigative Units: Molina Healthcare of Texas, AUD-20-011, May 22, 2020
- Audit of Medicaid and CHIP MCO SIUs: Blue Cross and Blue Shield of Texas, AUD-19-001, September 28, 2018
- Audit of Medicaid and CHIP MCO SIUs: Driscoll Health Plan, AUD-18-012, April 3, 2018
- Medicaid and CHIP MCO Special Investigative Units: Initiatives Underway to Improve Collaboration and Performance, IG-16-018, February 28, 2017
- Audit of Medicaid and CHIP MCO SIUs: Christus Health Plan SIU, IG-16-017, November 22, 2016
- Audit of Medicaid and CHIP MCO SIUs: Health Management Systems, Inc.: Third Party SIU, IG-16-15, August 29, 2016
- Audit of Medicaid and CHIP MCO SIUs: Superior HealthPlan, Inc. SIU, IG-16-014, August 26, 2016
- Audit of Medicaid and CHIP MCO SIUs: DentaQuest SIU, IG-16-013, August 24, 2016
- Audit of Medicaid and CHIP MCO SIUs: Texas Children's Health Plan SIU, IG-16-016, August 24, 2016
- Audit of Medicaid and CHIP MCO SIUs: Cigna Health-Spring SIU, IG-16-012, August 24, 2016
- Audit of Medicaid and CHIP MCO Special Investigative Units: Seton Health Plan, IG-16-011, June 9, 2016
- Audit of Medicaid and CHIP MCO Special Investigative Units: Informational Report, IG-16-010, February 5, 2016

Appendix E: Report Team and Distribution

Report Team

OIG staff members who contributed to this audit report include:

- Kacy J. VerColen, CPA, Deputy Inspector General of Audit and Inspections
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- Anton Dutchover, CPA, Audit Director
- Jeff Jones, CPA, CIGA, Audit Project Manager
- Kanette Blomberg, CPA, CIGA, Senior Managing Auditor
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Report Distribution

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- Maurice McCreary, Jr., Chief Operating Officer
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- Karen Ray, Chief Counsel
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Community First Health Plan

- Theresa Scepanski, President and Chief Executive Officer
- Susan Lomba, Chief Compliance and Quality Officer
- Angelica Ybarra, Director, Compliance and Risk Management
- Pamela Mata, Compliance Manager
- Helen Spaustat, Director, Audit Services

Appendix F: OIG Mission, Leadership, and Contact Information

The mission of OIG is to prevent, detect, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of OIG's mission and statutory responsibility includes:

- Sylvia Hernandez Kauffman, Inspector General
- Audrey O'Neill, Principal Deputy Inspector General, Chief of Audit and Inspections
- Susan Biles, Chief of Staff
- Erik Cary, Interim Chief Counsel
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Steve Johnson, Chief of Investigations and Reviews

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- Online: https://oig.hhs.texas.gov/report-fraud-waste-or-abuse
- Phone: 1-800-436-6184

To Contact OIG

- Email: OIGCommunications@hhs.texas.gov
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