

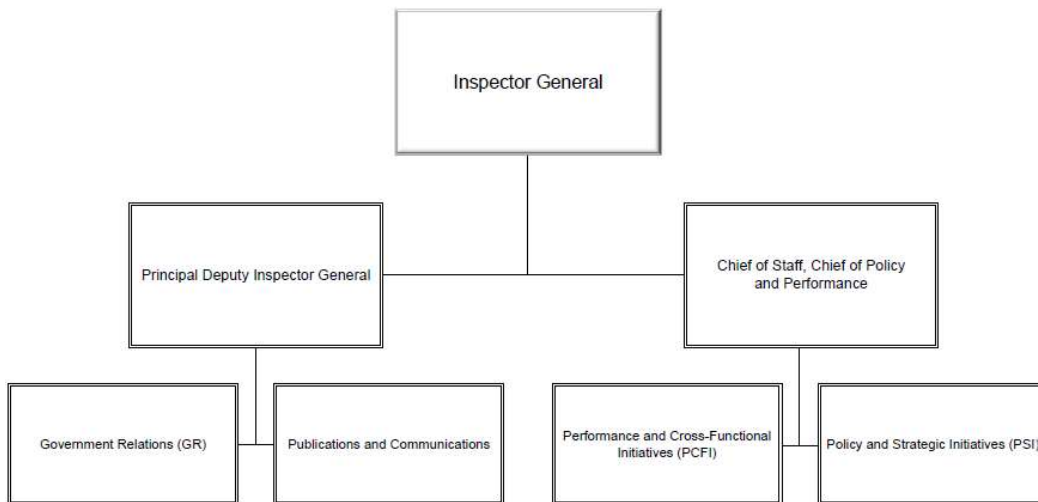
VII. Guide to Agency Divisions and Programs

Office of Inspector General

Established by the Texas Legislature in 2003, the Health and Human Services (HHS) Office of Inspector General (OIG) safeguards the integrity of the state’s health and human services programs and ensures the health and welfare of program clients. The OIG achieves this by overseeing health and human services activities, providers, and clients through compliance and enforcement measures aimed at identifying and reducing fraud, waste, and abuse (FWA). Additionally, OIG recovers taxpayer dollars and strives to enhance the efficiency and effectiveness of programs across HHS. OIG also receives reports of FWA from the public, government agencies, and health and human services providers.

Administration

Figure 1. OIG organizational chart.



A. Division or program information:

Name of division or program: Administration

Location within the agency: OIG

Contact name: Susan Biles, Principal Deputy Inspector General

Statutory citation: Texas Government Code, Sections 544.0103 (duties of the office) and 544.0101 (appointment of the Inspector General)

B. Objective and major activities:

Administration is comprised of the Inspector General, the Principal Deputy Inspector General Division, and the Chief of Staff Division.

Inspector General

The Inspector General, appointed by the Governor, manages all agency functions and priorities. The Inspector General is accountable for all OIG activities, directs all OIG initiatives and budgets, and represents the OIG with policymakers and stakeholders.

Principal Deputy Inspector General Division

The Principal Deputy Inspector General supports the Inspector General in the execution of OIG priorities and OIG day-to-day operation and administration. The division includes the Communications and Government Relations (GR) teams, which focus on engaging with and ensuring timely responses to OIG critical stakeholders and coordinating OIG-wide initiatives and special projects.

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

Government Relations: Serves as the primary liaison between OIG, executive and legislative branches, and key stakeholders. GR develops legislative initiatives and budget requests in addition to monitoring and analyzing legislation with an impact on the OIG. Additionally, GR oversees implementation of new laws, assists legislative offices with constituent inquiries, and communicates with stakeholders. GR ensures executive and legislative leadership offices remain informed about key developments within the OIG.

Chief of Staff Division

The Chief of Staff supports the Inspector General by providing counsel, helping to manage OIG priorities, coordinating projects and initiatives across all OIG areas, and ensuring OIG strategic initiatives are successfully implemented. The division includes the Policy and Strategic Initiatives (PSI) team and the Performance and

Cross Functional Initiatives (PCFI) team, which provide policy and project support across OIG divisions and act as liaisons between OIG, Health and Human Services Commission (HHSC), and outside stakeholders.

PSI: Led by a deputy inspector general who oversees staff that serve as the policy team and serves as a liaison between HHSC and the OIG. The team manages the OIG’s centralized risk review process to identify and evaluate potential areas of risk for OIG review, conducts policy research to support OIG functions, makes recommendations to HHSC for policy changes, contract changes, and liquidated damages or corrective action plans based on OIG work, develops and administers managed care training, and leads policy-related projects as needed.

PCFI: Led by a deputy inspector general who directs project managers and analysts in cross-divisional projects, including quality assurance, information technology project development and implementation, rules and audit coordination and consultation, facilitation, and ad hoc research.

C. Effectiveness and efficiency information:

Table 1. OIG metrics, fiscal year 2024.

Metric	Fiscal Year 2024
Principal Deputy Inspector General	
Statutorily Required Reports Published	9
Informational Articles Written for Stakeholders	12
Number of Issued OIG Update Newsletters	12
Reach of OIG Update Newsletter	20,708
Number of Media Inquiries Addressed	28
Number of Legislative Inquiries Addressed	132
Chief of Staff	
Program Integrity Topics Identified, Evaluated, and Approved	14
Policy Clarification Requests Completed	69
Policy and Managed Care Organization (MCO) Contract Changes Submitted	10
Managed Care Trainings Provided to OIG Staff	11
Implementation of Cross-Functional Projects	10
Facilitation of Rule Creation or Amendment	6

Metric	Fiscal Year 2024
Facilitation and Tracking of Responses to External Inquiries, Reviews, and Surveys	6
Initiation and Monitoring of New Information Technology Projects	7
Stakeholder Meetings Facilitated	11

D. History: Not applicable.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

Principal Deputy Inspector General: The GR team and Communications team are each managed by a director who reports to the Principal Deputy Inspector General. Formal policies and procedures exist and are reviewed annually for bill tracking, legislative inquiries, stakeholder inquiries, news media, and digital media management.

Chief of Staff: Led by the Chief of Staff, who also serves as the Chief of Policy and Performance. The two program areas, PSI and PCFI, are each led by a deputy inspector general. Policies, procedures, and job aids exist for quality control and other processes. OIG leadership directs the work of the teams and assigns projects throughout the fiscal year.

G. Funding: See "Agency Program Information" spreadsheet.

Table 2. Funding formulas.

General Revenue	Federal Funds	Other Funds
34.63%	31.78%	33.59% ¹

¹Other Funds includes interagency contract funding with the Texas Department of Family and Protective Services (DFPS) (25 percent) and the Texas Department of State Health Services (DSHS) (8 percent).

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

Principal Deputy Inspector General: Work with other governmental entities on an ad hoc basis to address specific issues that arise or to assist OIG program areas in

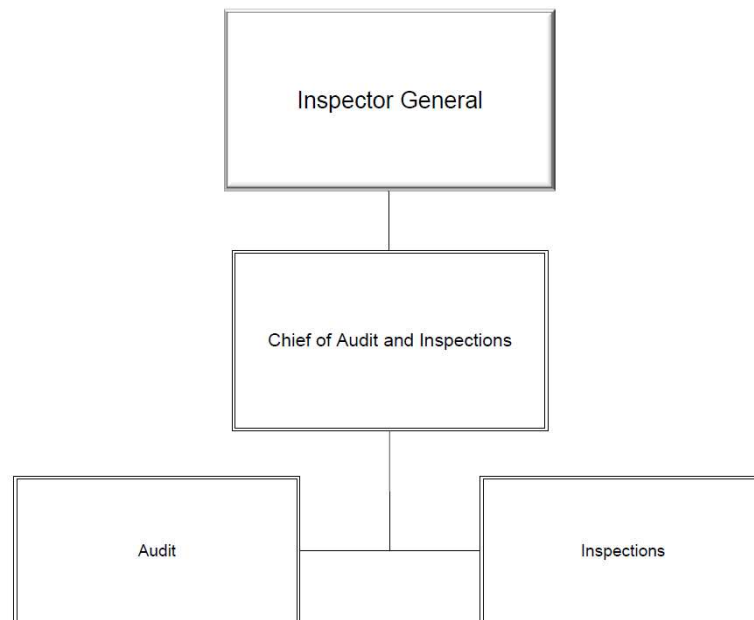
connecting with appropriate entities. This may include, but is not limited to, local law enforcement, prosecutorial entities, federal law enforcement, and regulatory entities.

Chief of Staff: The PCFI team coordinates with the HHSC Office of Audit and Compliance (OAC), OIG leadership and other OIG units to respond to audits, reviews, and other information requests from the U.S. Government Accountability Office (GAO), HHS-Office of Internal Audit, U.S. Department of Health and Human Services' (DHHS) Office of Inspector General, U.S. DHHS Centers for Medicare & Medicaid Services (CMS), U.S. Social Security Administration, auditors contracted by U.S. DHHS or Texas HHS, and other third-party auditors. The PCFI team also facilitates and coordinates meetings with other states' offices of inspectors general and program integrity offices.

J-M. Barriers and Challenges, Additional, Regulatory, and Complaint Information: Not applicable.

Audit and Inspections

Figure 2. Audit and Inspections organizational chart.



A. Division or program information:

Name of division or program: Audit and Inspections

Location within the agency: OIG

Contact name: Kacy VerColen, Chief of Audit and Inspections

Statutory citation: Texas Government Code, Sections 544.0103, 544.0109, 544.0354(b)(1), 544.0108(b) and 544.0109(1)

B. Objective and major activities:

The Audit and Inspections Division is comprised of the following units:

Audit: To help identify and reduce FWA, the Audit team conducts risk-based performance audits related to (a) the accuracy of medical provider payments, (b) the performance of HHS agency contractors, subcontractors, and grantees, (c) programs, functions, processes, and systems within HHS, and (d) local mental and behavioral health authorities. OIG Auditors also perform risk-based follow-up assessments to determine the resolution status of prior audit issues and limited scope audits of provider claims identified as outliers through data analysis algorithms to further assess the risk identified. Audits and reviews are performed in compliance with the Generally Accepted Government Auditing Standards (Yellow Book).

Inspections: Conducts inspections of providers and MCOs that are focused on compliance with applicable statutes and contract provisions as well as FWA. Additionally, inspections evaluate HHS programs, systems, and functions for systemic issues to improve HHS. Inspectors also perform follow-up assessments of actions taken in response to previous inspections. Inspections adhere to the Quality Standards for Inspection and Evaluation (Blue Book).

C. Effectiveness and efficiency information:

Table 3. Audit and Inspections measures, fiscal year 2024.

Metric	Fiscal Year 2024
Audit	
Audits Completed ¹	34
Audit Recommendations ²	87
Inspections	
Inspections Completed ³	9

Metric	Fiscal Year 2024
Inspection Recommendations ⁴	9

¹ LBB performance measure, which includes the total number of reports issued by or on behalf of the OIG audit team.

² Includes the number of recommendations in reports completed by or on behalf of the OIG audit team.

³ Includes the number of reports issued by the inspections team.

⁴ Includes the number of recommendations in reports issued by the inspections team.

D. History:

The audit function has existed since OIG’s inception in 2003. The Inspections team was developed in fiscal year 2016 and became a part of the Audit division in fiscal year 2020.

Senate Bill 26, 88th Regular Session, 2023, added the requirement that OIG audit local mental and behavioral health authorities on a revolving basis.

E. Qualifications or eligibility requirements:

OIG does not have its own qualifications or eligibility requirements; however, it enforces program requirements as part of its oversight responsibilities.

F. Administration and key processes:

The Audit and Inspections division is comprised of auditors and inspectors, with directors providing oversight and support staff for coordinating quality review, editing, and distribution of final reports. The audit and inspection process includes three phases: planning, fieldwork (testing), and reporting. Throughout these phases, auditors and inspectors maintain regular communication with the auditee or inspectee.

Planning: During planning, staff consult with program subject matter experts and HHSC policy personnel to understand program operations and identify appropriate criteria for evaluation. They also perform interviews to gain insight into the entity’s processes and internal controls. In addition, data is often obtained to gain further knowledge of the entity’s operations and to assist with determining the sampling and testing methodologies to be used in fieldwork.

Fieldwork: Fieldwork involves applying knowledge gained during planning to identify potential gaps or control weaknesses. Auditors and inspectors request documentation to verify practices and address discrepancies. Any discrepancies

identified are discussed with the entity, which is given the opportunity to submit additional information to resolve identified issues.

Reporting: Following fieldwork, a draft report is prepared and shared with the entity for review. The entity may submit relevant documentation to clarify or resolve identified issues, and if appropriate, the draft report is revised. Auditees and inspectees are also invited to submit management responses outlining corrective actions to address the findings and recommendations.

All documentation from the planning, fieldwork, and reporting phases is stored in Teammate software, which also guides staff through each step to ensure compliance with applicable standards and internal procedures.

G. Funding: See "Agency Program Information" spreadsheet.

Table 4. Funding formulas.

Department	General Revenue	Federal Funds	Other Funds
Executive Management	34.63%	31.78%	33.59% ¹
Audit	50.49%	42.27%	7.24% ²
Inspections	30.67%	35.74%	33.59% ³

¹ Other funds include interagency contract funding with DFPS (25 percent) and DSHS (8 percent).

² Other funds include interagency contract funding with DFPS (6 percent) and DSHS (1 percent).

³ Other funds include interagency contract funding with DFPS (25 percent) and DSHS (8 percent).

H. MOUs and interagency agreements or contracts: Not applicable.

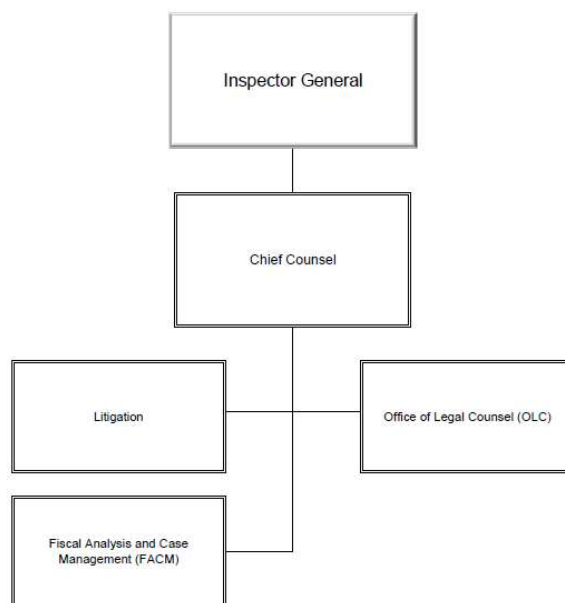
I. Relationship with other governmental entities:

Audit and Inspections work with CMS to give and receive training on Medicaid programs and to seek clarification on federal rules as needed. Additionally, Audit and Inspections works with the Texas Office of the Attorney General (OAG) by referring cases to them for further enforcement actions. Audit and Inspections also coordinate with the OAG Medicaid Fraud Control Unit (MFCU) and OAG Healthcare Program Enforcement Division (HPED) to deconflict potential concurrent audits, inspections, and investigations. Audit and Inspections collaborate with HHSC, DFPS, and the State Auditor’s Office (SAO) to avoid duplication.

J-M. Barriers and Challenges, Additional, Regulatory, and Complaint Information: Not applicable.

Chief Counsel

Figure 3. Chief Counsel organizational chart.



A. Division or program information:

Name of division or program: Chief Counsel

Location within the agency: OIG

Contact name: Erik Cary, Chief Counsel

Statutory citation: Texas Government Code, Sections 544.0102(b)(4) and 544.0052, Texas Human Resources Code, Section 32.039

B. Objective and major activities:

The OIG Chief Counsel Division provides legal counsel and support to the Inspector General. The OIG Chief Counsel Division works collaboratively with the HHSC Office of Chief Counsel, which provides legal support for administrative functions. The OIG Chief Counsel Division is comprised of the following:

Office of Legal Counsel (OLC): Provides legal advice and support to all aspects of the OIG's operations. OLC responsibilities include the following:

- Researching issues, draft policies, procedures, and rules;
- Reviewing and researching audit, inspection, and review criteria when requested;
- Recommending legislative considerations;
- Serving as liaison to HHSC for open records requests;
- Coordinating and processing expunction petitions and orders, bankruptcy filings, and proofs of claim;
- Reviewing draft contracts;
- Ensuring appropriate measures are taken to collect unpaid final debts arising from OIG actions; and
- Managing processes for the sharing of recoveries between OIG and Managed Care Organizations (MCOs) as authorized and required by state statute.

Litigation: Initiates administrative enforcement actions and sanctions resulting from OIG oversight activities and handles any associated appeals. Actions include the following:

- Providing notice and finalizing overpayments, penalties, payment holds, and provider enrollment terminations and exclusions against Medicaid providers for certain program violations; and
- Overseeing and managing the self-disclosure process, which involves providers self-reporting potential Medicaid violations.

Financial Analysis and Case Management (FACM): Supports the OIG Chief Counsel Division in the following ways:

- Processing referrals and open cases;
- Initiating accounts receivable for OIG Chief Counsel Division and other program areas;
- Estimating federal share liability, and initiating federal share payments and reclamation requests of federal share payments;
- Managing the enforcement and allocation of assessed final debt amounts and any associated collections activities, including, but not limited to,

coordinating with OLC to ensure final debts are appropriately accounted for and addressed in bankruptcy proceedings;

- Initiating collection remedies for unpaid final debts;
- Managing the process for sharing of recoveries between OIG and MCOs as authorized and required by state statute; and
- Overseeing the Texas OIG Exclusion Database.

C. Effectiveness and efficiency information:

Table 5. Chief Counsel measures, fiscal year 2024.

Metric	Fiscal Year 2024
Total Dollars Recovered ¹	\$17,158,657
Cost Avoidance from Excluded Provider – Ordered to Pay Restitution	\$2,959,267
Cases Opened	408
Cases Closed	484
Settlements ²	119
Exclusions	219
Payment Holds	6
Education Letters Sent	3

¹ Because Chief Counsel cases largely originate in other divisions, there is overlap in the dollars recovered. These amounts are not double counted in OIG reporting; however, they are included in each area's description in the Self Evaluation Report for informational purposes.

² While there is a potential for overlap between cases closed and the number of settlements, settlements are generally paid overtime, and cases are not considered closed until paid in full.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

OIG does not have its own qualifications or eligibility requirements; however, it enforces program requirements as part of its oversight responsibilities.

F. Administration and key processes:

The OIG Chief Counsel Division is led by the Chief Counsel, who oversees deputy inspectors general and directors for each of the following:

OLC: Provides general counsel functions for OIG. Most assignments are ad hoc in nature and at the request of a specific program area or OIG administration. Assignments are given to staff attorneys based on areas of expertise and workload. Project timelines vary based on the urgency of the request, the amount of research necessary, and the desired end-product – e.g., formal memo, email response, or meeting.

Litigation: Receives case assignments from FACM. Once a case is opened, the director of litigation assigns it to a staff attorney, who directs all necessary activities under the oversight of OIG Chief Counsel leadership.

Each week, staff attorneys present cases to the OIG Litigation Review Committee for initial input on legal theories and strategic direction. Key case decisions—such as issuing subpoenas, sending notices of administrative action, conducting examinations under oath, and evaluating settlement offers—are routed through the OIG Chief Counsel chain of command.

Case resolution timelines vary based on factors such as the need for additional evidence, the provider’s level of cooperation, the feasibility of settlement, and, if pursued, the duration of litigation. (See Appendix 19: Major Process Maps for OIG Enforcement Action Process Flow and OIG Appeals Flowchart.)

Financial Analysis and Case Management Section: FACM staff open cases based on referrals from OIG program areas, other state agencies (e.g., licensing boards, the OAG), provider self-reports, or self-generated matters from Litigation. Cases are then assigned, based on type and workload, to either FACM staff or Litigation attorneys, as directed by the director of litigation. FACM handles mandatory action cases, including exclusions, terminations, and contract cancellations.

In coordination with the Texas Medicaid & Healthcare Partnership (TMHP), FACM establishes accounts receivable for final debts resulting from OIG recoveries. FACM also manages collection activities for unpaid debts in collaboration with the OAG, OLC attorneys, and TMHP. FACM staff research and review federal data matches and take appropriate actions based on the results. They also coordinate bankruptcy matters, routing them to internal stakeholders and serving as the liaison with the HHSC Office of Chief Counsel Legal Services Division.

G. Funding: See “Agency Program Information” spreadsheet.

Table 6. Chief Counsel funding formulas.

Department	General Revenue	Federal Funds	Other Funds
Executive Management	34.63%	31.78%	33.59% ¹
Chief Counsel	50.11%	49.89%	0.00%

¹ Other funds include interagency contract funding with DSHS (25 percent) and DFPS (8 percent).

H. MOUs and interagency agreements or contracts:

OIG, OAG MFCU, and OAG HPED work together under a statutorily required MOU that ensures cooperation in detecting, investigating, and prosecuting Medicaid fraud. While OIG has jurisdiction over administrative matters, OAG has jurisdiction over criminal and civil fraud matters. Specifically, OAG MFCU conducts criminal investigations into allegations of fraud, physical abuse, neglect, and exploitation by health care providers in the Medicaid program. OAG's HPED is primarily responsible for civil enforcement of health care fraud. OIG refers potential fraud cases that may warrant civil or criminal enforcement action to OAG MFCU or OAG HPED.

Coordination activities include monthly meetings on cases being developed and a clear division of responsibilities. OAG HPED intervenes in privately filed *qui tam* actions and then elects to proceed in civil litigation. OIG provides investigative and supporting attorney resources to OAG HPED when requested by OAG and refers cases to OAG HPED that are more appropriately pursued in state district court. In addition to standing meetings, OAG and OIG units coordinate activities and strategies on an ad hoc basis, subject to ethical and legal restrictions on civil/criminal case coordination.

OLC maintains MOUs with licensing boards for the purpose of accessing criminal history record information obtained by the respective licensing boards. OIG uses this information during the enrollment and reenrollment of providers seeking to participate in the state's health care programs. The licensing boards include DFPS, DSHS, Texas Medical Board, Texas Board of Nursing, Texas State Board of Dental Examiners, Texas Department of Licensing and Regulation, Executive Council of Physical and Occupational Therapy Examiners, Texas Optometry Board, Texas Board of Chiropractic Examiners, Texas Behavioral Health Executive Council and Texas Board of Pharmacy.

OLC also maintains an memoranda of agreement (MOA) with the National Insurance Crime Bureau to allow the parties to share all information allowed by law to help prevent FWA.

I. Relationship with other governmental entities:

The OIG Chief Counsel Division works with federal agencies including the Department of Justice (DOJ), the Federal Bureau of Investigation (FBI), and CMS; state agencies including licensing agencies such as the Texas Department of Insurance and the Texas Department of Licensing and Regulation, as well as Texas and other states' criminal and civil Medicaid fraud control units; and local agencies including law enforcement and prosecutors to coordinate and deconflict criminal investigation and prosecution activities.

J. Barriers and challenges:

Challenge 1, Appeals: OIG due process procedures vary depending on the type of violation or dollar amount in question. These differences are driven by statute or rules and may involve varying deadlines for appealing adverse decisions, as well as different forums for dispute resolution.

Texas Government Code, Section 544.0507, governs appeals procedures for OIG investigations; however, in *Phillips v. McNeil*, 635 S.W.3d 620, 629-630 (Tex. 2021) the Texas Supreme Court held that the OIG failed to comply with this statute by not providing a hearing at the State Office of Administrative Hearings (SOAH) for an audit. The Court determined that the audit in question amounted to an "investigation of potential abuse," but the Court did not confirm whether the ruling would apply to OIG matters beyond the circumstances described in that case.

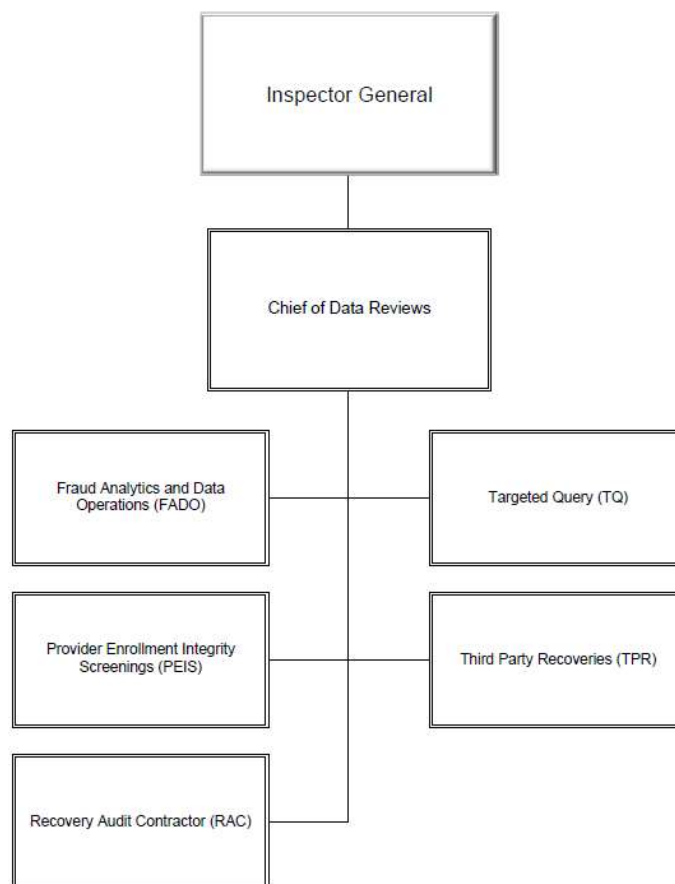
Challenge 2, CAF Holds: 42 CFR Section 455.23(a)(1) requires OIG (state Medicaid agency, etc.) to suspend all Medicaid payments to a provider if an investigation determines there is a credible allegation of fraud against that provider; this is known as a CAF (credible allegation of fraud) hold. Texas Government Code, Section 544.0303(d)(3)(B), which defines in State law when OIG may impose a payment hold requires the OIG to show that a person's CAF presents (i) a "significant risk to the State"; and (ii) a "threat to the integrity of the Medicaid" program. However, the state statute does not define any of the terms in these phrases nor does it provide assistance in interpreting this language.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Data Reviews

Data Reviews leverages data and technology to build tools and processes that effectively and efficiently prevent, detect, and deter FWA within Texas Medicaid and other health care programs, helping ensure that taxpayer funds for health and human services are spent properly.

Figure 4. Data Reviews organizational chart.



Fraud Analytics and Data Operations (FADO)

A. Division or program information:

Name of division or program: Fraud Analytics and Data Operations

Location within the agency: OAG, Data Reviews Division

Contact name: Diane Salisbury, Chief of Data Reviews

Statutory citation: Texas Government Code Sections 544.0103, 544.0451, 544.0152, and 544.0453

B. Objective and major activities:

FADO supports audits, investigations, inspections, and reviews through data analytics, data-informed research, sampling statistical models, and other support services described below. It is broken up into the following teams:

Fraud Analytics (FA): Responsible for performing advanced data analytics to proactively detect potential FWA by identifying trends and patterns that are used to self-initiate or support investigations, reviews, audits, and inspections. FA develops complex algorithms and models to analyze the behavior and billing practices of providers, clients, retailers, and MCOs.

FA also supports data initiatives projects, which focus on detecting program violations by Medicaid providers, using advanced algorithms to identify similar patterns of improper billing and reimbursement behavior across Medicaid providers that can be evidenced through data. Data initiative identified overpayments results in leads that are referred for investigation and litigation activities as appropriate.

Data Operations (DO): Oversees data management functions, conducts data-informed policy research, develops data intelligence solutions, and provides data system and application support to OIG. The team develops sampling and statistical models to support OIG investigations, reviews, audits, and inspections; designs, develops, and maintains OIG data visualization tools and operational dashboards; performs data queries and analyses; coordinates with the HHSC claims administrator and MCOs to collect and compile data to support OIG’s work; and serves as the liaison with HHSC Information Technology and external vendors to enhance and maintain OIG’s FWA technology systems.

C. Effectiveness and efficiency information:

Table 7. FADO measures, fiscal year 2024.

Metric	Fiscal Year 2024
Number of Data Requests Received ¹	562

Metric	Fiscal Year 2024
Number of Data Requests Completed ²	558
Number of Algorithms Executed ³	344
New Algorithms Developed ⁴	5

¹ This is the number of requests submitted to FADO. The data requests include ad hoc data pulls, data analysis and validation, provider analyses, statistical analysis and extrapolations, technical assistance with tools and systems, data research and analytical support, and special projects.

² This is the number of requests submitted by OIG divisions to FADO that have been completed. The data requests include ad hoc data pulls, data analysis and validation, provider analyses, statistical analysis and extrapolations, technical assistance with tools and systems, data research and analytical support, and special projects.

³ This measure is a count of "production" algorithms, which are algorithms that are programmed in a particular style with the intent to be replicated over time.

⁴ This measure is a count of "newly developed" algorithms. New algorithms are those that are developed in response to an identified behavior or pattern or in support of an investigation, audit, exploratory, or other ad hoc request.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

OIG does not have its own qualifications or eligibility requirements; however, it enforces program requirements as part of its oversight responsibilities.

F. Administration and key processes:

The two teams within FADO are each led by a deputy director who reports to the Chief of Data Reviews.

FA: Develops and maintains FWA detection algorithms and models, which include both rules-based approaches and the application of artificial intelligence/machine learning (AI/ML), and other statistical methods. FA delivers identified leads and risks from its algorithms and models to OIG stakeholders through its data analytics products, including dashboards and custom reports. In addition, FA is tasked with continuous monitoring and evaluation of algorithms and models to ensure sustained accuracy, effectiveness, and relevance over time. FA is responsible for maintaining documentation, metadata, and lineage information for algorithms, models, dashboards, and reports developed.

FA plays a supporting role in investigations, audits, inspections, and reviews by fulfilling ad-hoc data analytics requests, interpreting analytics outputs, providing

visual summaries, and offering consultative data and analytics expertise to OIG customers to support data-informed decision-making.

DO: Comprised of three operational teams: Data Research and Support, Statistical Analysis and Data Visualization, and Data Strategy.

The Data Research and Support team is responsible for data acquisition and validation of paid claims requests in support of OIG audits, investigations, inspections, and reviews; oversight and direction of all Medicaid Fraud Abuse Detection System (MFADS) projects; support for internal utilization review systems; coordination with external technology vendors/entities on behalf of OIG; and the development and administration of all OIG SharePoint sites.

The Statistical Analysis and Data Visualization team is responsible for the design and development of all statistically valid random samples and extrapolations for audits and investigations, provider analysis development and support, and administration of all OIG Tableau dashboards.

The Data Strategy team is responsible for assisting all OIG areas in the development of data strategy approaches (what data is available and how to structure/complete data requests) and data policy research and analysis functions.

G. Funding: See "Agency Program Information" spreadsheet.

Table 8. FADO funding formulas.

Department	General Revenue	Federal Funds	Other Funds
Executive Management	34.63%	31.78%	33.59% ¹
Data Operations	37.48%	40.54%	21.98% ²
Data and Technology	49.99%	50.01%	0.00%
MFADS Contract 50/50	50.00%	50.00%	0.00%
MFADS Contract 75/25	25.00%	75.00%	0.00%

¹ Other Funds includes interagency contract funding with DFPS (25 percent) and DSHS (8 percent).

² Other Funds includes interagency contract funding DFPS (17 percent) and DSHS (8 percent).

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

FADO provides data assistance to OAG MFCU, OAG HPED, and federal partners such as the U.S. Department of Health and Human Services Office of Inspector General, DOJ, and FBI. The data assistance provided includes data acquisition, data analysis, and summary reports to support active investigations and initiatives.

J-M. Barriers and Challenges, Additional, Regulatory, and Complaint Information: Not applicable.

Provider Enrollment and Integrity Screenings

A. Division or program information:

Name of division or program: Provider Enrollment Integrity Screenings

Location within the agency: OIG, Data Reviews Division

Contact name: Diane Salisbury, Chief of Data Reviews

Statutory citation: Texas Government Code, Sections 544.0151, 544.0152, 544.0153, 544.0154, and 544.0155

B. Objective and major activities:

The Provider Enrollment Integrity Screenings (PEIS) unit conducts federal and state-required screening activities for providers seeking to enroll in Texas Medicaid, Children’s Health Insurance Program (CHIP), and other state health care programs. This may include reviewing ownership, disclosures, licensure, criminal history, and site visits, based on the level of risk associated with the provider or provider type. The screenings prevent FWA and protect the health and safety of Texans by preventing providers who do not meet minimum standards from entering the program.

OIG screens all newly enrolling and re-enrolling providers, all high- and moderate-risk revalidating providers, and any other providers that match against federal or state databases or disclose information in their application requiring further review. On average, about 20-22 percent of all enrollment applications are routed to OIG for screening.

C. Effectiveness and efficiency information:

Table 9. PEIS Measures, fiscal year 2024.

Metric	Fiscal Year 2024
Percentage of Timely Completion (<10 days) ¹	93.83%
Provider Enrollment Applications Processed ²	26,538
Individuals Screened ³	76,086

¹ Texas Government Code, Section 544.0155 requires that the PEIS team complete all state and federally required screenings within 10 days of receiving a complete provider enrollment application. Compliance is calculated by comparing the number of applications processed within 10 days with the total number of applications processed in the reporting month.

² The total number of applications processed at the National Provider Identifier (NPI)-level.

³ Total number of individuals and entities screened by OIG as part of a provider enrollment application or informal desk review (IDR). Each provider enrollment application may contain multiple individuals (owners, managing employees, performing providers, etc.) who need to be screened.

D. History:

OIG’s provider enrollment screenings have increased with the deployment of the Provider Enrollment Management System (PEMS) in December 2021, which identifies more high-risk screenings and additional provider types required to undergo OIG screening to enroll in Texas Medicaid and other HHS programs. Prior to this system change, providers were required to submit a separate application for each provider type and practice location. PEMS allows for enrollment at the National Provider Identifier (NPI) level, meaning one application may include multiple different provider types and practice locations, substantially increasing the size and complexity of the application. All associated provider types and practice locations must be screened at the highest level applicable to any part of the NPI-based enrollment application. This has contributed to extended processing times for all aspects of provider enrollment, including the required screenings completed by PEIS.

E. Qualifications or eligibility requirements:

Providers seeking to enroll, re-enroll, or revalidate their enrollment in Texas Medicaid and other state health care programs are required to meet program requirements, as defined by federal and state laws and rules. These requirements apply to individual providers, performing providers, group providers, facility providers, and their owners, partners, officers/directors, and managing employees.

F. Administration and key processes:

Providers seeking to enroll, re-enroll, or revalidate their enrollment in Texas Medicaid or other health care programs are required to be screened based on their assigned risk level as a prerequisite for participation. Categorical risk levels are assigned by CMS or, for Medicaid-only provider types, HHSC (in collaboration with OIG) based on the provider type's risk of FWA. Many of the provider enrollment requirements are prescribed by CMS rules in the Code of Federal Regulations (CFR). More detailed technical guidance is provided by CMS through the [Medicaid Provider Enrollment Compendium](#) (MPEC).

The provider enrollment process in Texas requires close collaboration between Medicaid and CHIP Services (MCS), TMHP contractors, and OIG.

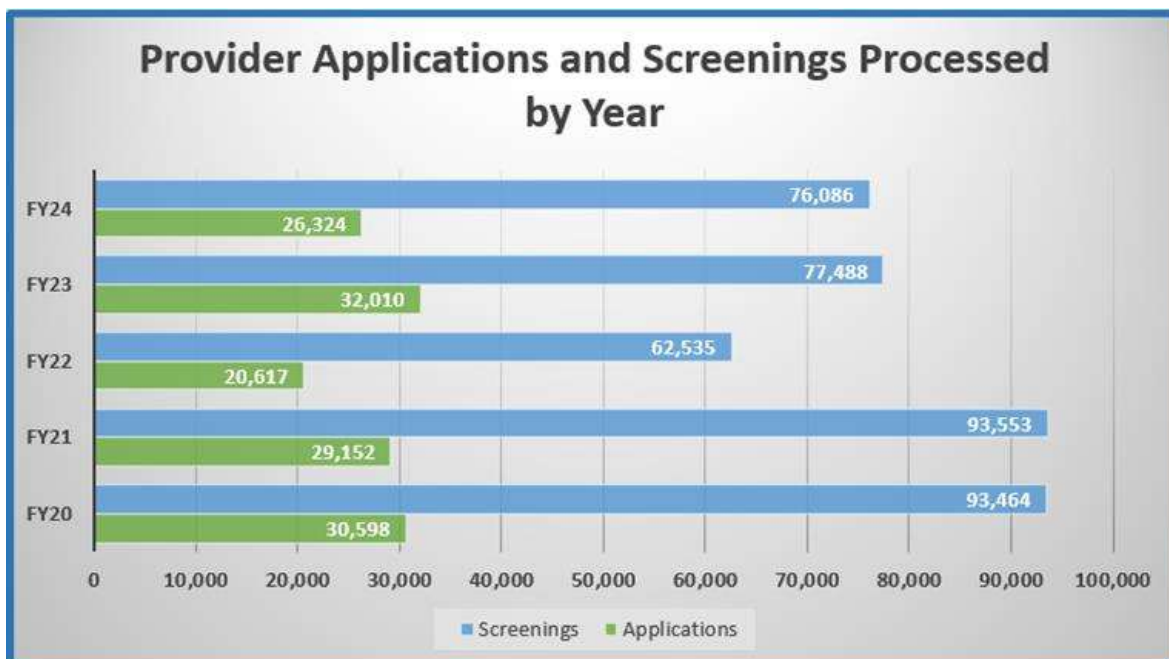
The PEIS team receives enrollment applications electronically via PEMS and conducts the following screening activities prior to making an enrollment recommendation and returning the application to TMHP. Certain activities apply only to moderate- and high-risk provider types, as assigned by CMS or, for Medicaid-only provider types, assigned by HHSC in collaboration with OIG.

- Criminal history background checks through the Texas Department of Public Safety (including FBI fingerprint checks for high-risk providers).
- License verification with the applicable licensing authority for the individual's occupation, including any actions taken against the individual's license (e.g., Texas Medical Board, Texas State Board of Dental Examiners, Texas Department of Licensing and Regulation, etc.).
- Review of any sanctions imposed (e.g., recoupments, payment holds, cancellations, debarments, suspension, exclusion, revocation, etc.).
- Medicare verification for moderate- or high-risk provider types that are required to be enrolled in Medicare prior to enrolling in Medicaid.
- Review site visit documentation for moderate- or high-risk providers.
- Review of disclosures (e.g., board orders, corporate integrity agreements, etc.).

On average, over the last five years, PEIS conducted approximately 80,625 individual screenings across 27,740 applications per year.

The following chart depicts the total number of applications processed and associated screenings completed by OIG for fiscal years 2020-24.

Figure 5. Provider applications and screenings processed, fiscal year 2020-24.



Note that the PEMS system was deployed in December 2021. Prior to PEMS, providers enrolled at the Texas Provider Identification (TPI) level (individual application per line of business/practice location). In PEMS, providers enroll at the National Provider Identification (NPI) level, meaning that applications are now more complex, including multiple programs, provider types, and locations.

G. Funding: See "Agency Program Information" spreadsheet.

Table 10. PEIS funding formulas.

Description	General Revenue	Federal Funds
PEIS	48.83%	51.17%
Fingerprint Checks	50.00%	50.00%

H. MOUs and interagency agreements or contracts:

MOUs for access to a licensing board’s criminal history record information are discussed in the OIG Chief Counsel’s response.

I. Relationship with other governmental entities:

CMS establishes many of the provider enrollment program integrity requirements that state enrollment processes must adhere to. Failure to appropriately screen and enroll providers in compliance with federal program integrity requirements may result in audit findings and potential loss or recoupment of federal funding.

PEIS works closely with HHSC MCS, Texas Medicaid Healthcare Partnership (TMHP) enrollment contractors, and CMS to ensure that health care professionals and medical entities are enrolled into Texas Medicaid and other state programs in accordance with state and federal requirements.

As described in previous questions, PEIS also works with professional licensing boards to validate licensure and examine board actions and orders.

J-M. Barriers and Challenges, Additional, Regulatory, and Complaint Information: Not applicable.

Third Party Recoveries

A. Division or program information:

Name of division or program: Third Party Recoveries

Location within the agency: OIG, Data Reviews Division

Contact name: Diane Salisbury, Chief of Data Reviews

Statutory citation: Human Resources Code, Sections 32.0421-32.0424 and 32.04242; Texas Government Code, Sections 532.0059 and 546.0403; 42 United States Code, Sections 1396p(b) and 1396a(a)(25), and 42 CFR Sections 433.135-433.154

B. Objective and major activities:

Under Section 1902(a)(25) of the Social Security Act, states are required to gather information about other liable third parties to ensure that Title XIX of the Social Security Act (Medicaid) funds are used for the payment of medical services only after all available third-party resources have been exhausted. With the exception of a few waiver programs, Medicaid is required to be the payor of last resort, meaning that any other third parties liable for a payment must pay before Medicaid. A third party is any individual, entity, or program liable for medical assistance provided to a Medicaid participant. Examples include private insurance carriers, cash medical assistance from child support arrangements, and responsible party insurance coverage related to accidents or injuries.

Third Party Recoveries (TPR) works to ensure that Medicaid is the payor of last resort by preventing payments and recovering Medicaid funds spent on services

that a third party is primarily responsible for paying. TPR also oversees the Medicaid Estate Recovery Program (MERP), a federally mandated program that recovers the costs of Medicaid long-term care benefits received by certain Medicaid recipients.

Note: TPR refers to the OIG unit; TPL refers to third-party liability processes, many of which are carried out by the Texas Medicaid Business Operations contractor.

C. Effectiveness and efficiency information:

Table 11. TPR measures, fiscal year 2024.

Metric	Fiscal Year 2024
Cost Avoidance ¹	\$168,645,943
TPR Total Identified Recoveries	\$949,264,071
TPR Gross Recoveries ²	\$276,794,427
TPL Gross Recoveries	\$76,180,540
Medicaid Estate Recovery Program Recoveries ³	\$5,855,903
Cash Medical Support Payment Recoveries	\$194,757,984
Liquidated Damages Recommended	\$125,000

¹ Cost avoidance is calculated based on the Medicaid-allowed portion of a claim that was submitted to Medicaid but denied due to the identification of other health insurance that should be the primary payor. The Medicaid allowed amount, rather than the billed amount, is counted for this measure in order to identify true cost savings to the program.

² This is used in the calculation of the LBB performance measure, Total Recoveries. It includes TPL, MERP, and Cash Medical Support Payment gross recoveries.

³ Recovery of the costs paid by Medicaid for long-term care benefits received by certain people on Medicaid after their death.

D. History:

The TPR unit has transitioned between HHSC and OIG over the years. Prior to 2015, TPR was part of OIG. In 2015, the TPR unit was moved to HHSC. In 2018, TPR returned to OIG.

E. Qualifications or eligibility requirements:

OIG does not have its own qualifications or eligibility requirements; however, it enforces program requirements as part of its oversight responsibilities.

F. Administration and key processes:

TPR is led by a director who reports to the Chief of Data Reviews.

The TPR unit is comprised of components described below. Texas relies on contractors to carry out these functions on behalf of the State, and the TPR team manages and oversees the related contracts and program functions.

TPR oversees a contract with the Texas Medicaid Business Operations contractor for the following:

- Identification of Liable Third Parties: This occurs either when clients report a liable third party (e.g., commercial insurance coverage) or when the State or its contractor identifies liable third parties through data-sharing and matching agreements.
- Cost Avoidance: When a primary payor is identified either through client disclosure or automatically through claims processing, claims are denied, and the provider is instructed to bill the other insurance first.
- Cost Recovery (Pay & Chase): When Medicaid or CHIP pays a claim, but data matching activities later determine that a primary payor should have been responsible, TPR seeks reimbursement from the liable third party (e.g., a commercial insurance carrier).
- Subrogation (Tort): When a Medicaid or CHIP client is injured, TPR seeks recovery of Medicaid or CHIP expenditures related to the client's injuries from any settlement with, or judgment against, a liable third party.

Additionally, TPR oversees:

- Cash Medical Support Payments: On behalf of TPR, OAG recovers cash medical support payments that are designated in a support order for medical purposes and that a child's caretaker has assigned to the State as a condition of Medicaid or CHIP eligibility.
- MERP: Involves the repayment of Medicaid expenditures from the estate of a deceased Medicaid recipient who received certain long-term care services through Medicaid, as required by 42 CFR Section 433.36 and the Social Security Act Section 1917(b).

Finally, MCOs are also required to cost avoid and recover from liable third parties. MCOs have 120 days to recover costs for prescriptions and medical services that should have been paid for by a third party. After 120 days, the state's TPR process will attempt to recover the funds and will then retain, in full, all recoveries received.

After 365 days from adjudication of a claim, the MCO loses all rights to pursue or collect any recoveries subject to TPR.

G. Funding: See “Agency Program Information” spreadsheet.

Table 12. TPR funding formulas.

Department	General Revenue	Federal Funds	Other Funds
Third Party Recoveries	50.00%	50.00%	
Motor Vehicle Program (MVP) Contract	50.00%	50.00%	
MERP Contract ¹			100.00%

¹ MERP is funded from appropriated receipts from estimated revenues in Fund 8044, which includes Medicaid revenue collections.

H. MOUs and interagency agreements or contracts:

OIG has an interagency contract with OAG for the reporting of Title IV-D child support case referrals where other insurance has been identified and for recovery of the associated cash medical support payments.

Additionally, OIG has an MOU with the Texas Comptroller’s Office (CPA) to identify potential recoveries in the Texas Achieving a Better Life Experience (ABLE) program. The ABLE program allows certain individuals to put funds aside in a protected savings account to be used for the individual’s care without counting against Medicaid eligibility resource limits. When an individual with an ABLE account passes away, the CPA notifies both TPR and the Texas Medicaid Business Operations contractor. If the individual received any Medicaid services during the time in which the ABLE account was in effect, the state may pursue recovery from remaining funds in the account.

I. Relationship with other governmental entities:

As discussed above, TPL works with OAG and CPA.

J-M. Barriers and Challenges, Additional, Regulatory, and Complaint Information: Not applicable.

Targeted Queries

A. Division or program information:

Name of division or program: Targeted Queries

Location within the agency: OIG, Data Reviews Division

Contact name: Diane Salisbury, Chief of Data Reviews

Statutory citation: Texas Government Code, Section 544.0102

B. Objective and major activities:

The Targeted Queries (TQ) unit uses data analytics to identify improper payments in Medicaid claims and works with providers to recover overpayments. The TQ model uses algorithms that can be replicated over time to detect ongoing patterns of waste or abuse in provider billing to recover misspent Medicaid funds for common errors or schemes. The model is also designed to identify lower-dollar overpayments that occur across a high volume of providers, such as payments made after a client’s date of death or billing for home health services when a client is hospitalized.

C. Effectiveness and efficiency information:

Table 13. TQ measures, fiscal year 2024.

Metric	Fiscal Year 2024
Dollars Recovered ¹	\$5,823,615
MCO Identified Overpayments	\$2,889,055
Fee for Service Identified Overpayments	\$3,719,384
Cases Opened	1,057
Cases Closed	1,278

¹ This is included in the LBB Measure, Total Dollars Recovered.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

OIG does not have its own qualifications or eligibility requirements; however, it enforces program requirements as part of its oversight responsibilities.

F. Administration and key processes:

TQ is led by a manager who reports to the Chief of Data Reviews. The TQ unit obtains retrospective payment review targets based on algorithms that detect potential FWA evidenced purely through data. The algorithms are typically run by either OIG’s FADO team or the TMHP Claims Administration contractor. The TQ unit confirms algorithm findings with applicable policy requirements, reviews the data, develops provider letters, and engages providers for potential recoveries.

G. Funding: See “Agency Program Information” spreadsheet.

Table 14. TQ funding formulas.

General Revenue	Federal Funds
50.00%	50.00%

H-M. MOUs, Relationships, Barriers and Challenges, Additional, Regulatory, and Complaint Information: Not applicable.

Recovery Audit Contractor

A. Division or program information:

Name of division or program: Recovery Audit Contractor

Location within the agency: OIG, Data Reviews Division

Contact name: Diane Salisbury, Chief of Data Reviews

Statutory citation: Texas Government Code, Sections 544.0504; 42 USC Section 1396(a)(a)(42)(B); and 42 CFR Sections 455.500-518.

B. Objective and major activities:

The Medicaid Recovery Audit Contractor (RAC) program is a federally required program through which the state contracts with a vendor to identify and recover Medicaid overpayments using both data analytics and clinical reviews of medical records. The unit has historically operated in Medicaid fee-for-service only. However, House Bill (H.B.) 142, 89th Regular Session, 2025, expands the RAC program into managed care effective September 1, 2025.

C. Effectiveness and efficiency information:

Table 15. RAC measures, fiscal year 2024.

Metric	Fiscal Year 2024
Net Recoveries ¹	\$66,491,493
Identified Recoveries	\$67,801,816

¹ Net Recoveries are gross recoveries less contingency fees. This is used in the calculation of LBB Measure, Total Recoveries.

In addition to LBB performance measures, the RAC unit performs contract monitoring activities to ensure the RAC vendor’s compliance with contract terms (e.g., completeness, timeliness, and accuracy of deliverables). Contract requirements that are regularly reviewed include:

- Medical record requests (MRR): Ensuring that the RAC vendor is not exceeding the mailing limitations established by OIG.
- Reducing potential redundancy: Ensuring that deconfliction takes place in accordance with OIG policies and procedures.
- Appeals success rate: Ensuring that the RAC vendor demonstrates quality work in identifying improper Medicaid payments by maintaining a 95 percent success rate.
- Scenario development: Confirming that the RAC vendor presents new scenarios for potential review in accordance with contract terms and applicable policies.

D. History:

Texas implemented the RAC program within HHSC in 2013. In 2016, oversight of RAC program activities was transitioned to OIG.

E. Qualifications or eligibility requirements:

OIG does not have its own qualifications or eligibility requirements; however, it enforces program requirements as part of its oversight responsibilities.

F. Administration and key processes:

RAC program functions are coordinated between OIG, MCS, the RAC vendor, and HHSC’s TMHP claims administrator.

- OIG oversees the RAC program and manages the RAC vendor contract. OIG serves as the programmatic liaison between the RAC vendor, HHSC’s TMHP claims administrator, and other HHSC areas with respect to RAC-related issues.
- The RAC vendor identifies improper payments by comparing Medicaid claims data with applicable federal and state laws, rules, and policies governing Texas Medicaid.
- The RAC vendor proposes scenarios to the OIG RAC team for review. Scenarios must be reviewed and approved by OIG RAC personnel and HHSC MCS policy staff. When a new scenario is approved, the RAC vendor will test the scenario on a limited number of claims and review the results with the OIG before full implementation (See [Attachment 19: Process Flowcharts](#), RAC Scenario Reviews).
- HHSC’s TMHP claims administrator recovers RAC-identified overpayments through provider billing offsets.
- HHSC MCS’ Office of the Medical Director performs complex RAC appeals, and HHSC MCS’ Provider Resolution and Administrative Appeals (PRAA) team conducts automated RAC appeal reviews.

G. Funding:

Table 16. RAC funding.

Strategy	General Revenue	Federal Funds
B.1.1	\$5,425,572	\$5,425,572
K.1.1	\$54,943	\$54,943

Table 17. RAC funding formulas.

General Revenue	Federal Funds
50.00%	50.00%

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

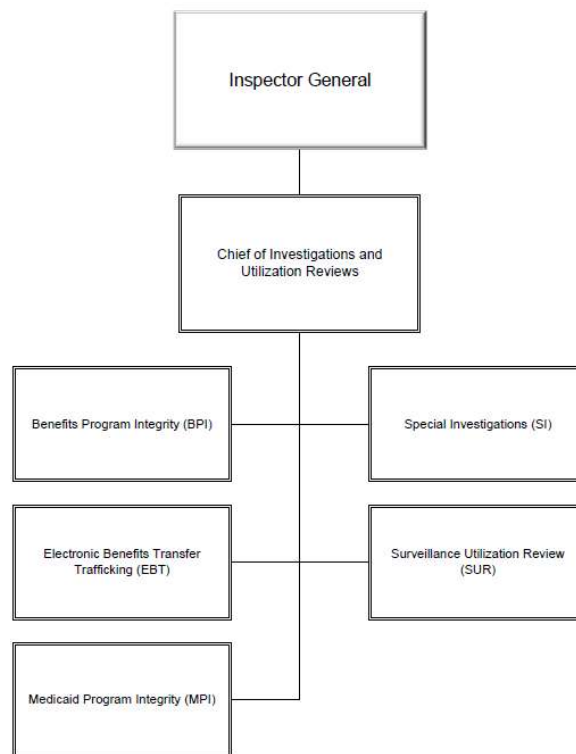
The RAC unit coordinates with MCS and OAG on deconfliction activities.

J-M. Barriers and Challenges, Additional, Regulatory, and Complaint Information: Not applicable.

Investigations and Utilization Reviews

The Investigations and Utilization Reviews (IUR) Division protects the integrity of HHS through investigations and reviews of HHS programs and systems. This includes oversight of providers, retailers, and clients, as well as oversight of HHS employees through Internal Affairs (IA) and the State Center Investigations Team (SCIT).

Figure 6. Investigations and Utilization Reviews organizational chart.



Benefits Program Integrity

A. Division or program information:

Name of division or program: Benefits Program Integrity (BPI)

Location within the agency: OIG, IUR Division

Contact name: Steve Johnson, IUR Chief

Statutory citation: Texas Government Code, Sections 544.0103(e) and 544.0402; 7 CFR Section 273.16(a)(1); and 7 USC Sections 2014 and 2015

B. Objective and major activities:

BPI investigates allegations of overpayments to and improper enrollments of health and human services program clients in the Supplemental Nutrition Assistance Program (SNAP); Temporary Assistance for Needy Families (TANF) program; Medicaid; CHIP; and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

C. Effectiveness and efficiency information:

Table 18. BPI measures, fiscal year 2024.

Metric	Fiscal Year 2024
Number of Completed Investigations ¹	16,707
Claims Established (Dollars Identified for Recovery) ²	\$86,611,879
Dollars Recovered ³	\$53,746,019
Total Number of Investigations Opened	17,103
Total Investigations Cleared in Less than 180 Days	15,295

¹ Completion is defined by either “no claim” (the equivalent of a closure), submission for criminal prosecution, submission for an administrative hearing, or by sending an overpayment demand letter for agency and client errors. This is used in the calculation of LBB performance measure, Number of Completed Provider and Recipient Investigations.

² Calculated in the Automated System for the Office of Inspector General (ASOIG) by totaling all claims submitted using the above completed investigation criteria for adjudication.

³ Calculated by HHS Fiscal Management Accounts Receivable by totaling all payments received from beneficiaries for a given timeframe. This is used in the calculation of LBB performance measure, Total Dollars Recovered.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

OIG does not have its own qualifications or eligibility requirements; however, it enforces program requirements as part of its oversight responsibilities.

F. Administration and key processes:

BPI is led by a deputy inspector general who reports to the IUR Chief. BPI is comprised of two areas: Intake and Full-Scale. BPI receives referrals concerning

beneficiary FWA from HHSC Access and Eligibility Services (AES), OIG’s public-facing website, and OIG’s public-facing telephonic hotline. BPI’s Intake Unit is responsible for reviewing all referrals from AES and from the public regarding beneficiary FWA to assess if an overpayment exists and to investigate cases with the highest potential for recovery. Once Intake has made a determination, the referral is either closed or it progresses to a full-scale investigation and is assigned to an investigator. Full-scale investigators have 180 days to gather evidence and determine whether an overpayment exists.

If an overpayment is identified the case can be resolved in one of three ways: 1) client declines a hearing and agrees to repay the amount; 2) the client is referred for an administrative disqualification hearing; or 3) in cases of criminal fraud, the client may be referred to the local prosecuting authority.

G. Funding: See “Agency Program Information” spreadsheet.

Table 19. BPI funding formulas.

Department	General Revenue	Federal Funds	Other Funds
Executive Management	34.63%	31.78%	33.59% ¹
BPI	48.89%	51.11%	0.00%
County District Attorneys – FS	0.00%	100.00%	0.00%
County District Attorneys – Medicaid	50.00%	50.00%	0.00%

¹ Other Funds includes interagency contract funding with DFPS (25 percent) and DSHS (8 percent).

H. MOUs and interagency agreements or contracts:

BPI maintains Interlocal Cooperation Contracts with individual counties and their associated judicial districts. The contracts outline OIG’s responsibilities in investigating FWA and subsequent referral to the local prosecuting authority. The contracts outline the county or district attorneys’ responsibilities in prosecuting cases referred by OIG. The contracts also outline the monetary payment that OIG will make to the local prosecuting authority to help offset the cost to prosecute and contain a data use agreement.

I. Relationship with other governmental entities:

BPI interacts with the following local and federal units of government:

- Local Prosecuting Authorities: District and county attorneys across the state that accept criminal referrals for beneficiary fraud submitted by OIG.
- Local Law Enforcement: Joint investigations with local law enforcement can occur when jurisdiction may overlap for criminal investigations.
- Federal Law Enforcement Agencies: Joint investigations with federal law enforcement when jurisdiction may overlap for criminal investigations.
- U.S. Department of Agriculture (USDA) Food and Nutrition Service (FNS): FNS provides federal oversight of the SNAP program. FNS sets federal SNAP policy, provides guidance, and offers clarification. They also conduct annual audits into the administration of the SNAP program, including program integrity.
- CMS: CMS provides federal oversight of the Medicaid and CHIP programs. CMS sets federal Medicaid and CHIP policy, provides guidance, and offers clarification.

J. Barriers and challenges:

BPI faces a key challenge in prosecuting beneficiary eligibility fraud due to a mismatch between federal and state timelines. Federal regulations require states to investigate and recover overpayments going back six years, but Texas Penal Codes commonly used for prosecution have shorter statutes of limitations, limiting potential recoveries.

Local prosecutors typically accept only three penal codes for fraud cases:

- Tampering with Governmental Record (Section 37.10) – 2-year statute
- Fraudulent Securing of Document Execution (Section 32.46) – 7-year statute
- Theft (Section 31.03) – 5-year statute

Of these, Section 37.10 is most often used due to its straightforward language and because it allows felony prosecution without a minimum dollar threshold. However, its 2-year statute of limitations often conflicts with the 6-year federal look-back, reducing potential restitution.

When local prosecuting authorities substitute Section 37.10 for charges originally recommended under Section 32.46 or Section 31.03, up to four years of

recoverable overpayments may be lost, undermining both program integrity and compliance with federal expectations.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Medicaid Provider Integrity

A. Division or program information:

Name of division or program: Medicaid Provider Integrity

Location within the agency: OIG, IUR Division

Contact name: Steve Johnson, Chief of Investigations and Utilization Reviews

Statutory citation: Texas Government Code, Sections 544.0051(b), 544.0054, 544.0103, 544.0103(e)(3) and (e)(5), 544.0104-544.0107, 544.0110, 544.0251-544.0257, and 544.0502; Social Security Act 1902(a)(3); and 42 CFR Part 455.

B. Objective and major activities:

Medicaid Provider Integrity (MPI) investigates allegations of FWA by Medicaid providers and other individuals who deliver Medicaid services to Medicaid clients. The MPI Intake Resolution Unit (IRU) conducts preliminary investigations, and the Provider Field Investigations (PFI) unit conducts full-scale investigations.

MPI is supported by the Program Integrity Development and Support team (PIDS), the Clinical Subject Matter Experts (CSMEs) team, and the Investigative Strategy Team (IST).

Clinical Subject Matter Experts: The CSME team consists of a physician, dentist, dental hygienist, and pharmacist who provide clinical expertise to OIG staff across the organization. This team also communicates with the compliance departments of MCOs and dental maintenance organizations (DMOs) to educate their staff and clarify questions regarding clinical documentation and OIG's application of program policy.

Program Integrity Development and Support and Investigative Strategy Teams: MPI is supported by PIDS and IST in the following ways:

- Develops and maintains the internal policies, procedures, and job aids;

- Develops and conducts staff training;
- Acts as a liaison between state and federal agencies and their contractors, other program areas within OIG, and MCO Special Investigative Units;
- Prepares reports related to investigative activities;
- Stores and maintains MPI evidence collected in association with investigative activity;
- Develops investigative plans and deconflicts with other programs;
- Develops high-quality deliverables;
- Researches Medicaid policies; and
- Leads special projects and performs other administrative duties as assigned.

C. Effectiveness and efficiency information:

Table 20. MPI measures, fiscal year 2024.

Metric	Fiscal Year 2024
MPI Recoveries	\$15,075,519
Intake	
Number of Referrals (Complaints) Received	2,442
Cases Opened ¹	1,652
Number of Completed Cases ²	1,639
Cases Referred to Other Entities	781
Number of Referrals to MFCU ³	272
Average days to complete a Preliminary Investigation ⁴	22.83
Full-Scale	
Number of Completed Cases ⁵	213
Referrals to Other Entities	7
Average number of days to complete a Full-Scale investigation ⁶	177.11

¹ Not all complaints become open cases due to a lack of information.

² Includes: Total number of closed cases, cases completed and transitioned to litigation, cases transferred to Acute Care Services (ACS), cases transferred to full-scale, and cases transferred to Accounts Receivable (AR).

³ Number of Intake cases with an informal Provider Notice sent to the MFCU in the period reported.

⁴ The average days between receipt of a case in Intake to case completion in the period reported.

⁵ Total number of closed cases, cases completed and transitioned to litigation, cases transferred to Medical Services (ACS), and cases transferred to (AR). Included in the LBB performance measure, Number of Completed Provider and Recipient Investigations.

⁶ The average days between receipt of a case in PFI to case completion in the month reported for cases received by PFI. A completed case is defined as a case transitioned to Litigation or Medical Services or closed.

D. History:

Senate Bill (S.B.) 207, 84th Legislature, Regular Session, 2015, required that full-scale investigations be completed within 180 days unless OIG determines more time is needed to complete the investigation.

H.B. 2379, 85th Legislature, Regular Session, 2017, amended Texas Government Code, Section 531.1131 (Section 544.0502 as of April 1, 2025) to outline the sharing of recoveries between OIG and MCOs. Specifically, MCOs are permitted to retain 50 percent of any recovery resulting from a fraud or abuse investigation and remit the remainder to OIG. OIG pays the federal share out of its 50 percent and deposits the remainder into the general revenue fund. If OIG initiates the recovery based on a referral from an MCO, it retains 50 percent and sends the other 50 percent to the MCO. Additional coordination with MCOs is required to ensure that both entities do not begin payment recovery efforts for the same case of FWA.

E. Qualifications or eligibility requirements:

OIG does not have its own qualifications or eligibility requirements; however, it enforces program requirements as part of its oversight responsibilities.

F. Administration and key processes:

MPI is led by a deputy inspector general who reports to the IUR Chief. Investigations start with IRU receiving a referral from any source, whether it be from the public, an MCO, or another agency. IRU conducts a preliminary investigation to determine if the referral should go to a full-scale investigation. This determination occurs within 45 days of assignment.

If the preliminary investigation does not find evidence supporting the complaint, IRU closes the case. If IRU determines the complaint falls within the purview of another agency, board, or entity, IRU closes the case and refers the complaint as appropriate.

Cases approved for transfer are assigned to a full-scale investigation unit based on current caseload, and the PFI manager assigns the case to the appropriate PFI investigator. Within the first 30 days of case assignment, the PFI investigator reviews the documentation and evidence obtained by IRU and obtains encounter data to determine the highest paid codes, payors, and to assess any data-driven allegation.

The PFI investigator conducts preliminary research, data analysis, and interviews to assess whether evidence supports the initial complaint or reveals additional indicators of FWA. Investigators may collaborate with OIG units such as Surveillance Utilization Reviews (SUR), OIG Chief Counsel, FADO, PIDS, and IST to ensure thorough investigation and complaint resolution.

Following initial research, a case consultation is held to determine the sampling population and methodology. The investigator then requests client and business records for review based on the approved sample. Regional field staff may assist with record collection and staff or client interviews when needed.

If medical determinations are involved, the investigator submits a request for clinical review. Otherwise, the investigator evaluates the records to determine whether the documentation substantiates the allegations. After completing the review, the investigator prepares case disposition documents summarizing findings and recommending a case outcome. These documents are reviewed by the PFI manager and IST for accuracy and clarity.

Referrals and complaints are received from several sources, including, but not limited to, the OIG fraud hotline; OIG’s online Waste, Abuse and Fraud Electronic Referral System (WAFERS); internal OIG staff; MCOs; and DMOs contracted with the State of Texas.

MPI makes referrals to OAG MFCU when a provider is suspected of fraud or abuse involving criminal conduct. MPI and OAG MFCU work together by sharing resources, training, and information that will lead to successful administrative or criminal prosecution.

G. Funding: See “Agency Program Information” spreadsheet.

Table 21. MPI funding formulas.

Dept	General Revenue	Federal Funds	Other Funds
Executive Management	34.63%	31.78%	33.59% ¹

Dept	General Revenue	Federal Funds	Other Funds
Medical and Dental Professionals (Administrative Costs)	50.00%	50.00%	0.00%
Medical and Dental Professionals (Salary)	37.28%	62.72%	0.00%
MPI	50.00%	50.00%	0.00%

¹ Other Funds includes interagency contract funding with DFPS (25 percent) and DSHS (8 percent).

H. MOUs and interagency agreements or contracts:

MOUs for access to a licensing board’s criminal history record information are listed in OIG Chief Counsel’s response to Question H.

I. Relationship with other governmental entities:

MPI works closely with federal health care task forces around the state and OAG MFCU. MPI provides OAG MFCU referrals at the preliminary investigation, full-scale investigation, and litigation stages, as warranted. OIG and OAG MFCU meet to discuss current cases. MPI provides investigative support, as needed.

OAG MFCU also acts as a conduit for MPI to work with FBI task forces. MPI may also serve as a liaison between OIG’s FADO or SUR units to ensure the task force obtains the necessary resources.

J-M. Barriers and Challenges, Additional, Regulatory, and Complaint Information: Not applicable.

Special Investigations

A. Division or program information:

Name of division or program: Special Investigations

Location within the agency: OIG, IUR Division

Contact name: Steve Johnson, Chief of Investigations and Utilization Reviews

Statutory citation:

- Electronic Benefits Transfer Trafficking: Texas Human Resources Code Sections 33.011 and 33.032; 7 CFR Section 273.16(a)(1)

- Internal Affairs: Texas Government Code Section 544.0102(h)
- Major Case Unit: Not applicable
- WIC Vendor Monitoring Unit: 42 USC Section 1786(f); 7 CFR Part 246
- State Centers Investigative Team: Texas Health and Safety Code, Sections 552.101 and 555.101

B. Objective and major activities:

Special Investigations is comprised of five units, including the Electronic Benefit Transfer Trafficking Unit (EBT), WIC Vendor Monitoring Unit (WIC VMU), Internal Affairs (IA), Major Case Unit (MCU), and SCIT.

EBT Trafficking: Comprised of commissioned law enforcement officers and non-commissioned investigators who conduct criminal investigations regarding SNAP benefit misuse. EBT operates in accordance with the State Law Enforcement Bureau (SLEB) Agreement with the USDA to investigate unauthorized use, possession, and trafficking of taxpayer dollars in the SNAP program.

WIC VMU: Conducts in-store reviews, compliance buys, and invoice audits to monitor vendors participating in WIC. WIC VMU operates in accordance with mandates from the USDA, safeguarding taxpayer dollars by verifying and enforcing compliance with contracts put in place by Texas WIC.

IA: Conducts criminal and administrative investigations involving allegations of employee misconduct and contract fraud for HHSC, DFPS, and DSHS. IA also supports the OIG with computer and cellular phone forensics capabilities.

MCU: Is a team of multidisciplinary experts with extensive investigative and forensic accounting experience. MCU conducts or assists in high-complexity, high-risk cases.

SCIT: Comprised of commissioned peace officers who conduct criminal investigations involving abuse, neglect, and exploitation committed by HHSC employees against clients at State Supported Living Centers (SSLCs) and state hospitals.

C. Effectiveness and efficiency information:

Table 22. Special Investigations measures, fiscal year 2024.

Metric	Fiscal Year 2024
Electronic Benefits Transfer Trafficking	
Referrals Received	2,151
Investigations Opened	345
Completed Investigations ¹	368
Dollars Recovered ²	\$754,349
Claims Established for Recovery	\$2,618,102
WIC Vendor Monitoring Unit	
Completed Inventory Audits	104
Completed Compliance Buys	301
Completed On-site Reviews	351
Number of Cases Closed (Compliance Buys & On-site Reviews)	429
Number of Cases Closed (Inventory Reviews)	104
Number of Education Letters Sent	846
Internal Affairs	
Referrals Received	483
Investigations Opened	282
Completed Investigations	166
Major Case Unit	
Completed Investigations ¹	7
State Centers Investigative Team	
Referrals Received	5,003
Investigations Opened	898
Completed Investigations	920
Investigations Referred for Prosecution	51

¹ This is included in LBB performance measure, Number of Completed Provider and Recipient Investigations.

² This is included in the calculation of LBB performance measure, Total Dollars Recovered.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

OIG does not have its own qualifications or eligibility requirements; however, it enforces program requirements as part of its oversight responsibilities.

F. Administration and key processes:

The units within Special Investigations are each led by a director who reports to the Chief of Investigations and Utilization Reviews.

EBT Trafficking: Consists of commissioned peace officers, non-commissioned investigators, management, and support staff who operate across different regions within the State. The officers and investigators perform traditional investigative activities such as surveillance, undercover buys, interviews of witnesses, and reviews of records related to the trafficking of SNAP benefits. Trafficking includes the use of SNAP benefits outside the rules and regulations established in the CFR. Investigations are conducted on retail stores (both authorized and non-authorized by USDA-FNS as SNAP retailers). EBT works in cooperation with the USDA-FNS as well as a variety of local law enforcement and district attorneys, where cases may be referred for possible criminal prosecution.

WIC VMU: Inspectors conduct compliance buys and on-site store inspections in WIC-contracted stores throughout the State of Texas. The visits involve ensuring stores are compliant with their WIC contracts. Additionally, WIC VMU monitors perform inventory reviews to verify WIC stores are correctly redeeming or charging the State for items they have purchased.

IA: Receives internal and external referrals, which are processed by an intake team that determines whether the referral falls under IA's investigative purview, whether an investigation should be opened, whether the matter should be closed without an investigation, or whether it should be referred to another entity.

If an investigation is opened, the case is assigned to an IA field investigator who gathers documentation, conducts interviews, and determines whether the investigation meets the evidentiary standard for a criminal or administrative case. Investigations are documented in investigative and final reports, which are sent to HHSC, DFPS, or DSHS. Criminal cases that document a violation of law are also submitted to a district or county attorney for prosecutorial consideration.

IA has a Forensics Research and Analysis Team (FRAT) that performs evidentiary searches on and related to electronic devices. FRAT produces forensics reports that are used by field investigators as evidence. FRAT provides support to several OIG programs and units.

MCU: Works on complex investigations from other areas of OIG, generally from IA and MPI. These investigations move through the intake process of the referring OIG area and are then referred to MCU due to the complex nature of the case. For reporting requirements, these cases remain with the referring area but are also tracked internally by MCU. If MCU identifies criminal activity in an investigation, MCU will make a referral to the proper law enforcement agency, whether that be OAG MFCU, FBI, a local district attorney, or local law enforcement. MCU assists the law enforcement agency by providing evidence from the investigation indicating potential criminal activity.

MCU supports MPI investigations when there is a need for one or all MCU members' special skill sets. Also, MCU provides OIG Chief Counsel with financial forensics, data analysis and programming, and advanced investigation skills when requested. Case referrals and requests for MCU assistance are reviewed by MCU management, and a determination is made on whether the case or request aligns with MCU's skill sets.

SCIT: Consists of commissioned peace officers who investigate employees accused of client abuse, neglect, exploitation, and other criminal offences that occur at SSLCs and State Hospitals. These officers are co-located within the regions near the facilities to conduct investigations in a timely manner.

SCIT receives referrals via an intake mailbox or directly from local law enforcement. The referral is evaluated by a captain and, if it is determined that a case should be opened, the recommendation is then sent to the lieutenant, who assigns a sergeant to conduct the investigation. Should evidence of criminal activity be identified, the case is referred to the local district attorney for prosecution. SCIT's process map can be found in Attachment 19: Major Process Maps.

G. Funding: See "Agency Program Information" spreadsheet.

Table 23. Special Investigations funding formulas.

Department	General Revenue	Federal Funds	Other Funds
Internal Affairs	34.63%	31.78%	33.59% ¹
WIC Vendor Monitoring	0.00%	100.00%	0.00%
Medicaid Fraud Law Enforcement	50.00%	50.00%	0.00%
EBT Investigations	50.00%	50.00%	0.00%
DDS CDI	0.00%	100.00%	0.00%

Department	General Revenue	Federal Funds	Other Funds
Management	32.46%	67.55%	0.00%
SCIT	58.96%	38.86%	2.18% ²

¹ Other Funds includes Interagency contract funding with DFPS (25 percent) and DSHS (eight percent).

² Other Funds includes HHSC Intellectual and Developmental Disability Appropriated Receipts.

H. MOUs and interagency agreements or contracts:

EBT Trafficking: Operates under an SLEB, which is a partnership with the USDA-FNS to address SNAP trafficking.

IA: Uses two documents to coordinate activities and avoid duplications or conflicts with HHSC, DFPS, and DSHS. Both documents outline information sharing, reporting requirements, and provide a framework for the investigative purviews of IA and the respective agency. For DFPS, there is an MOU (HHS 000334100001), and for HHSC and DSHS, there is a single interagency circular (C-027).

WIC VMU: Has an MOU with the HHSC WIC program to coordinate compliance activities on existing WIC-contracted vendors and prevent duplication of work.

SCIT: Has an MOU with HHSC to delineate the roles and responsibilities of the parties relating to the investigation of a report of alleged abuse, neglect, or exploitation in SSLCs or State Hospitals.

I. Relationship with other governmental entities:

The Special Investigations division collaborates with federal, state, and local agencies to support its mission. At the federal level, it partners with agencies such as USDA and FBI to investigate cases involving federal benefit programs and complex, high-profile matters. OIG also works with the FBI McAllen Complex Financial Crimes Task Force to identify and pursue health care fraud and financial crimes involving individuals and organized groups. At the state level, OIG coordinates with law enforcement and regulatory agencies to align efforts and share information on FWA and misconduct. Locally, Special Investigations engages with law enforcement to address cases within local jurisdiction. IA supports these efforts by coordinating with HHSC, DFPS, DSHS, and various legal entities at the local, state, and federal levels to meet investigative needs, including the review and prosecution of sustained criminal cases.

J-M. Barriers and Challenges, Additional, Regulatory, and Complaint Information: Not applicable.

Surveillance Utilization Review (SUR)

A. Division or program information:

Name of division or program: Surveillance Utilization Review

Location within the agency: OIG, IUR Division

Contact name: Steve Johnson, Chief of Investigations and Utilization Reviews

Statutory citation: Texas Government Code Section 544.0103; 42 CFR Section 456.3

- Hospital Utilization Review: 42 USC Section 1396a(a)(3) and 42 CFR Part 456, Subpart C
- Nursing Facility Utilization Review: 42 USC Section 1396r and 42 CFR Part 483, Subpart B
- Lock-In: 42 CFR Section 431.54(e) and (f)

B. Objective and major activities:

SUR is comprised of clinical (nurses) and non-clinical support staff who conduct claim and medical record reviews on various HHS programs. SUR also provides clinical consultation to other OIG divisions. It includes the following:

Hospital Utilization Review (HUR): OIG nurses perform retrospective desk utilization reviews of paid inpatient hospital claims for services provided to Medicaid recipients to assess the medical necessity for inpatient care; appropriateness of the diagnosis related group assignment, including whether diagnoses are supported by the information in the medical record and whether coding was consistent with federal coding guidelines; and quality of care provided during the inpatient stay.

Nursing Facility Utilization Review (NFUR): OIG nurses perform retrospective desk and onsite utilization reviews of nursing facility records to evaluate whether facilities correctly assessed and documented residents' needs, whether Medicaid reimbursements were appropriate for the level of care provided, and whether care provided was medically necessary. The reviews result in changes to the Resource

Utilization Group (RUG), which determines the amount Medicaid pays for the resident.

Lock-In Program: Receives referrals from MCOs and the public for identified Medicaid recipients who may require restricted access to a single designated pharmacy. This may be due to duplicative, excessive, contraindicated, or conflicting health care services, including drugs, or evidence of abuse, misuse, or fraud related to Medicaid benefits.

Acute Care Surveillance (ACS): Nurses conduct retrospective reviews of acute care provider billing to ensure compliance with Texas Medicaid policies and guidelines. ACS nurses use data queries, referrals, and special projects to identify cases for review.

SUR Support: Program specialists provide support to clinical staff through operational functions and project management, including process improvements, report and template development, and research. Regional administrative assistants support HUR and NFUR reviews by initiating and maintaining processes to request, collect, and organize records, as well as communicate with providers.

C. Effectiveness and efficiency information:

Table 24. SUR measures, fiscal year 2024.

Metric	Fiscal Year 2024
Nursing Facility Reviews Completed ¹	215
Nursing Facility Collections ²	\$2,002,532
Nursing Facility Dollars Identified for Recovery	\$3,838,792
Acute Care Cases Completed	194
Acute Care Provider Collections ³	\$1,152,520
Acute Care Dollars Identified for Recovery	\$985,250
Hospital Reviews Completed	922
Hospital Collections ⁴	\$19,539,141
Hospital Dollars Identified for Recovery	\$21,605,974
Lock-in Cost Avoidance	\$7,070,246
Average number of Lock-In Program Clients	2,734

¹ LBB performance measure.

² Included in the calculation of LBB performance measure, Total Dollars Recovered.

³ Included in the calculation of LBB performance measure, Total Dollars Recovered.

⁴ Included in the calculation of LBB performance measure, Total Dollars Recovered.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

OIG does not have its own qualifications or eligibility requirements; however, it enforces program requirements as part of its oversight responsibilities.

F. Administration and key processes:

SUR is led by a deputy inspector general who reports to the IUR Chief. The deputy inspector general oversees two directors: one who oversees HUR and NFUR review staff and regional administrative assistants, and the other who oversees ACS, Lock-In, NFUR reconsiderations, and non-clinical support.

SUR conducts ongoing retrospective reviews of acute care, inpatient hospital, and nursing facility records to identify overpayments and educate providers. SUR generates cases for review based on a variety of methods, including data analytics, risk assessments, and stratification. Following preliminary research and deconfliction, SUR requests medical records from providers. Once received, the records are reviewed by a clinician and, depending on the services, may also be reviewed by a certified coder and a physician consultant. SUR sends preliminary findings to the provider outlining the errors identified and the provider's due process rights.

Once all due process is exhausted, SUR recovers overpayments from providers in HUR and ACS cases. SUR also recovers overpayments from MCOs based on RUG adjustments submitted from nursing facility review findings.

SUR administers the Lock-In program. MCOs review members' pharmacy and acute care claims history and make referrals to OIG based on utilization trends and Lock-In program criteria. Lock-In program staff conduct reviews and analyze data and incoming referrals from MCOs, medical providers, state agencies, law enforcement officials, and members of the public that identify Texas Medicaid recipients who may meet criteria for lock-in. The Lock-In program restricts an individual's access to a single designated pharmacy and designated provider for primary care if it finds that:

- A recipient received duplicative, excessive, contraindicated, or conflicting health care services, including drugs; or

- A review indicates abuse, misuse, or fraudulent actions related to Medicaid benefits and services.

G. Funding: See “Agency Program Information” spreadsheet.

Table 25. SUR funding formulas.

Department	General Revenue	Federal Funds	Other Funds
Executive Management	34.6%	31.8%	33.6% ¹
Quality Review 50/50	50.0%	50.0%	0.0%
Quality Review	39.8%	60.2%	0.0%
Acute Care Surveillance	40.6%	59.4%	0.0%
Lock In Program 50/50	50.0%	50.0%	0.0%
Lock in Program	32.1%	67.9%	0.0%

¹ Other Funds includes interagency contract funding with DFPS (25 percent) and DSHS (8 percent).

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities: Not applicable.

J. Barriers and challenges:

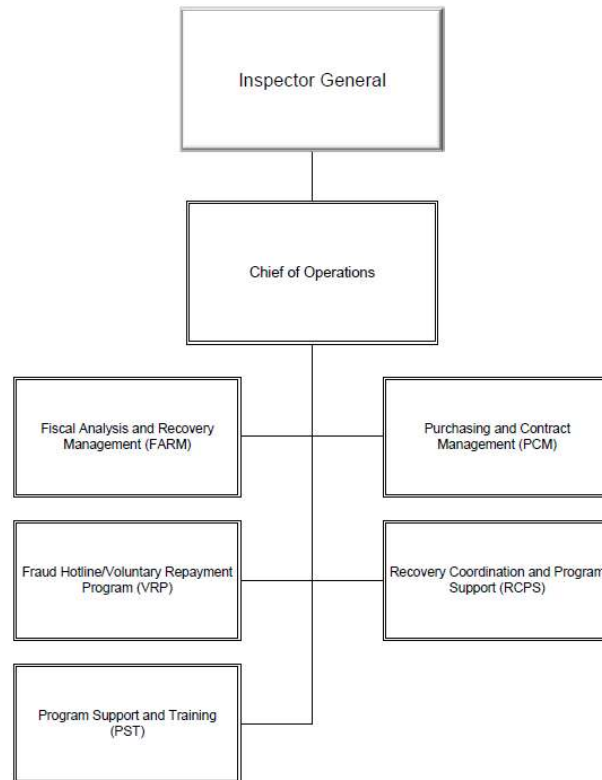
Challenge 1: The technology systems utilized by SUR to conduct reviews and track cases are outdated, inflexible, and lack integration. Developed in 2012, these applications are spread across multiple platforms and require manual workarounds to perform basic functions such as gathering information, generating notices, and calculating recoupment amounts. Requested updates are time-consuming to implement, and the systems do not support real-time inventory or case status reporting.

Challenge 2: This fragmented and manual process reduces productivity, increases the risk of errors, and limits the ability to adjust workflows to address high-risk areas. The lack of a centralized platform for tracking review-related information complicates reporting, hinders data analysis, and burdens clinical staff with repetitive tasks. These limitations collectively hamper efficient operations and obstruct efforts to modernize and streamline review processes.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Operations

Figure 7. Operations organizational chart.



A. Division or program information:

Name of division or program: Operations

Location within the agency: OIG

Contact name: Matt Chaplin, Chief of Operations

Statutory citation: Not applicable

B. Objective and major activities:

The Operations Division supports the daily operations of OIG by providing program support, training, fiscal analysis, recovery management and coordination, purchasing, contract management, and managing the OIG Fraud Hotline and the Voluntary Repayment Program (VRP).

C. Effectiveness and efficiency information:

Table 26. Operations measures, fiscal year 2024.

Metric	Fiscal Year 2024
Number of Trainings	172
Recovery Payments Processed	4,155
Fraud Hotline Contacts Received ²	34,986
Fraud Hotline Contacts Handled ³	32,549
Fraud Hotline Handle Rate ⁴	93%
Fraud Hotline Internal Referrals	5,407
VRP Calls Handled	763
VRP Payment Letters Mailed	614
VRP Collections	\$136,841

¹ Contacts include phone calls, emails, voicemails, postal mail, and faxes.

² Contacts Handled include contacts received that the OIG Fraud Hotline handled (e.g., answered phone calls, responded to emails, postal mail, and faxes, returned voicemail messages).

³ The Handle Rate is calculated by dividing the number of contacts handled by the number of contracts received.

D. History: Not applicable.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

The Operations Division is led by the Chief of Operations, who oversees a deputy inspector general and directors who manage each of the following:

Program Support and Training (PST): Promotes OIG training services and internal policy development. PST organizes office-wide training initiatives, assists the divisions of OIG in developing and delivering targeted training, and manages the agency's internal policies and procedures. PST reviews and updates policies on an annual basis to ensure alignment with current laws, best practices, and operational needs.

Purchasing and Contract Management (PCM): Helps ensure compliance with procurement, contracting, and other purchasing requirements by coordinating with

OIG division staff, HHSC Procurement and Contracting Services (PCS), and HHS System Contracting (Office of Chief Counsel).

Processes include supplementary activities, including records management, Centralized Accounting and Payroll/Personnel System (CAPPS) Financials, and System of Contract Operations and Reporting (SCOR) data entry and document uploads, invoice and expenditure tracking, and reporting requirements.

Fiscal Analysis and Recovery Management (FARM): Manages OIG’s budget and accounts receivable. FARM identifies and addresses any budget, expenditure, or method of finance issues, and collaborates with HHSC Budget staff to ensure timely handling of OIG budget adjustments and communicates OIG’s budget requests for the Legislative Appropriations Request.

FARM collaborates with OIG programs and HHSC Accounts Receivable to process payments and apply those payments against established accounts receivable. This ensures OIG programs receive credit for recoveries resulting from audits, investigations, settlements, targeted queries, and retrospective reviews.

OIG Fraud Hotline: Accepts reports of FWA within Texas health care and benefits programs through a toll-free hotline, mail, email, and fax. Once documented, complaints are referred to OIG investigative areas or referred to a more appropriate hotline, agency, or department.

VRP: Manages repayment by non-US citizens to HHSC for emergency Medicaid services, often related to childbirth. VRP staff review Medicaid claims, determine the outstanding balances, process and provide receipt of payments, and send a paid-in-full receipt after the balance has been paid.

G. Funding: See “Agency Program Information” spreadsheet.

Table 27. Operations funding formulas.

General Revenue	Federal Funds	Other Funds
34.63%	31.78%	33.59% ¹

¹ Other Funds includes Interagency contract funding with DFPS (25 percent) and DSHS (8 percent).

H-M. MOUs, Relationships, Barriers and Challenges, Additional, Regulatory, and Complaint Information: Not applicable.