TEXAS HEALTH AND HUMAN SERVICES COMMISSION

OFFICE OF INSPECTOR GENERAL

AUDIT OF STAR+PLUS SERVICE COORDINATION

UnitedHealthcare Community Plan

June 26, 2019
OIG Report No. AUD-19-018

HHSC OIG
TEXAS HEALTH AND HUMAN SERVICES COMMISSION
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WHY OIG CONDUCTED THIS AUDIT

The Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) Audit Division has completed an audit of service coordination for STAR+PLUS Level 1 members at UnitedHealthcare Community Plan (United), a Medicaid and CHIP managed care organization.

The objective of this audit was to evaluate whether United complied with contractual requirements for performing service coordination in support of STAR+PLUS Level 1 members. The scope of the audit included relevant activities during the period from September 1, 2016, through August 31, 2018.

WHAT OIG RECOMMENDS

HHSC Medicaid and CHIP Services (MCS), through its contract oversight responsibility, should ensure United:

- Provides two face-to-face visits annually for HCBS members and quarterly face-to-face visits for members residing in a nursing facility.
- Checks on HCBS members' receipt of approved services within four weeks of the ISP start date.
- Assesses members within 30 days of a member's entry into a nursing facility.

MCS should clarify requirements for the intervals between the two required face-to-face service coordination visits each year for HCBS members and consider establishing a maximum length of time allowed between the required visits.

For more information, contact:
OIG.AuditDivision@hhsc.state.tx.us

WHAT OIG FOUND

United assigned service coordinators to all 113 STAR+PLUS Level 1 members selected for testing; assessed, within 90 days of enrollment, 34 members whose STAR+PLUS enrollment date fell within the audit period; and completed individual service plans (ISPs) for all 44 members in the Home and Community-Based Services (HCBS) program.

However, 24 of 113 STAR+PLUS Level 1 members (21 percent) did not receive one or more of the required service coordination activities. Specifically:

- 19 of 113 members did not receive the number of face-to-face visits required by the contract.
- 9 of 44 members in the HCBS program did not receive contacts following up on the receipt of approved services within 4 weeks of the ISP date, as required by the contract.
- 4 of 21 members entering a nursing facility after February 28, 2017, did not receive assessments within 30 days of admission, as required by the contract.

The length of time between the two required HCBS member visits each year ranged from one to 14 months. Applicable contracts do not specify an expected interval between the two required visits each year, which may result in extended timeframes between service coordination visits for HCBS members.

United served 39,882 STAR+PLUS Level 1 members during the audit scope. The OIG Audit Division selected a statistically valid random sample of 113 of those members for testing. For certain tests, the sample of 113 Level 1 members was divided into subsets based on whether the member was served through the HCBS program, was in a nursing facility, or transitioned between both, because of the differing specific service coordination requirements for each group.

STAR+PLUS is a Texas Medicaid managed care program for adult members who have disabilities or are age 65 or older. Managed care organizations (MCOs) are required to provide service coordination to their STAR+PLUS members. A STAR+PLUS service coordinator from the MCO works with the member, the member's family, and with the member's doctors and other providers to help ensure the member receives needed medical and long-term service and supports.

The OIG Audit Division presented preliminary audit results, issues, and recommendations to MCS in a draft report dated May 30, 2019. MCS provided management responses indicating agreement with the recommendations and will require United to submit a corrective action plan to correct the issues noted. MCS further indicated that its Results Management unit is developing an enhanced service coordination oversight module as part of the biennial onsite operational review process that will include checking for MCO compliance with the contractual requirements noted in this audit. The MCS management responses are included in the report following each recommendation.

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INTRODUCTION

The Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) Audit Division has completed an audit of service coordination for State of Texas Access Reform Plus (STAR+PLUS) Level 1 members performed by UnitedHealthcare Community Plan (United),[1] a Medicaid and Children's Health Insurance Program (CHIP) managed care organization (MCO).

STAR+PLUS is a Texas Medicaid managed care program for adult members who have disabilities or who are age 65 or older. STAR+PLUS members receive Medicaid health care and long-term services and supports through an MCO they select from a choice of at least two available MCOs, based on where a member lives. Five MCOs in Texas participate in the STAR+PLUS program: Amerigroup, Cigna-HealthSpring, Molina Healthcare of Texas, Superior HealthPlan, and United. The STAR+PLUS program served an average of 527,331 members per month in state fiscal year 2017 (September 1, 2016, through August 31, 2017), of which United served an average of 114,719.[2]

The selected MCO assesses the STAR+PLUS member to determine the services the member needs. Based on the results of the assessment, the member is assigned a level ranging from Level 1 to Level 3. Level 1 members are those with the greatest medical need, and are generally members who are enrolled in the Home and Community-Based Services (HCBS) program or who are residents in nursing facilities. United served 39,882 STAR+PLUS Level 1 members in state fiscal years 2017 and 2018 (September 1, 2016, through August 31, 2018).[3]

MCOs are required to provide service coordination to their STAR+PLUS members. MCO service coordinators work with the member, the member's family, and with the member's doctors and other providers to help ensure the member receives needed medical and long-term service and supports.

[1] "UnitedHealthcare Community Plan" collectively refers to UnitedHealthcare Community Health Plan of Texas, L.L.C, which operates the STAR+PLUS Program in Harris, Jefferson, Nueces, and Travis counties, and UnitedHealthcare Insurance Company, which operates the STAR+PLUS program in the Medicaid Rural Service Areas Central and Northeast. Both contracting entities operate under the brand name "UnitedHealthcare Community Plan."

[2] "Medicaid and CHIP MCO Enrollment by SDA, Final (SFY 2017)," HHSC, https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/healthcare-statistics (accessed Mar. 13, 2019).

[3] HHSC Medicaid Premiums Payable System data.

MCO service coordinators:

- Identify physical health, mental health, and long-term services and supports needs, and develop a service plan.
- Assist members in receiving timely access to providers and covered services.
- Coordinate covered services with non-managed care programs.

HHSC Medicaid and CHIP Services (MCS) is responsible for overall management of the STAR+PLUS program and for oversight of MCOs, including United's administration of health care services through STAR+PLUS. Unless otherwise described, any year referenced is the state fiscal year, which covers the period from September 1 through August 31.

Objective and Scope

The objective of the audit was to evaluate whether United complied with contractual requirements for performing service coordination in support of STAR+PLUS Level 1 members.

The scope of the audit included relevant activities during fiscal years 2017 and 2018, which covers the period from September 1, 2016, through August 31, 2018.

Methodology

To accomplish its objectives, the OIG Audit Division collected information through discussions and interviews with management and staff at United and by reviewing documentation of service coordination activity United provided to a sample of STAR+PLUS Level 1 members, and by reviewing:

- Policies and practices associated with the provision of service coordination activities to members.
- Information systems that support service coordination activities.
- General controls around data and the IT systems used by service coordinators.

For STAR+PLUS Level 1 members selected for testing, the OIG Audit Division reviewed service coordination data obtained from United to corresponding eligibility information from OIG Data and Technology and individual service plans (ISPs) information from Texas Medicaid and Healthcare Partnership. The data was determined to be sufficiently reliable for audit purposes.

For the purposes of the audit, Level 1 members were defined as those in HCBS or nursing facility status at some time during the audit period, September 1, 2016, through August 31, 2018. For certain tests, the sample of 113 Level 1 members was divided into subsets based on whether the member was served through HCBS, was in a nursing facility, or transitioned between both, because of the differing specific service coordination requirements for each group.

For the 34 members whose STAR+PLUS enrollment date fell within the audit period, auditors tested whether each member was assessed within 90 days of enrollment.

For the 40 members being served by HCBS, auditors tested:

- Whether ISPs had been created for members.
- If service coordinators followed up with members regarding receipt of service in the members' ISPs.
- Whether members received the two annual face-to-face visits required during the audit period.

For the 69 members in nursing facilities, auditors tested:

- Whether members received the required quarterly face-to-face visits during the audit period.
- Whether 21 members who entered a nursing facility after February 28, 2017, received an assessment within 30 days of admission.

For the four members who transitioned from nursing facilities to HCBS or HCBS to nursing facilities, auditors tested:

- Whether members received required service coordination for applicable periods of time they were either in the HCBS program or a resident in a nursing facility.

The OIG Audit Division presented preliminary audit results, issues, and recommendations to MCS in a draft report dated May 30, 2019. MCS provided management responses indicating agreement with the recommendations and will require United to submit a corrective action plan to correct the issues noted. MCS further indicated that its Results Management unit is developing an enhanced service coordination oversight module as part of the biennial onsite operational review process that will include checking for MCO compliance with the contractual requirements noted in this audit. The MCS management responses are included in the report following each recommendation.

Criteria

- Uniform Managed Care Contract, Attachment B-1 §§ 8.3.2.1, 8.3.2.2, 8.3.2.3, 8.3.3.2, and 8.3.64 v. 2.19 (2016) through v. 2.25.1 (2018)

- STAR+PLUS Medicaid Rural Service Area Contract, Attachment B-1 §§ 8.1.36.1, 8.1.36.2, 8.1.36.3, 8.1.37.2, and 8.1.42 v. 1.10 (2016) through 1.14 (2018)

- STAR+PLUS Handbook, §§ 1200 and 1210 (2017 through 2018)

Auditing Standards

Generally Accepted Government Auditing Standards

The OIG Audit Division conducted this audit in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the issues and conclusions based on our audit objectives. The OIG Audit Division believes the evidence obtained provides a reasonable basis for our issues and conclusions based on our audit objectives.

RESULTS

United assigned service coordinators to all 113 STAR+PLUS Level 1 members; assessed, within 90 days of enrollment, 34 members whose STAR+PLUS enrollment date fell within the audit period; and completed ISPs for all 44 members in the HCBS program.

However, 24 of 113 STAR+PLUS Level 1 members (21 percent) did not receive one or more of the required service coordination activities. Details about these exceptions are given in Appendix A. Specifically:

- 19 of 113 members did not receive the number of face-to-face visits required by the contract.
- 9 of 44 members in the HCBS program did not receive contacts following up on the receipt of services within 4 weeks of the ISP date, as required by the contract.
- 4 of 21 members entering a nursing facility after February 28, 2017, did not receive assessments within 30 days of admission, as required by the contract.

Issues related to face-to-face visits, follow-up contacts for HCBS members, and initial assessments for nursing facility residents are discussed in the sections that follow.

FACE-TO-FACE VISITS

MCOs are required to provide a minimum of two face-to-face service coordination visits annually to STAR+PLUS Level 1 members in the HCBS program, and quarterly face-to-face visits to members residing in a nursing facility. Nursing facility face-to-face visits may include nursing facility care planning meetings or interdisciplinary team meetings. MCOs are required to maintain, and make available upon request, documentation verifying the occurrence of required face-to-face service coordination visits.[4]

[4] Uniform Managed Care Contract, Attachment B-1 § 8.3.2.1, v. 2.19 (Sept. 1, 2016) through v. 2.25.1 (July 1, 2018) and STAR+PLUS Medicaid Rural Service Area Contract, Attachment B-1 § 8.1.36.1, v. 1.10 (Sept. 1, 2016) through v. 1.14 (Mar. 1, 2018).

Issue 1: Service Coordinators Did Not Provide All Required Face-to-Face Visits

United service coordinators did not provide all required face-to-face visits to STAR+PLUS Level 1 members. Of 113 sampled STAR+PLUS Level 1 members, 19 (17 percent) did not receive one or more of the service coordination visits United should have provided.

There should have been 438 service coordination visits provided to the 113 sampled members. The 19 members who did not receive all visits should have received 103 visits, but received 69 visits. Overall, 34 (8 percent) of the 438 required visits were not provided. Members in HCBS and nursing facilities require different numbers of visits, and so are presented separately here. Table 1 summarizes the exceptions in Issue 1.

Table 1: Summary of Missing Face-To-Face Visits

Member Status	Number of Members	Number of Required Visits	Number of Visits Received	Missing Visits
HCBS	9	36	24	12
Transition to HCBS	1	4	1	3
HCBS Subtotal	10	40	25	15
Nursing Facility	8	59	44	15
Transition to Nursing Facility	1	4	0	4
Nursing Facility Subtotal	9	63	44	19
Total	19	103	69	34

Source: OIG Audit Division

HCBS Members

Of the 40 members in the sample who were HCBS program-only members, 9 (23 percent) received fewer than the required number of face-to-face service coordination contacts. Of the 4 members in the sample who transitioned between HCBS and nursing facilities, one (25 percent) received fewer than the required number of face-to-face visits while in HCBS status.

There should have been 116 service coordination visits provided to these 44 members. The 10 members who did not receive all visits should have received 40 visits, but received 25 visits. Overall, 15 (13 percent) of the 116 required visits were not provided.

For the ten members who received fewer than the required number of face-to-face service coordination visits:

- Six members did not receive one required visit
- Three members did not receive two required visits
- One member did not receive three visits

The incidence of missed visits declined from 15 percent in 2017 to 11 percent in 2018. Table 2 shows HCBS members and missed visits by fiscal year.

Table 2: HCBS Members and Missed Visits by Fiscal Year

Audit Results	2017	2018
Members in Sample[5]	29	29
Members With Missing Visits[6]	9	5
Required Visits for Members in Sample	60	56
Missing Visits	9	6
Percent of Required Visits Missed	15	11

Source: OIG Audit Division

The length of time between the two required HCBS member visits each year varied widely. For the 44 members, there were 59 instances where 2 visits were required in a year. The length of time between visits, for the purposes of this audit, are called intervals. The 59 intervals between visits ranged from one to 14 months. The interval between visits ranged from one to four months in ten instances. The interval between visits ranged from 12 to 14 months in 7 instances.

Applicable contracts do not specify an expected interval between the two required visits each year. The contracts say only that HCBS members "must receive a minimum of two face-to-face service coordination contacts annually."[7] The lack of clarity regarding expectations for the interval between the two required visits each year may result in extended timeframes between service coordination visits for HCBS members.

Nursing Facility Members

Of the 69 members in the sample who were nursing facility-only members, 8 (12 percent) received fewer than the required number of face-to-face service

[5] Of the 44 members in the sample, 6 should have received face-to-face visits in 2017 only, 4 should have received face-to-face visits in 2018 only, and 27 should have received face-to-face visits in both years. The remaining members in the sample did not require face-to-face visits.

[6] Service coordinator visits were missed in both years for some members.

[7] Uniform Managed Care Contract, Attachment B-1 § 8.3.2.1, v. 2.19 (Sept. 1, 2016) through v. 2.25.1 (July 1, 2018) and STAR+PLUS Medicaid Rural Service Area Contract, § 8.1.36.1, v. 1.10 (Sept. 1, 2016) through v. 1.14 (Mar. 1, 2018).

coordination contacts. Of the 4 members in the sample who transitioned between HCBS and nursing facilities, one (25 percent) received fewer than the required number of face-to-face visits while in a nursing facility.

There should have been 322 service coordination visits provided to these 73 members. The 9 members who did not receive all visits should have received 63 visits, but received 44 visits. Overall, 19 (6 percent) of the 322 required visits were not provided.

For the 9 members who received fewer than the required number of quarterly face-to-face service coordination visits:

- Four members did not receive one required visit
- One member did not receive two required visits
- Three members did not receive three required visits
- One member did not receive four required visits

There was no significant change in the incidence of missed visits from 2017 to 2018. Table 3 shows nursing facility members and missed visits by fiscal year.

Table 3: Nursing Facility Members and Missed Visits by Fiscal Year

Audit Results	2017	2018
Members in Sample[8]	50	55
Members With Missing Visits[9]	6	5
Required Visits for Members in Sample	151	171
Missing Visits	9	10
Percent of Required Visits Missed	6	6

Source: OIG Audit Division

By not ensuring service coordinators make the required number of face-to-face contacts with members, United did not meet its contractual obligations. Further, United may not have been aware of members' current conditions or ensure that members were receiving the appropriate services.

[8] Of the 73 members in the sample, 11 should have received face-to-face visits in 2017 only, 16 should have received face-to-face visits in 2018 only, and 39 should have received face-to-face visits in both years. The remaining members in the sample did not require face-to-face visits.

[9] Service coordinator visits were missed in both years for some members.

Recommendation 1.1

MCS, through its contract oversight responsibility, including the use of tailored contractual remedies as appropriate, should ensure United provides:

- Two face-to-face visits annually for HCBS members
- Quarterly face-to-face visits for members in a nursing facility

Management Response

Action Plan

Medicaid and CHIP Services Department (MCS) agrees with the recommendation. Managed Care Compliance and Operations (MCCO) will require United to submit a corrective action plan (CAP) to document how United will ensure members receive the contractually required number of visits for HCBS members and members in nursing facilities. Results Management (RM) is currently developing and will implement an enhanced service coordination oversight module as part of the biennial onsite Operational Review process. Compliance with contract requirements for service coordination visits will be included as part of this enhanced oversight module.

Responsible Manager

Director, Managed Care Compliance and Operations
Director, Results Management

Target Implementation Date

March 2020 to close CAP and implement oversight module

Recommendation 1.2

MCS should clarify requirements for the interval between the two required face-to-face service coordination visits each year for HCBS members and consider establishing a maximum length of time that may elapse between the required visits.

Management Response

Action Plan

MCS will use its service coordination workgroup to develop the appropriate maximum length of time that may elapse between required visits and consider application across managed care programs for consistency. MCS will implement a

contract change with the new maximum length of time effective 9/1/2020 in line with the annual managed care contract cycle.

Responsible Manager

Director, Policy and Program Development

Target Implementation Date

September 2020

FOLLOW-UP CONTACTS FOR HCBS MEMBERS

An MCO must complete an initial ISP, which is a written detail of the supports, activities, and resources required, for a STAR+PLUS Level 1 member once the member becomes a participant in the HCBS program. A service coordinator, or a member of the MCO's service coordination team, must contact a STAR+PLUS Level 1 member in the HCBS program no later than four weeks after the member's ISP start date to determine whether the services identified in the ISP are in place. After the initial ISP is established, the MCO must complete a new ISP for the member on an annual basis.[10]

Issue 2: Service Coordinators Did Not Always Follow Up Within Required Timeframes to Check on Members' Receipt of Approved Services

United did not provide evidence to show that service coordinators contacted all HCBS members within four weeks of the ISP start date to determine whether the members were receiving the services identified in their ISPs.

The 44 members in the sample who participated in the HCBS program had 53 ISPs with beginning dates during the audit period. For 11 of the 53 ISPs (21 percent), associated with 9 of the 44 members, United service coordinators did not contact the member within 4 weeks of the ISP start date. For seven members, there was no evidence of a timely follow-up contact in 2017. For four members, there was no evidence of a timely follow-up contact in 2018. For two of the nine members, there was no evidence of a timely follow-up contact in either year. Details about these exceptions are given in Table 4.

[10] Uniform Managed Care Contract, Attachment B-1 § 8.3.3.2, v. 2.19 (Sept. 1, 2016) through v. 2.25.1 (July 1, 2018) and STAR+PLUS Medicaid Rural Service Area Contract, Attachment B-1 § 8.1.37.2, v. 1.10 (Sept. 1, 2016) through v. 1.14 (Mar. 1, 2018).

Table 4: HCBS Members Without Evidence of a Timely Follow-Up Contact

Sample ID	2017	2018
6	✓	
13	✓	
29	✓	
30	✓	
51		✓
66	✓	✓
77	✓	✓
82		✓
108	✓	
Total	7	4

Source: OIG Audit Division

By not ensuring service coordinators verified the members' timely receipt of approved services, United did not meet its contractual obligations. In addition, United may not have been aware of members who did not receive approved services within four weeks of the ISP start date and may have been experiencing delays in obtaining services.

Recommendation 2

MCS, through its contract oversight responsibility, including the use of tailored contractual remedies as appropriate, should ensure United check on members' receipt of approved services within four weeks of the ISP start date.

Management Response

Action Plan

MCS agrees with the recommendation. MCCO will require United to submit a CAP to document how United will ensure United verifies members' receipt of approved services within four weeks of the ISP start date. RM is currently developing and will implement an enhanced service coordination oversight module as part of the biennial onsite Operational Review process. Compliance with contract requirements for service coordination verification of members' receipt of approved services within four weeks of the ISP start date will be included as part of this enhanced oversight module.

Responsible Manager

Director, Managed Care Compliance and Operations
Director, Results Management

Target Implementation Date

March 2020 to close CAP and implement oversight module

INITIAL ASSESSMENTS FOR NURSING FACILITY RESIDENTS

Effective March 1, 2017, MCOs are required to assess a STAR+PLUS Level 1 member within 30 days of the member's entry into a nursing facility.[11] No such requirement was in place for the first six months of the audit period.

Issue 3: Service Coordinators Did Not Always Assess Members in Nursing Facilities Within 30 Days of Admission

United service coordinators did not always conduct assessments of STAR+PLUS Level 1 members within 30 days of a member's entry into a nursing facility. Of the 21 members who entered nursing facilities during the audit period, 4 (19 percent) did not receive a timely assessment.

By not ensuring service coordinators assessed members within 30 days of the members' admission to a nursing facility, United did not meet its contractual obligations. Also, United may not have been timely aware of a member's current condition and may not have known to take appropriate action to ensure the member received appropriate care.

Recommendation 3

MCS, through its contract oversight responsibility, including the use of tailored contractual remedies as appropriate, should ensure that United's service coordinators assess members within 30 days of a member's entry into a nursing facility.

Management Response

Action Plan

MCS agrees with the recommendation. MCCO will require United to submit a CAP to document how United will ensure service coordinators assess members within 30 days of entry into a nursing facility. RM is currently developing and will implement an enhanced service coordination oversight module as part of the

[11] Uniform Managed Care Contract, Attachment B-1 § 8.3.6.4, v. 2.19 (Sept. 1, 2016) through v. 2.25.1 (July 1, 2018); STAR+PLUS Medicaid Rural Service Area Contract, Attachment B-1 § 8.1.42, v. 1.10 (Sept. 1, 2016) through v. 1.14 (Mar. 1, 2018); and STAR+PLUS Handbook, § 1210, rev. 17-1 (Mar. 1, 2017) through rev. 18-1 (Mar. 1, 2018).

biennial onsite Operational Review process. Compliance with contract requirements for service coordinator assessment of members within 30 days of a member's entry into a nursing facility will be included as part of this enhanced oversight module.

Responsible Manager

Director, Managed Care Compliance and Operations
Director, Results Management

Target Implementation Date

March 2020 to close CAP and implement oversight module

CONCLUSION

United assigned service coordinators to all 113 STAR+PLUS Level 1 members; assessed, within 90 days of enrollment, 34 members whose STAR+PLUS enrollment date fell within the audit period; and completed ISPs for all 44 members in the HCBS program.

However, 24 of 113 STAR+PLUS Level 1 members (21 percent) did not receive one or more of the required service coordination activities. Specifically:

- 19 of 113 members did not receive the number of face-to-face visits required by the contract.
- 9 of 44 members in the HCBS program did not receive contacts following up on the receipt of approved services within 4 weeks of the ISP start date, as required by the contract.
- 4 of 21 members entering a nursing facility after February 28, 2017, did not receive assessments within 30 days of admission, as required by the contract.

The OIG Audit Division offered recommendations to MCS which, if implemented, will result in United complying with its contractual requirements to:

- Provide two face-to-face visits annually for HCBS members and quarterly face-to-face visits for members residing in a nursing facility.
- Check on HCBS members' receipt of approved services within four weeks of the ISP start date.
- Assess members within 30 days of a member's entry into a nursing facility.

In addition, the OIG Audit Division offered a recommendation to MCS which, if implemented, will clarify requirements for the interval between the two required face-to-face service coordination visits each year for HCBS members.

The OIG Audit Division thanks management and staff at United for their cooperation and assistance during this audit.

Appendix A: Audit Exceptions Detail

The table below provides details about the members who did not receive one or more of the required service coordination activities for the following issues discussed in the report.

Issue 1: Service Coordinators Did Not Provide All Required Face-to-Face Visits

Issue 2: Service Coordinators Did Not Always Follow Up Within Required Timeframes to Check on Members' Receipt of Approved Services

Issue 3: Service Coordinators Did Not Always Assess Members in Nursing Facilities Within 30 Days of Admission

Sample ID	Issue 1	Issue 2	Issue 3
6	✓	✓	
13	✓	✓	
14			✓
25	✓		
29	✓	✓	
30	✓	✓	
51		✓	
52	✓		
55	✓		✓
59	✓		
64	✓		
66	✓	✓	
77	✓	✓	
82		✓	
86	✓		
87			✓
88	✓		
90			✓
92	✓		
93	✓		
101	✓		
107	✓		
108	✓	✓	
110	✓		
Total Members: 24	19	9	4

Source: OIG Audit Division

Appendix B: Report Team and Distribution

Report Team

OIG staff members who contributed to this audit report include:

- Steve Sizemore, CIA, CISA, CGAP, Audit Director
- Anton Dutchover, CPA, Audit Manager
- Bruce Andrews, CPA, CISA, Audit Project Manager
- Yania Munro, CFE, CGAP, Audit Project Manager
- JoNell Abrams, CIGA, Staff Auditor
- Ben Ringer, Staff Auditor
- Megan Pedersen, Staff Auditor
- Marcos Castro, CIGA, Staff Auditor
- Mo Brantley, Senior Audit Operations Analyst

Report Distribution

Health and Human Services

- Dr. Courtney N. Phillips, Executive Commissioner
- Cecile Erwin Young, Chief Deputy Executive Commissioner
- Victoria Ford, Chief Policy Officer
- Karen Ray, Chief Counsel
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- Enrique Marquez, Chief Program and Services Officer, Medical and Social Services Division
- Stephanie Muth, State Medicaid Director, Medicaid and CHIP Services
- Dee Budgewater, Deputy Associate Commissioner of Policy and Program, Medicaid and CHIP Services
- Grace Windbigler, Director, Managed Care Compliance and Operations, Medicaid and CHIP Services

- Juliet Charron, Director, Results Management
- Michelle Erwin, Director, Policy and Program Development

UnitedHealthcare

- Don Langer, Chief Executive Officer for Texas and Oklahoma
- Julie Garcia, President of STAR+PLUS Services
- Debbie Deska, Compliance Officer for Texas

Appendix C: OIG Mission 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
- Susan Biles, Chief of Staff
- Dirk Johnson, Chief Counsel
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Olga Rodriguez, Chief of Strategy and Audit
- Quinton Arnold, Chief of Inspections and Investigations
- Brian Klozik, Chief of Medicaid Program Integrity
- Tony Owens, Deputy IG for Third Party Recoveries
- David Griffith, Deputy IG for Audit
- Alan Scantlen, Deputy IG for Data and Technology
- Lizet Hinojosa, Deputy IG for Benefits Program Integrity
- Judy Hoffman-Knobloch, Assistant Deputy IG for Medical Services

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- Online: https://oig.hhsc.texas.gov/report-fraud
- Phone: 1-800-436-6184

To Contact OIG

- Email: OIGCommunications@hhsc.state.tx.us
- Mail: Texas Health and Human Services Commission
  Office of Inspector General
  P.O. Box 85200
  Austin, Texas 78708-5200
- Phone: 512-491-2000