

TEXAS HEALTH AND HUMAN SERVICES COMMISSION
OFFICE OF INSPECTOR GENERAL

**LONG-TERM SERVICES
AND SUPPORTS**

Inspection of Community Attendant Services



August 7, 2018
OIG Report No. INS-16-005



LONG-TERM SERVICES AND SUPPORTS: *Inspection of Community Attendant Services*

WHY THE OIG CONDUCTED THIS INSPECTION

An inspection was conducted to determine if Community Attendant Services (CAS) are billed to Medicaid and rendered to clients in accordance with program requirements.

The inspection objectives were to:

- Determine how the HHSC Community Supports section of Access and Eligibility Services (AES) provides oversight of the CAS program to ensure services are being rendered and properly billed.
- Determine if home health providers are effectively monitoring whether Community Attendant Services that are billed are actually provided to clients.

In 2015 and 2016, the OIG Medicaid Program Integrity (MPI) division initiated investigations due to complaints received about home health providers and attendants. MPI investigators involved in the cases observed select home health providers had incomplete or missing documentation of personal attendants' arrival and departure times and supporting medical necessity for the number of hours billed. Additionally, MPI investigators involved in the cases observed a lack of sufficient oversight of the CAS program by the Department of Aging and Disability Services/HHSC, specifically with the client enrollment process, the regional staff responsible for reviewing the statements of medical need, and the caseworker requirement to authorize services annually with an announced visit.

View the report online
For more information, contact:
IG_Inspections_Division@hhsc.state.tx.us

WHAT THE OIG FOUND

The OIG Inspections Division found that the HHSC Community Supports section has an eligibility and authorization process for Community Attendant Services (CAS). However, there is no requirement for a practitioner to conduct an in-person assessment with the client on a regular basis, and several required forms of documentation are missing from the home health provider's client files and the Service Authorization System Online (SASO).

The OIG Inspections Division reviewed a statistically valid random sample consisting of 60 clients from Region 6 - Gulf Coast, conducted onsite visits of eight home health providers in Region 6 - Gulf Coast, and interviewed staff at each home health provider's office. The results of that work indicated that home health providers use supervisory visits, surveys and questionnaires, direct client calls, and the Electronic Visit Verification (EVV) system as methods to monitor attendants providing services to their assigned clients. All eight of the home health providers interviewed stated that the EVV system is the primary oversight method used to monitor that services billed are actually provided to clients, even though EVV only provides reasonable assurance that an attendant was present at the client's home, not that services were rendered.

The OIG Inspections Division made the following observations:

- The CAS program does not require a practitioner to conduct an in-person assessment of the client for the initial Practitioner's Statement of Medical Need form or for annual reauthorization of services.
- At least four types of required documentation are missing from the home health provider's client file and SASO.

The OIG Inspections Division identified potentially erroneous overpayments for CAS in fiscal year 2016, Region 6 - Gulf Coast. The final estimated overpayment amount for isolating the missing Practitioner's Statement of Medical Need form was \$14,368,240. The final estimated overpayment amount for all four missing forms required by the home health provider was \$37,231,477.

Texas Medicaid spends over \$400 million statewide for 59,000 CAS clients annually, which equates to approximately \$6,779 per client, per year. In comparison, the average cost of nursing home care is \$55,000 annually for a semi-private room and \$72,500 annually for a private room. In fiscal year 2016, Texas Medicaid paid \$146,971,836 for 16,413 CAS clients in Region 6 - Gulf Coast, which is approximately \$8,954 per client.

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I. PURPOSE AND OBJECTIVES

The Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) Inspections Division conducted an inspection to determine if Community Attendant Services (CAS) are billed to Medicaid and rendered to clients in accordance with program requirements. The inspection focused on the following objectives:

- Determine how the HHSC Community Supports section of Access and Eligibility Services (AES) provides oversight of the CAS program to ensure services are being rendered and properly billed.
- Determine if home health providers are effectively monitoring whether Community Attendant Services that are billed are actually provided to clients.

II. BACKGROUND

CAS provides non-technical, medically related services to eligible adults and children whose health problems cause them to be functionally limited in performing activities of daily living (ADL) according to a Practitioner's Statement of Medical Need. Services are provided by an attendant. CAS is a Medicaid fee-for-service (FFS) program offered under the Primary Home Care program, within Long-Term Services and Supports (LTSS).

LTSS provides care for eligible adults and children with disabilities who need support due to: (a) age, (b) physical, cognitive, developmental, or chronic health conditions, or (c) other functional limitations that restrict their ability to care for themselves. Attendants provide a wide range of services to help clients live independently by assisting them with personal and healthcare needs. Attendants assist with ADLs, such as eating, bathing, and dressing, as well as instrumental ADLs, such as preparing meals, managing medications, and housekeeping.

Texas Medicaid spends over \$400 million statewide for 59,000 CAS clients annually, which equates to approximately \$6,779 per client, per year.¹ In comparison, the average cost of nursing home care is \$55,000 annually for a semi-private room and \$72,500 annually for a private room.²

In fiscal year 2016, Texas Medicaid paid \$146,971,836 for 16,413 CAS clients in Region 6 - Gulf Coast, which is approximately \$8,954 per client.^{3,4}

¹ Per HHSC AES Community Supports interview in November 2016.

² North Central Texas Area Agency on Aging, *Understanding your Options for Care in a Nursing Home or Assisted Living Facility, 2018*, <https://www.nctcog.org/cs/aging/pdf/nursinghome.pdf>

³ Per OIG Data and Technology (DAT)

⁴ Region 6 - Gulf Coast consists of the following counties: Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Harris, Liberty, Matagorda, Montgomery, Walker, Waller, and Wharton

Historically, the Department of Aging and Disability Services (DADS) was responsible for licensing, certifying, and surveying home and community support services agencies for compliance with state and federal laws and regulations. Currently, HHSC Regulatory Services is responsible for regulating licensing companies that provide attendant services. The HHSC AES Community Supports section is responsible for: (a) determining CAS eligibility for individuals applying for services, (b) determining the tasks and hours of attendant services needed, (c) enrolling individuals in the CAS program once eligibility is determined, (d) sending the service authorization form to the chosen home health provider, (e) monitoring satisfaction with the services, and (f) reporting contract issues to the contract manager. Intake specialists, caseworkers, and regional nurses within HHSC Community Supports assist with the various roles and responsibilities of managing the program. Community Supports uses the Community Care for Aged and Disabled (CCAD) handbook and the Texas Administrative Code (TAC) as the guidelines for CAS.⁵

In 2015 and 2016, the OIG Medicaid Program Integrity (MPI) division initiated investigations due to complaints received about home health providers and attendants. MPI investigators involved in the cases observed select home health providers had incomplete or missing documentation of personal attendants' arrival and departure times and supporting medical necessity for the number of hours billed. Additionally, MPI investigators involved in the cases observed a lack of sufficient oversight of the CAS program by DADS/HHSC, specifically with the client enrollment process, the regional staff responsible for reviewing the statements of medical need, and the caseworker requirement to authorize services annually with an announced visit.

In 2016, MPI recommended the OIG Inspections Division conduct a thorough review or inspection of CAS program policies and procedures. In the second quarter of fiscal year 2017, the OIG identified 46 percent of all complaints received through the fraud hotline were related to home health agencies and personal attendants.⁶ As a result of MPI's and HHSC Community Supports' recommendation, and the number of complaints received through the OIG Fraud Hotline, the OIG Inspections Division conducted an inspection focused on the CAS program. The scope of the inspection covered fiscal year 2016 in Region 6 - Gulf Coast.⁷

⁵ The CCAD handbook provides guidelines for services in a person's home or community for aging or disabled Texans who are not self-sufficient and may be subject to premature institutionalization or to abuse, neglect, or exploitation.

⁶ OIG Quarterly Report, March 2017, <https://oig.hhsc.texas.gov/sites/oig/files/reports/IG-Quarter-2-17-Report-2%20.pdf>

⁷ See *Scope of Inspection* in Appendix A.

CAS Eligibility and Authorization Process

The CAS eligibility and authorization process begins when an individual, family member, or other entity requests assistance with ADL. The intake specialist receives the request for the potential CAS client, documents the request in the Service Authorization System Online (SASO), and creates Form 2110, Community Care Intake, so a caseworker can be assigned according to the appropriate area within the region.^{8,9} The intake specialist sends the form to the correct unit to be assigned to the regional HHSC Community Supports caseworker.

Once assigned, the HHSC Community Supports caseworker schedules a visit with the potential CAS client and completes an in-person initial assessment, which includes Form 2060, the Needs Assessment Questionnaire and Task/Hour Guide.¹⁰ The questionnaire is used by the caseworker to collect and document the functional eligibility information of the client and the weekly hours of services to be rendered. According to the CCAD handbook, the Needs Assessment Questionnaire must be completed in its entirety, with each task given an impairment score to determine the client's capacity for self-care. The caseworker enters information from the completed Needs Assessment Questionnaire into SASO. In addition to the questionnaire, at the initial assessment the caseworker completes all of the other associated paperwork including, but not limited to: the Application for Assistance, Summary of Individual Need for Services, Medicaid Estate Recovery Program (MERP) Receipt Acknowledgement, Rights and Responsibilities, Opportunity to Register to Vote/Declination, and the Provider Agency Selection form, which allows the client to select a home health provider.

After completion of the initial assessment, the caseworker sends the Application for Assistance to HHSC AES Medicaid for the Elderly and People with Disabilities (MEPD) to determine financial eligibility for CAS. When MEPD notifies the caseworker that the client qualifies for CAS financial eligibility, the caseworker sends all of the other associated paperwork, including the Authorization for Community Care Services form to the home health provider to begin the CAS approval process and initiate services.¹¹ The Authorization for Community Care Services form is used to authorize or reauthorize services, change services, or terminate services. According to the CCAD handbook, all authorizations must be completed in SASO and copies must be kept in the case record for 3 years and 90 days. The home health provider must also maintain a current copy of the authorization form in the client's file.¹²

⁸ SASO is an online application used to create the authorizations for all Medicaid LTSS. Within SASO is a "forms wizard" that acts as a repository for all of the required forms and documentation. The Claims Management System cannot pay a provider if a valid Service Authorization record does not exist in SASO.

⁹ [Form 2110, Community Care Intake](#), last updated February 2013

¹⁰ [Form 2060, Needs Assessment Questionnaire and Task Hour Guide](#), last updated May 2015

¹¹ [Form 2101, Authorization for Community Care Services](#), last updated July 2013

¹² 40 Tex. Admin. Code § 47.73

Once services are authorized, the home health provider must develop a Service Delivery Plan for the client. The Service Delivery Plan is a document that is agreed upon and signed by the client, or their representative, and the home health provider. The plan indicates the location of service delivery, authorized tasks, weekly hours of service, service schedule, and frequency of supervisory visits by the home health provider. The home health provider must maintain a current copy of the Service Delivery Plan in the home health provider's client medical file.¹³ The completed plan ensures the home health provider and client are in agreement with the services to be rendered.

Next, the home health provider must obtain a completed Form 3052, Practitioner's Statement of Medical Need, signed by the practitioner.^{14, 15} The home health provider completes Part I: Individual Information and Part II: Provider's Statement, and then sends the form to the practitioner. The practitioner completes Part III: Practitioner's Statement and Certifications and Part IV: Medical Diagnoses and ICD-10 Codes, and then signs the Statement of Medical Need and sends it back to the home health provider. The practitioner must complete the form for initial CAS referrals and referrals for clients whose initial medical need for services was temporary. The home health provider sends the completed and signed form to the HHSC Community Supports regional nurse for review. According to the CCAD handbook, the HHSC Community Supports caseworker or regional nurse must keep the form in the client's file as part of the case record for 3 years and 90 days after the case is closed. Additionally, the home health provider must maintain documentation of the form in the client's file.¹⁶

Eligibility for CAS is pending until the HHSC Community Supports regional nurse provides final approval. The regional nurse makes an approval determination for authorization of services once they receive the completed and signed Practitioner's Statement of Medical Need form. All authorizations must be completed and maintained in SASO. Once the regional nurse approves CAS services, an attendant is assigned by the home health provider to provide services to the client. See Figure 1 for the complete CAS eligibility and authorization process.

Determining Services Billed and Rendered

The Electronic Visit Verification (EVV) system was designed to deter fraud, waste, and abuse in attendant services in Texas Medicaid. EVV is a telephone and computer-based system intended to verify when home service visits for Medicaid clients occur by creating electronic documentation of when a service visit begins

¹³ 40 Tex. Admin. Code § 47.45

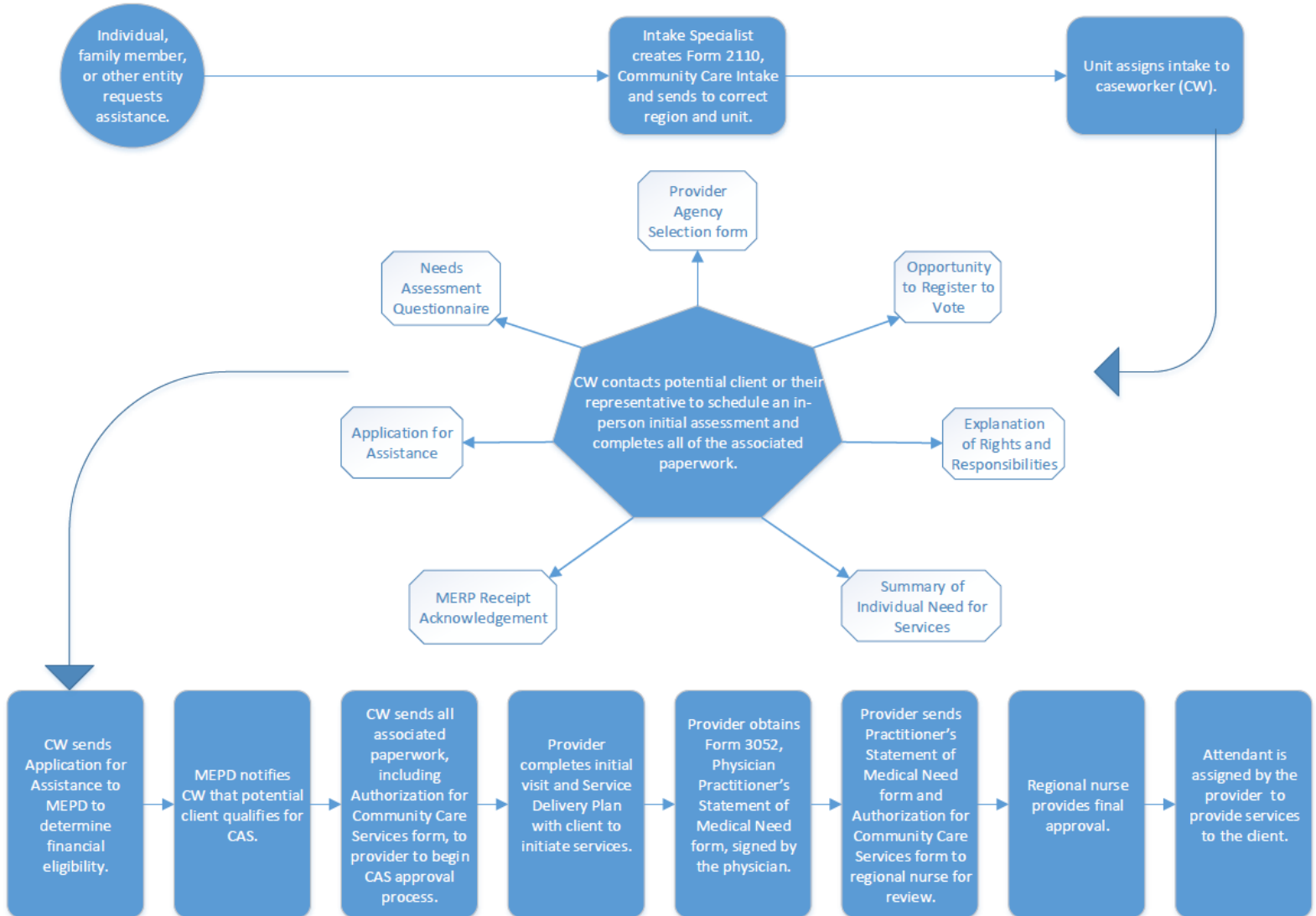
¹⁴ Practitioners include medical doctors, physician assistants, advanced practice nurses, and doctors of osteopathic medicine.

¹⁵ [Form 3052, Practitioner's Statement of Medical Need](#), last updated May 2018

¹⁶ 40 Tex. Admin. Code § 47.45

and ends. Texas implemented EVV to verify when clients receive select authorized services for which the state is billed and, as required by state rule, to adjudicate claims. HHSC Medicaid and CHIP Services (MCS) administers EVV, which is required for certain home and community-based services.¹⁷ CAS is required to use the EVV system to determine when attendants are in the homes rendering services.¹⁸

Figure 1. CAS Eligibility and Authorization Process



Source: Interview with HHSC AES Community Supports, December 21, 2016

¹⁷ See Table 1: Programs that Use EVV, in Appendix A.

¹⁸ 1 Tex. Admin. Code § 354.77

III. INSPECTION RESULTS

The OIG Inspections Division found that the HHSC Community Supports section has an eligibility and authorization process for CAS. However, there is no requirement for a practitioner to conduct an in-person assessment with the client on a regular basis, and several required forms of documentation are missing from the home health provider's client files and SASO.

The OIG Inspections Division reviewed a statistically valid random sample consisting of 60 clients from Region 6 - Gulf Coast, conducted onsite visits of eight home health providers in Region 6 - Gulf Coast, and interviewed staff at each home health provider's office.¹⁹ The results of that work indicated that home health providers use supervisory visits, surveys and questionnaires, direct client calls, and the EVV system as methods to monitor attendants providing services to their assigned clients. All eight of the home health providers interviewed stated that the EVV system is the primary oversight method used to monitor that services billed are actually provided to clients, even though EVV only provides reasonable assurance that an attendant was present at the client's home, not that services were rendered.

Observation 1: The CAS program does not require a practitioner to conduct an in-person assessment of the client for the initial Practitioner's Statement of Medical Need form or for annual reauthorization of services.

CAS requires a Practitioner's Statement of Medical Need form signed by the client's practitioner for the initial assessment. However, CAS does not require the practitioner or nurse to conduct an in-person assessment of the client for the initial assessment or for the annual reauthorization of services.²⁰ For the initial assessment, the practitioner is required to acknowledge that they have evaluated the client, have ongoing knowledge about the client's medical status, or that they have reviewed the client's file in the last 12 months.

For reauthorization of services, CAS only requires the caseworker to complete an Authorization for Community Care Services form. The Practitioner's Statement of Medical Need form is not required. As a result, the client's needs for CAS are not assessed over time by a practitioner or nurse and clients may not receive medically necessary services appropriate to their needs, or, they may be authorized to receive more services than necessary. Additionally, caseworkers and attendants are not clinically trained or required to assess a client's physical or functional state and may not be aware if a client has a critical health need that warrants a nurse or practitioner to conduct an in-person assessment.

¹⁹ See *Sampling Information: Home Health Providers and Client Records* in Appendix A

²⁰ 40 Tex. Admin. Code § 47.73

The Personal Care Services (PCS) program provides the same types of services as CAS, but for a different population of clients. Although similar in nature, each program is regulated by different TAC rules because CAS is a Medicaid FFS program, while PCS is a managed care program. The key differences are in the initial assessment of the client and annual reauthorization of services. Unlike CAS, PCS requires the practitioner to conduct an in-person assessment of the client when completing the Practitioner’s Statement of Medical Need form during the initial assessment. An in-person assessment of the client is also required for reauthorization of services. For PCS, the Practitioner’s Statement of Medical Need form must be signed by a practitioner, advanced practice nurse, or practitioner assistant who has personally examined the client in the last 12 months and reviewed all appropriate files.²¹

Observation 2: At least four types of required documentation are missing from the home health provider’s client file and SASO.

CAS requires several documents to be maintained in the home health provider’s client records and SASO. This inspection only focused on four: (1) Needs Assessment Questionnaire, (2) Service Delivery Plan, (3) Practitioner’s Statement of Medical Need, and (4) Authorization for Community Care Services.

The OIG Inspections Division reviewed a statistically valid random sample of home health provider client files and the associated information contained in SASO for 60 clients from home health providers in Region 6 - Gulf Coast, during fiscal year 2016 and found:²²

Table 1. Missing Documentation

Form	Issue	Percentage
Needs Assessment Questionnaire	Forms were missing from the home health provider’s client records as required by the CCAD handbook. The forms were also missing from the HHSC client files in SASO.	41%
Service Delivery Plan	Forms were missing from the home health provider’s client records as required by TAC.	18%
Practitioner’s Statement of Medical Need	Forms were missing from the home health provider’s client records as required by TAC. The forms were also missing from the HHSC client files.	22%
Authorization for Community Care Services	Forms were missing from the home health provider’s client records as required by TAC. The forms were also missing from the HHSC client files in SASO.	15%

Source: Data provided by Region 6.

²¹ 1 Tex. Admin. Code § 363.605

²² See *Sampling Information: Client Records* in Appendix A.

The CCAD handbook and Tex. Admin. Code requires documentation to be completed in SASO and copies of forms to be kept in the caseworker's case record and in the home health provider's client files.²³ Additionally, the Claims Management System cannot pay a provider if a valid service authorization record does not exist in SASO. Since all payments must have supporting documentation, the missing forms indicate that the services were not authorized and were paid in error. The OIG Inspections Division identified potentially erroneous overpayments for CAS in fiscal year 2016, Region 6 - Gulf Coast. The final estimated overpayment amount for isolating the Practitioner's Statement of Medical Need form was \$14,368,240. The final estimated overpayment amount for all four forms required by the home health provider was \$37,231,477.²⁴

²³ 40 Tex. Admin. Code § 47.45 and § 47.73

²⁴ See *Extrapolation Information* in Appendix A.

IV. CONCLUSION

The OIG Inspections Division completed an inspection to determine if Community Attendant Services are billed to Medicaid and rendered to clients in accordance with program requirements.

The OIG Inspections Division made the following observations:

- The CAS program does not require a practitioner to conduct an in-person assessment of the client for the initial Practitioner's Statement of Medical Need form or for annual reauthorization of services.
- At least four types of required documentation are missing from the home health provider's client file and SASO.

The OIG Inspections Division identified potentially erroneous overpayments for CAS in fiscal year 2016, Region 6 - Gulf Coast. The final estimated overpayment for isolating the Practitioner's Statement of Medical Need form was \$14,368,240. The final estimated overpayment amount for all four forms required by the home health provider was \$37,231,477.²⁵

The OIG Inspections Division thanks HHSC Access and Eligibility Services, OIG Data and Technology, and Regions 6 and 7 home health providers for their cooperation and assistance during this inspection.

²⁵ See *Extrapolation Information* in Appendix A.

V. APPENDICES

Appendix A: Methodology

Scope of Inspection:

In order to geographically focus the inspection, OIG Data and Technology (DAT) conducted an initial review of CAS claims for fiscal years 2015 and 2016 across all HHSC regions. Analysis of the data suggested that Region 3 - Metroplex, Region 6 - Gulf Coast, and Region 11 - Lower South Texas had the highest utilization and expenditures of CAS in fiscal years 2015 and 2016. A closer look at the data suggested that Region 6 - Gulf Coast had decreased client enrollment, yet higher expenditure in fiscal year 2016 compared to fiscal year 2015. Therefore, the scope of this inspection was narrowed to Region 6 - Gulf Coast.

Table 2. Programs that Use EVV

Program	Services
STAR+PLUS Dual Eligible Integrated Care Demonstration	<ul style="list-style-type: none"> • Personal assistance services (PAS) • Personal care services (PCS) • In-home respite services • Community First Choice (CFC) - PAS and Habilitation (HAB)
STAR Health	<ul style="list-style-type: none"> • PCS • CFC (PAS/HAB)
STAR Kids (effective Nov. 1, 2016)	<ul style="list-style-type: none"> • PCS • In-home respite services • Flexible family support services • CFC (PAS/HAB)
Acute-care Fee for Service	<ul style="list-style-type: none"> • Comprehensive Care Program - PCS • CFC (PAS/HAB)
Community Living Assistance and Support Services (CLASS)	<ul style="list-style-type: none"> • In-home respite services • CFC (PAS/HAB) as of June 1, 2015
Medically Dependent Children Program (MDCP)	<ul style="list-style-type: none"> • In-home respite services provided by an attendant • Flexible family support services provided by an attendant
Community Attendant Services (CAS)	<ul style="list-style-type: none"> • PAS
Family Care (FC)	<ul style="list-style-type: none"> • PAS
Primary Home Care (PHC)	<ul style="list-style-type: none"> • PAS

Source: HHSC (<https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/electronic-visit-verification>)

Sampling Information: Home Health Providers

A population of home health providers was generated for Region 6 - Gulf Coast. The population was comprised of 392 home health provider contracts serving 28,043 clients across fiscal years 2015 and 2016. A sample of 68 home health providers serving a total of 5,621 clients was generated from the population. Home health providers who billed for services to less than 10 clients were excluded from the population.

The inspection team requested records from the 68 home health provider contracts, reviewed and analyzed the contracts, and documented the compliance score and overpayments for each. Based on the compliance score and overpayments, the team selected two home health providers from high compliance scores and two from low scores, as well as two home health providers from high overpayment balances and two from low balances to generate a final sample of eight home health providers for onsite visits.

Sampling Information: Client Records

A final population was generated for Region 6 - Gulf Coast. The population was comprised of 9,863 clients who received 12 months of services during fiscal year 2016 and a statistically valid random sample consisting of 60 clients was generated from the population.

Extrapolation Information

The final estimated amount for isolating the Practitioner's Statement of Medical Need Form is \$14,368,240. The lower limit of a two-sided 80 percent confidence level was used to estimate isolating Practitioner's Statement of Medical Need Form, resulting in a 90 percent likelihood that the actual amount of isolating Practitioner's Statement of Medical Need Form is greater than or equal to \$14,368,240.

The final estimated amount for all four forms required by the home health provider is \$37,231,477. The lower limit of a two-sided 80 percent confidence level was used to estimate all four forms required by the home health provider, resulting in a 90 percent likelihood that the actual amount of all four forms required by the home health provider is greater than or equal to \$37,231,477.

Standards

The OIG Inspections Division conducts inspections of the Texas Health and Human Services programs, systems, and functions. Inspections are designed to be expeditious, targeted examinations into specific programmatic areas to identify systemic trends of fraud, waste, or abuse. Inspections typically result in recommendations to strengthen program effectiveness and efficiency. The OIG Inspections Division conducted the inspection in accordance with Quality Standards for Inspection and Evaluation issued by the Council of the Inspectors General on Integrity and Efficiency.

Appendix B: Report Team and Report Distribution

Report Team

The OIG staff members who contributed to this OIG Inspections Division report include:

- Lisa Pietrzyk, CFE, CGAP, Director of Inspections
- Xavier Ortiz, Inspections Manager
- Robin Zenon, BSN, RN, CPC, Inspection Team Lead
- Kenin Weeks, Inspector
- Amelia Lay, BSN, RN, Inspector
- Christopher Henry, Investigator
- Coleen McCarthy, MS, CHES[®], Program Specialist
- Laura Cadena, Investigative Data Analyst
- Xiaoling Huang, Chief Statistician
- Junqun Xiong, Statistical Analyst

Report Distribution

Texas Health and Human Services:

- Cecile Erwin Young, Acting Executive Commissioner
- Victoria Ford, Chief Policy Officer
- Karen Ray, Chief Counsel
- Enrique Marquez, Chief Program and Services Officer
- Wayne Salter, Deputy Executive Commissioner, Access and Eligibility Services
- Stephanie Muth, Deputy Executive Commissioner, Medicaid and CHIP Services
- Todd B. Byrnes, Deputy Associate Commissioner, Eligibility Operations
- Ivan Libson, Deputy Associate Commissioner, Program Enrollment and Support
- Karin Hill, Director, Internal Audit

Appendix C: OIG Mission and Contact Information

Inspector General Mission

The mission of the OIG is to prevent, detect, and deter fraud, waste, and abuse through the audit, review, 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
- Anita D'Souza, OIG Chief Counsel and Chief of Staff
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Olga Rodriguez, Chief Strategy Officer
- Lizet Hinojosa, Deputy IG for General Investigations
- Brian Klozik, Deputy IG for Medicaid Program Integrity
- David Griffith, Deputy IG for Audit
- Quinton Arnold, Deputy IG for Inspections and Investigations
- Alan Scantlen, Deputy IG for Data and Technology
- Judy Knobloch, Assistant Deputy IG for Medical Services

To obtain copies of OIG reports

- OIG website: <https://oig.hhsc.texas.gov/>

To report fraud, waste, and abuse in Texas HHS programs

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

To contact the Inspector General

- Email: OIGCommunications@hhsc.state.tx.us
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