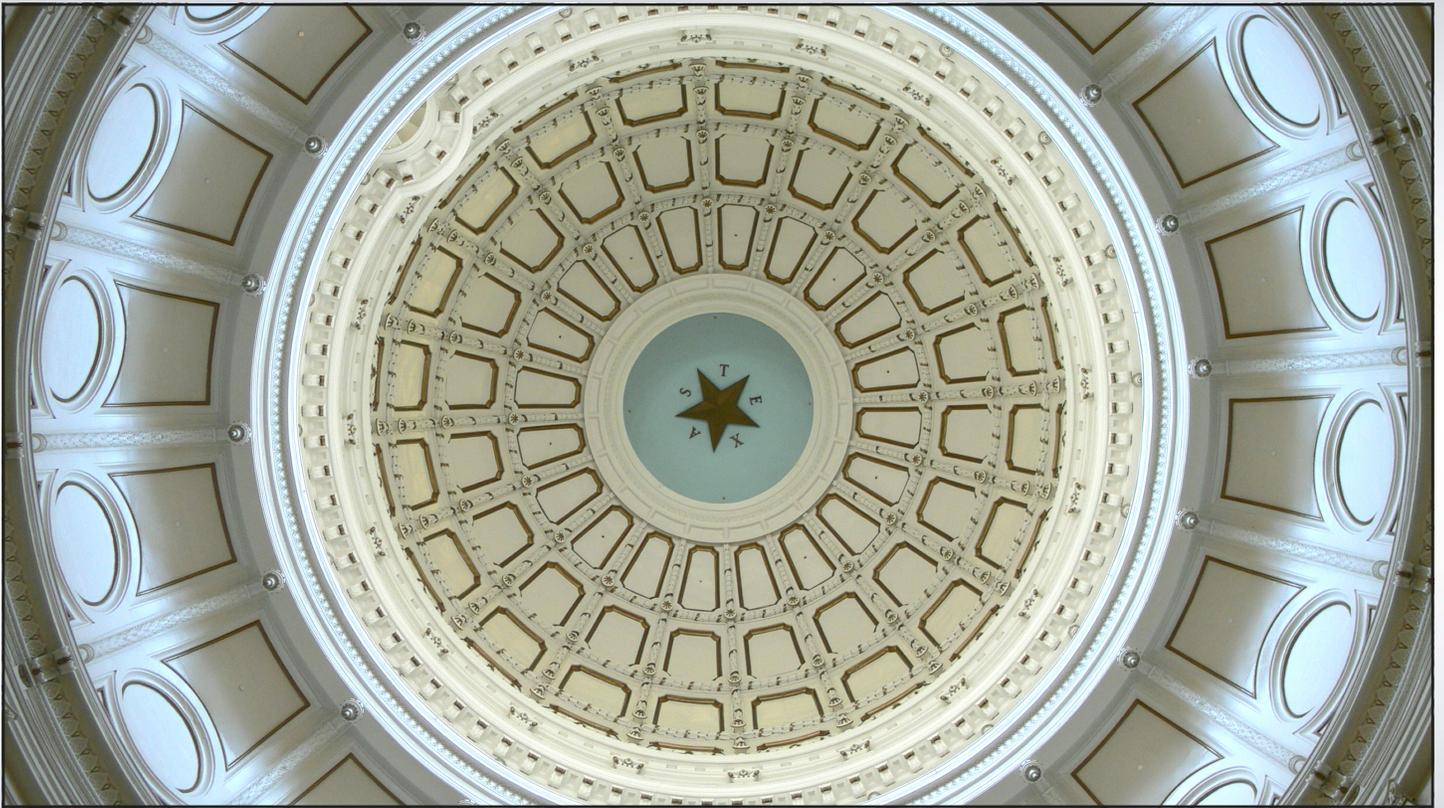


TEXAS HEALTH AND HUMAN SERVICES COMMISSION
INSPECTOR GENERAL



QUARTERLY REPORT TO THE GOVERNOR
SEPTEMBER 21, 2015





PROFESSIONALISM
PRODUCTIVITY
PERSEVERANCE

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To report fraud, waste, or abuse

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Cover photo by Paul Norris

Message from the Inspector General

I am pleased to submit to Governor Greg Abbott, Executive Commissioner Chris Traylor, the members of the Texas Legislature, and the citizens of Texas the first Quarterly Report to the Governor from the Health and Human Services Commission Inspector General. Responsive to new legislative requirements, this report will ensure transparency and accountability regarding my office's continuing oversight work of the tens of billions in state and federal dollars allocated to fulfill the Commission's many important missions.



Stuart W. Bowen, Jr.

I thank Governor Abbott for the honor he bestowed by appointing me Inspector General and am grateful to Commissioner Traylor for his strong and collaborative support. I appreciate advice, counsel, and support received from Lt. Gov. Dan Patrick, Speaker Joe Straus, and many legislators, including Senators Jane Nelson, Chuy Hinojosa, Charles Schwertner, Kirk Watson, and Lois Kolkhorst; and Representatives Richard Raymond, Four Price, and Myra Crownover.

This report comprises five sections. Section One contains an overview of IG functions and responsibilities and includes a review of internal reforms I am implementing to strengthen our performance and improve our results. Further, it highlights notable changes to my office's operations required by new legislation. Section Two summarizes our new strategic plan, which we developed during a three-day retreat at the Pickle Center in June that included more than 80 of my leadership and managerial staff. Sections Three, Four, and Five provide summaries of work accomplished this quarter, as

FY 2015 Highlights

Dollars recovered

SANCTIONS	
Overpayments and CMPs	\$9,483,937
OPERATIONS	
Third Party Liability	\$160,550,260
RAD reviews	\$9,718,804
GENERAL INVESTIGATIONS	
Overpayments collected	\$39,846,491
Total	\$219,599,492

Dollars identified for recovery

COMPLIANCE	
WIC vendor monitoring	\$7,846
Contract audits	\$112,271
UTILIZATION REVIEWS	
Hospitals	\$14,059,155
Nursing homes	\$4,526,619
AUDIT	
Subrecipient financial review	\$112,109
MCOs	\$205,429
Medicaid/CHIP	\$3,728,699
INVESTIGATIONS	
MPI potential overpayments	\$42,177,868
GI Claims established	\$38,899,331
Total	\$103,829,327

well as planned work, by my audit, investigation, and inspection divisions.

Upon my confirmation by the Texas Senate on February 18, 2015, I began a systemic review of IG structure and operations. My internal investigations revealed an eager but diffident staff with many areas requiring significant restructuring and recovery. Troublingly, I found large legal and investigative backlogs, with many pending cases more

Message from the Inspector General

than five years old. I identified an operational insularity that vitiated relationships with HHSC and the Legislature.

In response, I developed a roadmap for reform, using a very helpful and thorough Sunset Commission report, the apt and insightful Governor's Strike Force Report, and a contracted office-wide analysis.

My first moves entailed the hiring of new senior staff and, in concert with them, rationalizing and re-ordering the agency's structure to meet our mission. I brought on an outstanding Principal Deputy Inspector General, Frank Bryan, and an excellent new Chief of Staff, Quinton Arnold. They have helped me push forward many new remedial measures.

We have a highly rewarding and important mission: to detect, prevent, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used to deliver health and human services in Texas. My IG team has joined me in enthusiastic commitment to our overarching goal: success in achieving our critical mission.

I am pleased to report we have made significant progress since February. My legal and investigative divisions, with my close engagement, reduced case backlogs by 50 percent, settling most of our active litigation in the process. My new Deputy Inspector General for Investigations restructured his division for efficiency and effectiveness. My new Deputy Inspector General for Audit developed the most meaningful audit plan ever generated by this office. And my newly established Inspections Division, led by an eminently qualified Deputy, produced its first inspection report.

Our agency will be the best state-level IG office in the country; our values — Profes-

FY 2015 Highlights

Cost avoidance

SANCTIONS

Providers ordered to pay	\$38,089,259
Excluded providers not ordered to pay	\$5,574,910

OPERATIONS

Third Party Liability	\$95,968,262
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COMPLIANCE

WIC vendor monitoring	\$8,729,176
Limited Program	\$59,882

AUDIT

Cost report review, net disallowed costs	\$41,680,262
Outpatient hospital net disallowed costs	\$8,492,325

GENERAL INVESTIGATIONS

Disqualifications	\$4,560,264
Income eligibility matches	\$24,661
Other data matches	\$2,209,318

Total	\$205,388,319
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sionalism, Productivity, and Perseverance will guide us. I and my 700 IG teammates will live out those values to achieve our vision. In so doing, we will ensure that more of every tax dollar appropriated for the delivery of health and human services to needy people in Texas actually gets spent on those services, thus improving our state's collective well-being. I am pleased and honored to pursue that goal.

Respectfully submitted,



Stuart W. Bowen, Jr.

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Overview

Section

1

About IG

A brief history

In 2003, the 78th Texas Legislature created the Office of Inspector General to strengthen the Health and Human Services Commission's capacity to combat fraud, waste, and abuse in publicly funded state-run Health and Human Services programs.

The IG's mission, as prescribed by statute, is the "prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services in the state, including services through any state-administered health or human services program that is wholly or partly federally funded, and the enforcement of state law relating to the provision of those services."

In forming this office, Texas adopted the federal IG model: operational independence is an essential feature. Just as the president appoints most federal IGs, the Texas governor analogously appoints the HHSC/IG. Similar to federal IGs, this office is housed within and is administratively supported by the agency it oversees, with direct reporting responsibilities to the chief executive officer of the executive branch and concurrent reporting duties to the department head.

Our primary tools for detecting, deterring, and preventing fraud, waste, and abuse are audits (conducted under the federal "Yellow Book" standard), investigations (conducted pursuant to generally accepted investigative policies), and inspections (conducted under the federal "Silver Book" standard).

Twelve states have inspector general offices with general statewide jurisdiction, while 28, including Texas, have inspectors general with agency-specific jurisdiction. Of

note, Texas has three other agency inspectors general, but only this one manifests itself along the lines of the federal model, with gubernatorial appointment and operational independence as distinctive and distinguishing features.

Federal law requires states to create oversight offices that investigate fraud, waste, and abuse in Medicaid programs. Some have used the independent IG model, while others maintain a less independent office housed within the agency (which Texas previously had).

The move in 2003 by the Texas Legislature to pursue the federal model included empowering this office to oversee not just Medicaid expenditures, but also those made under these federal programs: Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), and the Special Supplemental Nutrition Program for Woman, Infants, and Children (WIC).

Three IGs preceded Stuart Bowen's February appointment. Brian Flood, a former assistant district attorney in Dallas County, stood the office up in 2003 and served until 2007. Bart Bevers, who also came from the Dallas County District Attorney's Office and was Mr. Flood's Deputy for Enforcement, served as IG until 2011. Doug Wilson, who previously was Deputy Director of the Medicaid Fraud Control Unit at the Texas Attorney General's Office, served until 2014.

Recent developments

Last year, the Inspector General's office was the subject of much scrutiny for poor management and suspect contracting practices. A review of the office's operations

About IG

by a private contractor observed the following weaknesses:

1. Insufficient internal controls.
2. Inconsistent case management and monitoring of performance and outcomes.
3. Inadequate communication both within OIG and outward to HHSC programs and providers.
4. Use of a statistical sampling tool that is not the industry standard.

The Texas Sunset Commission reached these similar conclusions:

OIG's investigative processes, especially Medicaid provider investigations, lack structure, data, and performance measures needed for overall management and evaluation, resulting in limited outcomes.

OIG's wide array of responsibilities distract its focus from functions most critical to its mission.

OIG's methods of communicating and sharing information need improvement.

OIG's structure results in blurred accountability and little oversight of effectiveness of accomplishing its fraud, waste, and abuse mission.

Governor Abbott's Strike Force Commission's report, which looked into the contracting problems, also found a lack of transparency and poor communication practices pervading IG operations.

New leadership and reorganization

In late January 2015, Governor Abbott announced the appointment of Stuart W. Bowen, Jr. as the new Inspector General, and he was confirmed by the Texas Senate on February 18, 2015.

After taking his oath and assessing the office, the Inspector General began a thorough review of the agency and its operations. That internal review, supplemented by the recommendations from various outside reviews, catalyzed a series of structural, operational, and staff changes that this report outlines.

Q&A with Stuart Bowen



Stuart W. Bowen, Jr., the fourth Inspector General for the Texas Health and Human Services Commission, has nearly 27 years of public service experience, including extensive background as a federal inspector general and nearly ten years of state legal service in Texas.

Prior to returning to Austin, Mr. Bowen served for nearly a decade as the Special Inspector General for Iraq Reconstruction, leading the agency charged with overseeing \$62 billion in U.S. tax dollars appropriated for Iraq's reconstruction. Reporting to the Secretaries of Defense and State, Mr. Bowen secured nearly \$2 billion in taxpayer benefits, obtained more than 100 convictions, produced more than 500 reports, and traveled to Iraq 35 times as IG.

Prior to his tenure as the SIGIR, Mr. Bowen served President George W. Bush as Deputy Assistant to the President and Deputy Staff Secretary, and Special Assistant to the President and Associate Counsel. His public service career also includes stints as Deputy General Counsel to Governor Bush, as an Assistant Attorney General of Texas, and as a Briefing Attorney to Texas Supreme Court Justice Raul Gonzalez. Mr. Bowen served four years on active duty as a United States Air Force intelligence officer.

Why did you take the HHSC/IG appointment?

I was very honored when Governor Abbott's office called me last January and asked that I return to Texas to take this appointment. The Governor has a vision for a more transparent and accountable state government, a vision with which I very much agree. Moreover, I recognized that this particular leadership position offers countless opportunities to make a difference for the good in our state, most particularly in the healthcare arena.

Since arriving, I have sought to improve IG operations, strengthen our mission performance, boost morale, and establish better relationships with HHSC leadership as they manage more than \$30 billion annually to help needy Texans. Now, six months into the job, I remain grateful to Governor Abbott for giving me this extraordinary opportunity. I am committed to collaborating with Executive Commissioner Traylor as he achieves success in leading the HHSC team in fulfilling its crucial mission.

What are the significant challenges now facing the IG and the Commission?

HHSC and my office are still adjusting to the very rapid evolution of Medicaid in Texas from a fee-for-service arrangement to a managed care structure. From 1998 to 2014, Texas went from a program that delivered 20 percent of its Medicaid services through managed care to one that delivers more than 80 percent via that structure. This change caused data access to become more difficult. The contracting out of the delivery of Medicaid services, which embodies managed care, changed the way the state acquires information about health-care delivery, effectively reducing data granularity. We're now seeking

Q&A with Stuart Bowen

to remedy that challenge. Specifically, I am working on strengthening the state's managed care contracts, so that we and the Commission receive better claims and encounter data.

Improved data access will bolster the entire enterprise. HHSC makes judgments about how managed care corporations perform, and detailed data about claims and costs is key to ensuring that those judgments are good.

I realized shortly after arriving that my office needed much internal reform and restructuring. I have since worked with my new deputies to revamp our Audit and Investigation Divisions. I created a new Inspections Division, which addressed a mission shortfall, and now have an excellent leader in place there.

I also recognized our weakened credibility with legislators, HHSC leadership, and the provider community, as evidenced by an insightful Sunset Commission Report. To help address that issue, I created a new position—Deputy IG for Policy and External Relations. This additional capacity will assist me in advancing my commitment to engage ever more closely with the Legislature and HHSC. We also initiated a stakeholder outreach initiative to open doors into the provider community.

These efforts already produced good fruit, helping us begin to earn the confidence of the Legislature, the Commission, and the provider community; further, our actions to eliminate our unacceptable case

backlog are dispelling lingering skepticism.

Is there a guiding philosophy you bring to the office?

My vision is to turn our office into the premiere state-level Inspector General organization in the country. As my staff knows, my values are professionalism, productivity, and perseverance. My new calling here in Texas enables me to continue to realize my life's mission: to do well by doing good. I previously realized it as the Special Inspector General for Iraq Reconstruction, where I rooted out fraud, waste and abuse in the \$62 billion rebuilding program in Iraq. That was a tough job, too, and certainly prepared me for this significant challenge.

I previously realized it as the Special Inspector General for Iraq Reconstruction, where I rooted out fraud, waste and abuse in the \$62 billion rebuilding program in Iraq. That was a tough job, too, and certainly prepared me for this significant challenge.

What positives do you see in the agency?

Our staff has responded to the "new day" here at the

IG with enthusiasm and energy. Rising morale will add momentum to our collective efforts to improve operations, achieve excellence, and succeed in our mission.

At our strategic planning retreat in June, we worked together as a team—80 members of our leadership staff—to write our new strategic plan. I've been pleased to see deep and meaningful engagement by everyone in that process; it points to a bright and collaborative future of results-oriented success.

What goals do you have for the agency this fiscal year?

My primary goal is to strengthen our capacity to investigate and audit in the managed care world. To be frank, this office

'I expect all IG staff to conduct themselves respectfully in all engagements, be they internal or external, and I insist on absolute integrity in all the work we do.'

Stuart W. Bowen, Jr.,
Inspector General

Q&A with Stuart Bowen

egregiously lagged in achieving concrete results and meaningful deterrence in the managed care environment. But we are now obtaining and implementing innovative operational insights from investigators and auditors about how we succeed in accomplishing our mission.

Our job is to root out fraud, waste, and abuse in the expenditure of the more than \$30 billion annually that is under the commission's aegis. We must hold those accountable who violate the trust vested in them. But we must also emphasize due process and avoid the abuses to which this office was previously prone.

We have to be firm in rooting out fraud, waste, and abuse, but we must also be insistently fair in that process, striving in every investigative effort to focus only on those who clearly do wrong. We also must be independent in our operations to preserve the integrity of our oversight; but we must be collaborative with the Commission to ensure that our work effectively supports HHSC as it achieves success. There are inherent tensions in oversight work; but our professionalism, productivity and perseverance will overcome them.

‘My main goal is to strengthen our capacity to investigate and audit in the managed care world.’

Stuart Bowen, Jr.,
Inspector General

What is your number one priority?

Securing the commitment of every employee in my office to live by the values we espouse: professionalism, productivity, and perseverance. If we do that, we will achieve excellence, we will succeed, we will serve the people of Texas well.

What changes have you made to the agency?

We have virtually an entire new senior staff: I hired a new Principal Deputy and Deputy IGs for Audit, Inspections and Investigations. The Deputy IG for Inspections is a brand new position, and his team will continue to grow.

We've implemented an aggressive effort to reduce our case backlog and made significant progress on it. Specifically, we have cut our legal and investigative backlog by more than 40 percent, and we're in the middle of another round of reduction efforts, so we will soon cut further into that backlog.

We have initiated reforms that will enable us to succeed in investigations executed in the managed care world. And we developed a strategic plan to ensure we stay true to our mission and on course toward success. Our strategic plan can be found in Section 2 of this report.

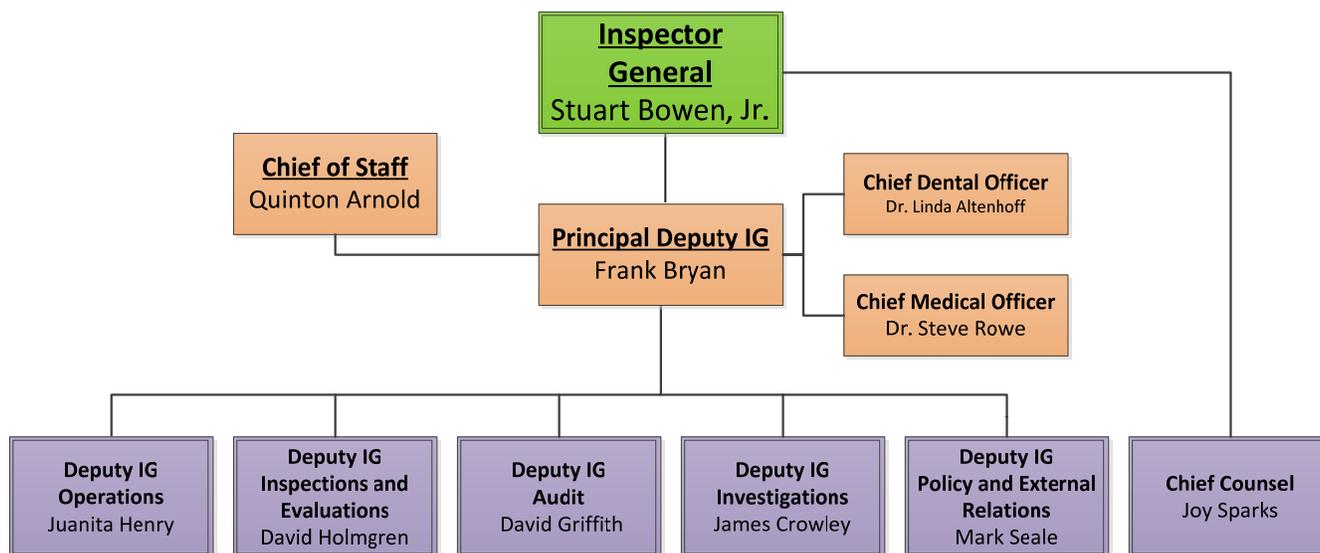
Agency organization

Mr. Bowen arrived in February 2015 to find an office composed of five divisions: Internal Affairs, Enforcement, Compliance, Operations, and Chief Counsel. His initial analysis of functions and duties revealed that some divisions had responsibilities that did not fit their mission. Some functions needed to be transferred to other divisions

within IG while others belonged at HHSC.

The IG restructured the agency divisions into Audit, Investigations, Inspections, Legal, Operations, and Policy and External Relations. He created new Deputy Inspector General positions, and a Chief of Staff to help direct the agency.

This is the new IG organizational chart:



Investigations Division

Structure and operations

The Investigations Division helps preserve and protect the integrity of the Texas Medicaid program and other health and human services and assistance efforts. It pursues allegations of provider and recipient fraud, waste, and abuse.

Investigations refers seriously wrongful conduct to the IG litigation section for sanctions or to other law enforcement agencies for further investigation and prosecution. Additionally, it conducts personnel investigations at the State Supported Living Centers as well as within all HHSC agencies.

The division sends cases of suspected criminal fraud in Medicaid to the Attorney General's Medicaid Fraud Control Unit. Other matters go to licensing boards for administrative action or to other state and federal regulatory or law enforcement agencies. It may recommend civil and administrative sanctions, to include recovery of overpayments within the Medicaid program.

Within the Electronic Benefit Transfer programs, the division investigates individuals and authorized retailers suspected of criminal conduct in the EBT program, with suspected criminal fraud investigations referred to local prosecutors or handled through administrative hearings. Currently, these investigators do not possess criminal investigative authority under Texas law,

J.J. Crowley, Deputy IG, Investigations

J.J. "Jay" Crowley became Deputy Inspector General for Investigations in March 2015. Mr. Crowley began his career as a postal inspector in Texas in August 1971. In 1980, he transferred to the Office of Inspector General, U.S. Department of Agriculture (USDA-OIG) as a special agent in Texas. He ascended through the ranks at USDA-OIG, becoming Special Agent in Charge of the Southwest Region. Mr. Crowley retired from federal law enforcement in 2004. Mr. Crowley then worked as a deputy for investigations for six years with Inspector General Bowen during his tenure as a Special Inspector General for Iraq Reconstruction.

which presents obstacles to their investigative processes.

Backlogs

The Investigations Division had a massive backlog when Mr. Bowen began his tenure in February. He charged his new Deputy to immediately address that unacceptable condition.

Investigations has since reduced its case backlog by approximately 50 percent. The Legislature instituted new investigative timelines to prevent future backlogs and the division has restructured its processes to ensure that it will meet them.

Q&A with Jay Crowley

Why did you choose to join the agency?

When Governor Abbott appointed Mr. Bowen, he asked me to join him to lead the Investigations Division. The respect I have for him is the reason I came back to work. Fortunately, I have a history with the old Texas Health and Human Services enterprise through my years as the USDA IG Special Agent in Charge for all of Texas. Lots of successful partnerships back then to crack down on food stamp fraud. The USDA opinion was that Texas was the best in the U.S. in terms of forward thinking. Plus, I wanted to help Mr. Bowen to restore this agency, to make it the best in the nation.

What positives do you see in this division?

The people. They have a strong work ethic. They want to succeed and do good. I also like the mission of the division. It is very diverse and thus very challenging.

What goals do you have for your division?

Our goals are very simple: produce quality, timely, and well-reported investigations. Our productivity measures will be monies recovered and sanctions adjudicated. I want our staff to write clear, concise, well-structured reports. We are standardizing the reporting system, and it is going to be exhibit-based. Our other major goal is parity for the staff in terms of salaries. Our core mission is to be collaborative with all HHSC programs with which we deal and to live out the values Mr. Bowen set for us.



What changes have you made to your division?

With Senate Bill 207, we have new restrictions to fulfill, specifically, time constraints regarding investigations. I looked around our investigations organization and saw the need for restructuring. I combined the old Research, Analysis and Detection unit with our Preliminary Intake Unit to form the Intake Resolution Division. This will ensure that we fulfill the 45-day requirement to complete an investigation and adjudicate minor policy issues that previously and unwisely went to full-scale investigations. We will now aggressively go after egregious violations.

‘I believe in empowering managers and empowering employees to make decisions that get the job done.’

Jay Crowley, Deputy IG,
Investigations

Q&A with Jay Crowley

What other organizational changes have you made?

We have centralized all the peace officers into one division. They will have one set of policies and procedures, and we will consolidate their training, setting them up for future success through integration. I hope in the next Legislative session we can discuss the limitations on our existing peace officers, as well as the need to expand our criminal investigative authority.

Do you have a guiding philosophy you bring to the office?

I believe in empowering managers and empowering employees to make decisions that get the job done. I inherited a group that was afraid to make investigative decisions. It's all about timely, well-written investigations that lead to good results. I want them to stop circling the wagons and instead to make prompt and wise decisions.

Your top priority?

Make this a place where people want to come to work, be productive, have a sense of ownership, a sense of pride, and succeed.

Audit Division

Structure and operations

The operational units within the Audit Division embrace the Audit Directorate and the Quality Review Directorate.

The Audit Directorate conducts compliance and performance audits of contractors, providers, and HHSC programs. The findings of these risk-based audits identify overpayments and disallowed costs, and they make recommendations to improve control weaknesses, performance issues, and IT security vulnerabilities.

In the Quality Review Directorate, the Utilization Review Unit identifies overbilling and recovers overpayments based on its performance of the following:

- Retrospective reviews of nursing facility records that support Resource Utilization Group classifications used to determine payment amounts;
- Reviews of hospital records to evaluate medical necessity, quality of care, and diagnosis related group coding accuracy.

The Lock-In Program limits access to prescription drugs of high-risk recipients.

Recent organizational changes in the Audit Directorate include the transfer of the Cost Report Review Unit to HHSC Financial Services Rate Analysis (pursuant to legislative direction), and the transfer of the Texas Women, Infants, and Children Vendor Monitoring Unit to the IG Inspections and Evaluations Division. The Executive Commissioner wisely approved the transfer of the federal external audit coordination function to the IG in August 2015 as a six-month pilot program.

The Audit Directorate is being restructured with the addition of the Audit Operations Section, which will provide support to the operational sections, including quality assurance, risk assessment, IT application support, and workload production management. Other changes include adding IT audit and performance audit staff positions within the Audit Directorate.

Backlogs

When Mr. Bowen began in February, he found a massive audit backlog. His new Deputy for Audit reported that only 8 of 88 audit projects on the Fiscal Year 2015 IG Audit Plan had been issued. This included 56 audits from previous fiscal year audit plans.

By the end of FY 2015, the division issued 15 audit reports, with 16 draft audit reports submitted for management comment. Audits issued in fiscal year 2015 identified \$8,492,325 in disallowed costs and \$411,459 in provider overpayments.

Of the remaining 36 audits from 2015, 7 were cancelled because either the risks related to the planned audits changed or preliminary results identified no significant issues. Audit will release the balance of the pending draft audits by November 2015.

A significant backlog of nursing facility utilization review appeals built up over a number of years at the Department of Aging and Disability Services, which is responsible for coordinating resolution of appeals. In a collaborative effort involving the IG, the

David Griffith, Deputy IG, Audit

David Griffith became the Deputy Inspector General for Audit in May 2015 after serving one year as the Director of HHS Risk and Compliance Management and more than 10 years as the HHSC Internal Audit Director.

Prior to joining HHSC, Griffith worked for the State Auditor's Office, served as Director of the City of San Antonio's Office of Internal Review, and was an auditor for the federal Railroad Retirement Board's Office of Inspector General. He served 21 years in the United States Air Force before starting his career in auditing.

Griffith has a Master of Science in Administration from Central Michigan University and a Bachelor of Science in Management Accounting from Park College. He is a Certified Public Accountant, a Certified Internal Auditor, and a Certified Government Financial Manager.

DADS Commissioner, and the State Office of Administrative Hearings, 66 of the 471 appeals that were pending in February 2015 were resolved by August 31, 2015.

Q&A with David Griffith

Why did you choose to join the agency?

I felt I was a good match for this position because of my audit leadership experience and risk management background, as well as my exposure to HHSC agency programs. Add to that the opportunity to work with Mr. Bowen and the outstanding team he has put together, along with the challenge of helping make this the best IG in the country, how could I pass that up!

Name the biggest challenges facing the agency and the enterprise.

One of the primary challenges I see for the IG and the Audit Division is related to oversight of Medicaid in a managed care environment.

We need a huge and significant rethink about how we should do our work. We have to execute that shift in collaboration and communication with the Medicaid/CHIP Division and our federal partners, so that we end up with a well integrated approach that produces worthwhile outcomes.

Second, we need to continuously work to reestablish the credibility of the IG with other HHSC agencies and our stakeholders. We will do this by following the values that Mr. Bowen has laid out, coordinating, collaborating, and communicating at every opportunity. Our business partners have already recognized that this is a new IG - but there is a difficult history that created harmful perceptions; we will have to work hard to overcome them.

Another big challenge is recruiting and retaining outstanding staff. In general, we are faced with an aging workforce and an improved economy. Further, we are limited by the resources available to us in state government. The impact on an organization



when experienced staff retire or when high performers leave for higher paying, or what they think will be more interesting jobs, can be significant. To help address this, we have received permission to pursue a career ladder for our audit classification positions as an IG pilot. If that goes well, I hope to expand the career ladder approach to our nurse staff in Utilization Review. We are planning other initiatives to recruit college graduates, and offer incentives, based on performance results, to our staff.

I also see challenges with respect to work production. For example, when I arrived at IG, a large percentage of the projects on the audit plan hadn't been completed, even though year end was approaching. There were some good reasons for that, such as the issue with extrapolation that impacted some of the audits, especially pharmacy audits, which had been put on hold.

And then there was staff uncertainty related to functions relocating in response to the Sunset report and other recommendations. We knew some of our activities were going to move out of the Audit Division, but we weren't certain when that would occur.

Q&A with David Griffith

That kind of uncertainty can impact people's morale and work production.

Is there a guiding philosophy you bring to the office?

My job as the Deputy IG for Audit is to provide resources, develop a plan, and establish an infrastructure in which staff can succeed. The goal behind the changes we are in the process of making, and those we are planning, is to create an environment where those who work here and our division as a whole can be successful, and meet our goals and objectives.

The emphasis of the internal changes we are making is to have processes in place that will enable staff do their work well and allow our management team to support and guide them. Our efforts externally are focused on working with HHSC management as part of a team, letting them know we can inform them about their programs and contracts, and help reduce waste and improve performance.

When we work as a team, we can more effectively support IG's mission.

What positives do you see in the agency?

I found a staff really interested in doing good work. They are focused on the mission here, and focused on outcomes in terms of making things better for recipients of the services HHSC agencies provide. Considering everything that had gone on here prior to my arriving, I think their attitudes are very positive.

What goals do you have for the division this fiscal year?

Collaborate and communicate. Not only is this a best business practice, it is now mandated by state law. We will work continuously to maintain and expand our interaction with the Medicaid/CHIP Division, internal audit shops, program areas with a high reliance on contracted services, and HHS agency executive management. The Audit Division cannot be successful if this does not become our normal way of doing business.

We must develop strategies for improving our Medicaid audit and utilization review work in a managed care environment. Managed care has been predominant in Texas for several years, but the fee-for-

service system still shapes our review process. We need to create new processes, new strategies, and new approaches to be effective in the managed care world.

We also must improve operational and support processes. Too much manager and staff time

has been taken away from our primary mission due to inefficiencies and administrative requirements. By improving our processes and consolidating our support functions, we will increase the quality and timeliness of our primary work product.

What are your top priorities?

Production. A big emphasis will be placed on improving production management and operational processes. We are revising our policies and procedures to make sure that they are not only comprehensive enough for our audits to meet auditing standards, but that they also adequately

'We must continue to build relationships with the program areas we support.'

David Griffith, Deputy IG,
Audit

Q&A with David Griffith

support the work the auditors and reviewers do. That is, they must be streamlined so that they actually function as a guide for staff to use as a work resource. Previously, our policies and procedures were massively cumbersome.

We need to plan, perform, and manage our work to achieve our objectives. That includes completing our audit plan and our work plans that target high quality outcomes, identify overpayments, support the collection of those overpayments, reduce risks, increase compliance and efficiency, and provide useful information to management.

What changes have you made within the division?

The first thing I did was establish the Audit Operations Section. The purpose of Audit Operations, whose director is Robert Anderson, is to consolidate some of the administrative support activities in a way that will provide the operational staff in Audit and Quality Review more time to perform their primary functions.

Audit Quality Assurance has been assigned to Audit Operations, and we are

working to create a new quality assurance function for utilization review to address a concern that has been voiced by providers that our utilization review results are inconsistent. By having a retrospective review of the work we do across the state, we can start to identify whether there are inconsistencies, and if there are, how they can be addressed through training or process improvement.

Along with the addition of Federal External Audit coordination, which has been assigned to IG as a six-month pilot, Audit Operations will be the lead for audit risk assessment, and will support audits by editing or drafting audit reports, which will help us develop a consistent style of reporting.

I am hiring a second audit director so that we can focus the span of control within the Audit Section, with three audit managers assigned to each director. That should allow our management team to spend more of their time guiding and supporting audit teams with mentoring and coaching.

Inspections and Evaluations Division

Structure and Operation

The Inspector General established this division in May 2015, with the mission to conduct a variety of inspections, including reviews of providers, supporting organizations, and HHSC programs. Inspections and Evaluations (I&E) offers practical recommendations to improve system efficiency and effectiveness, with a focus on preventing fraud, waste, and abuse.

I&E also monitors the impact its recommendations and evaluations have on HHSC programs by tracking legislative or regulatory changes, documented savings, improved coordination efforts and other benchmarks; it provides Legislative staff with technical assistance and briefings on proposed or completed work; and it works in concert with other IG components to identify vulnerabilities meriting further review.

Recently, I&E took on oversight of the state's Women, Infants, and Children Vendor Monitor Unit, which inspects retail vendors for WIC-based fraud, waste, and abuse through the use of invoice audits and compliance buys.

David Holmgren, Deputy IG, Inspections and Evaluations

David Holmgren is the new Deputy Inspector General for Inspections and Evaluations (I&E). He joined the OIG staff on June 24, 2015. After a distinguished military career, he previously served as the Inspector General for the Office of Naval Intelligence, Inspector General for the Navy Installations Command, and as the Deputy Inspector General of the Marine Corps where he directed oversight programs that included inspections, assessments, evaluations, investigations, and intelligence oversight. Mr. Holmgren most recently served as a career member of the federal senior executive service as the Treasury Inspector General for Tax Administration Deputy Inspector General for Inspections and Evaluations. He assumed that position in November 2008, where he was responsible for oversight of major Internal Revenue Service activities and programs. His evaluation of the IRS Tax Gap was recognized with an Award of Excellence in 2014 by the Council of the Inspectors General on Integrity and Efficiency.

Q&A with David Holmgren

Why did you choose to join the agency?

I retired from the federal government in November and moved to Austin. This was about the time all the news was breaking in the papers about the agency. I've been in the Inspector General business since 1999 and I was interested in what I could offer to the organization. When the Inspector General was named, I reached out to him be-

cause everything online indicated the inspection function had never been performed by this agency. The Inspector General had noticed the same thing. Fortunately, I was a nice match. I have a proven record of starting organizations from scratch. I believe I bring something to the Inspector General organization that will take this agency forward.

What positives do you see in this

Q&A with David Holmgren

division?

Being given the opportunity to start something from scratch has given me the latitude to set up policies and procedures and hire the best people. I've done this before. It also allows me to establish relationships in the Inspector General's office and the HHS enterprise.

What goals do you have for your division this fiscal year?

To be able to provide the Inspector General and the HHS enterprise the capability to provide quick reaction, agile reviews of programs and processes within the enterprise that allow senior management to make better informed decisions in the near term. If you are the Executive Commissioner or chief of staff and need information, traditional products may take six or twelve months. We can do it much quicker. An inspection or evaluation can give you enough information to make a decision because it is primarily program based; it's easier for us to go in and say, "Yes, you are doing it right" or "No, you are not." We can provide value in a fast-changing environment.

Do you have a guiding philosophy you bring to the office?

It goes back to providing value and following the Inspector General's values: the three Ps (professionalism, productivity, and perseverance). Taking care of people and getting the right staff, establishing relationships, producing a product that brings value to the enterprise. If you have the right people, do the job right, and treat stakeholders well, inspections can add tremendous value to the entire enterprise.

What's your top priority?

Conduct objective risk assessments and



develop a program plan for establishing a risk assessment system across the enterprise. If we can do that in FY 2016, then in FY 2017 we'll be in great shape, producing a trove of useful inspections.

Also, I have been named the agency ombudsman, so my other objective is to define what an IG ombudsman with whistle-blower protection will look like. I have to focus on that as well.

What primary challenges face the agency and the enterprise?

I think the challenge we face as an organization is the problems that have piled up over the last two years and have impacted morale. As the new team moves forward, we must involve everyone in the success plan. If we leave people behind, we didn't do it right. We have buy-in from the top of the organization; it's getting the rest of the staff involved that stands before us now. Are we bringing everyone along with us? We have a team committed to doing this; we just have to get everyone committed to it and understand what we are trying to do. When we do that, we will be the best state IG in the country.

Operations Division

Structure and Operation

The IG Operations Division comprises three units: Business Analysis and Support Services, Business Operations (BASS), and Research, Referral and Managed Care Integration.

The BASS Unit provides automated solutions and technology assistance for IG business needs, in addition to providing contract and project management for the Medicaid Fraud and Abuse Detection System.

Business Operations includes the Quality Assurance and Decision Support (QADS) and Administrative Services teams. QADS provides support through the planning, management, and administration of critical staff and operating resources. It prepares complex budget, actuarial, staffing, and performance measure analysis and reporting. The Administrative Services team ensures that IG daily operations run efficiently by providing support to facilities management, employee building access, evidence control and security.

The Research, Referral and Managed Care Integration Unit (MCU) includes the Provider Integrity Research (PIR) team, the Fraud, Waste and Abuse Hotline, and the Managed Care Unit. The PIR team conducts background screenings on provider

Hotline FY 2015 statistics

Calls received: 46,004

Calls answered: 37,142

Call answering percentage: 81%

Referrals generated: 20,478

Calls generating referrals: 55%

PIR FY 2015 statistics

Background checks conducted: 27,198

Juanita Henry, Deputy IG, Operations

Juanita Henry serves as the Deputy Inspector General for Operations. Prior to joining Operations, she was the Deputy Inspector General for Compliance. Ms. Henry is a graduate of Lamar University with a Bachelor of Science degree in Criminal Justice. Prior to joining OIG, Ms. Henry worked as a Special Agent with the U.S. Health and Human Services OIG. Additionally, she was the Manager of Investigations with the former Office of Investigations and Enforcement. Ms. Henry also spent nine years as a criminal investigator and four years as the Manager of Investigations with the Texas Attorney General's Medicaid Fraud Control Unit.

Ms. Henry has extensive management experience and knowledge related to program integrity and more than 19 years of experience investigating healthcare fraud. She has her Certification in Health Care Compliance and is a Certified Inspector General.

enrollment in Medicaid and other state programs; the IG Hotline receives allegations of fraud, waste, or abuse from state employees, Medicaid recipients, and the general public; and the MCU researches and analyzes managed care trends, issues, and best practices to provide assistance, recommendations, and education to IG Divisions regarding managed care. It also serves as liaison with HHSC Medicaid-CHIP division and external stakeholders.

Division changes

Pursuant to HHSC request, the Third Party Liability Unit was moved from IG Operations to the HHSC Medicaid/CHIP Division in June 2015. This move will cut into future IG recovery results, as TPL brought in more than \$100 million annually.

The Special Investigative Unit Coordina-

Operations Division

tor was moved from the MCU to the Medicaid Provider Integrity Unit, and the Research Analysis and Detection Unit was moved from IG Operations to IG Investigations in July 2015.

TPL FY 2015 statistics

Total costs recovered: \$160,550,260

Total costs avoided: \$95,968,262

Note: Figures are for first three FY quarters

Chief Counsel Division

Structure

The Chief Counsel Division provides general legal services to the Inspector General, renders advice and opinions on health and human services programs and operations, and provides legal support for all of the Inspector General's internal operations. The Litigation Section imposes administrative sanctions and penalties against Medicaid providers and litigates those actions in contested case hearings.

Division changes

Mr. Bowen found structural discontinuities in Chief Counsel structure and management and, as part of the remedy, created a new position—Deputy Chief Counsel for Litigation—and renamed the Sanctions Division as the Litigation Section. Mr. Bowen also is pushing for a closer working relationship with HHSC Chief Counsel as part of the administrative consolidation required by the Legislature.

Backlog

Mr. Bowen found a massive case backlog upon acceding to his position. Pursuant to his directive, Litigation Section attorneys

The end of payment suspensions

The Affordable Care Act requires states to withhold payments to Medicaid providers if a credible accusation of potential fraud is discovered during the review or investigation of a provider's billings to the program.

In practice, the provider is notified of the hold and the reason for the hold, and then payment for future billings is withheld by the Inspector General's office until such time as the issue is resolved or the payments on hold cover the overpayments discovered. Most often a provider negotiates a settlement with the Litigation Section. In some cases, the payment hold is litigated before the State Office of Administrative Hearings in a formal hearing.

Historically, the Inspector General has used this tool to bring providers into compliance and to recoup large overpayments. Unfortunately, the practice of implementing payment holds increased inordinately over the past several years, leading the Sunset Commission to conclude that the holds were being over utilized and sometimes abused.

In reaction to this finding, the Legislature set a new SOAH evidentiary standard for payment holds. Now, for a hold to be upheld, the Inspector General must prove probable cause and show that the actions of the provider could potentially damage the state budget and threaten the integrity of the Medicaid program. This standard is so restrictive that it effectively prevents the Inspector General from successfully instituting holds. Our discussions with CMS indicate this provision may be in conflict with federal law.

Chief Counsel Division

have carefully reviewed aging case files and made settlement recommendations to the IG.

Many cases were tainted by a problematic extrapolation tool that was in place when Mr. Bowen arrived. One of his first actions was to replace that tool, but, because of its previous use, many older cases may need to be settled. Since he started as the IG, the office has settled 26 cases worth \$8,604,072.

Litigation FY 2015 statistics

Cases opened:	483
Cases closed:	638
Exclusions:	476
Identified provider overpayments and civil penalties:	\$9,483,937
Cost avoidances (providers ordered to pay restitution):	\$39,846,491
Integrity/Litigation administrative penalties collected:	\$8,960

Policy and External Relations Division

Mr. Bowen created this division to address concerns raised by the Sunset Commission, which found that the Inspector General's office lacked adequate communication and outreach to the Legislature, HHSC, providers, and other stakeholders.

The division provides the IG with support in policy development, legislative and media relations, stakeholder outreach, agency communications, and IG report production. It serves as the point of contact and outreach for legislators and state officials who have questions or concerns about the Inspector General's office. The division's Stakeholder Outreach Initiative will offer providers the opportunity to interact directly with Mr. Bowen and his senior staff, opening a dialogue that will enable better oversight through training and transparency.

The Center for Policy and Outreach researches and recommends policy changes to HHSC Medicaid/CHIP division that stem from fraud, waste, and abuse. Through regular meetings with HHSC policy staff, it coordinates the formulation and interpretation of Medicaid policy for the Inspector General.

The Policy unit is developing standard-

Mark Seale, Deputy IG, Policy and External Relations

Mark Seale is the Deputy Inspector General for Policy and External Relations. He has worked in state and federal government affairs for more than 20 years, serving on staff in both the Texas House and Senate and has experience in statewide campaigns. He directs press and outreach initiatives for the Inspector General.

ized policies and procedures for the Inspector General's office and researching best practices from other Inspector General offices around the country.

This division also provides training for the entire Inspector General's office. It is creating a learning management system (called "IG University") that will conduct in-house training, manage external training, and ensure employees receive ongoing, comprehensive professional education. It will maintain a training library, conduct team-building for staff workgroups, organize and coordinate strategic planning sessions, and represent the Inspector General on the HHSC Leadership Development Strategy Workgroup.

Senate Bill 207 Summary and Implementation

The 84th Texas Legislature passed Senate Bill 207, which made a number of changes to the statutes that govern the Inspector General.

Coordination with the Executive Commissioner

The bill requires the Inspector General to work in consultation with the Executive Commissioner to adopt rules necessary to implement a power or duty related to the operations of the Inspector General.

The HHSC Executive Commissioner is responsible for performing all administrative support services necessary to operate the Inspector General's office, including functions of the Inspector General related to

- Procurement
- Information technology
- Legal Services
- Budgeting
- Personnel and employment.

Implementation note

The office is working closely with HHSC staff to consolidate and coordinate support services.

The Inspector General will closely coordinate with the Executive Commissioner and his staff when performing functions related to the prevention of fraud, waste, and abuse in the health and human services system and the enforcement of state law related to the provision of those services, including audit utilization reviews, provider education, and data analysis.

The Inspector General will conduct audits and investigations independent of the Executive Commissioner and HHSC, but will coordinate among the offices, program

staff, and with the Executive Commissioner.

Implementation note

These audits are scheduled in our internal Audit plan, which can be found in Section 4 of this report.

Definition of fraud

The bill changed the definition of "fraud" to specify that the term does not include unintentional technical, clerical, or administrative errors. The Legislature implemented this amendment because of investigative and prosecutorial overreaches by the office.

Criminal background checks

The Inspector General will enter into memoranda of understanding with each Texas licensing authority that requires a fingerprint background check of a health care professional. The memoranda will include processes for the Inspector General to confirm that a health care professional is licensed and in good standing for the purposes of Medicaid enrollment. The licensing authority will immediately notify the Inspector General if a provider's license has been revoked or suspended or if it has a disciplinary action against the provider.

Implementation note

The Inspector General disseminated these MOUs in July.

New subpoena power

The bill authorizes the Inspector General to issue subpoenas in connection with an investigation. Previously, only the Executive Commissioner possessed the subpoena power. Subpoenas may be issued to compel the attendance of a relevant witness or the production of evidence.

Senate Bill 207 Summary and Implementation

Shorter investigation timelines

SB 207 requires the Inspector General to complete preliminary investigations of Medicaid fraud and abuse by the 45th day after the date of receipt of a complaint or allegation (or the date the IG had reason to believe that fraud or abuse had occurred). Further, the IG must complete a full investigation by the 180th day after the date the full investigation began unless more time is needed.

If the IG determines that it needs more time, it must notify the provider of the delay and specify why it is unable to complete the investigation within the 180-day period. The Inspector General need not give notice to the provider if notice would jeopardize the investigation.

Implementation note

The Investigations Division has adjusted its investigative processes such that it is already meeting these deadlines.

Payment holds

A payment hold is a serious enforcement tool, required by Federal law, that the IG imposes to mitigate ongoing financial risk to the state, which takes effect immediately. The bill requires the Inspector General to consult with the state's Medicaid Fraud Control Unit in establishing guidelines regarding the imposition of certain payment holds.

The bill also requires the IG to notify a provider affected by the payment hold within five days of imposing the payment hold. This notice must include a detailed summary of the IG's evidence relating to the allegation and a description of administrative and judicial due process rights and remedies.

SB 207 specifies under which circumstances the Inspector General could impose a payment hold or find that good cause existed not to impose a payment hold, not to continue a payment hold, to impose a partial payment hold, or to convert a full payment hold to a partial payment hold. The Inspector General cannot impose a payment hold on claims for reimbursement that a provider submitted for medically necessary services and for which the provider has obtained prior authorization unless the office has evidence that the provider has materially misrepresented documentation of the provided services.

The bill specifies that the Inspector General could impose a payment hold without notice to a provider only if a payment hold is needed to compel the provider to give records to the Inspector General, when requested by the state's Medicaid Fraud Control Unit or on the determination that a credible allegation of fraud exists.

SOAH review of holds

To impose a payment hold, the IG must now prove probable cause that the credible allegation of fraud exists. Further, it must show the provider would be an ongoing significant financial risk to the state and a threat to the integrity of the Medicaid program.

The bill removes the requirement that the Inspector General and the provider share the costs of an expedited administrative hearing. Instead, the Inspector General is responsible for the costs of the hearing but the provider is responsible for its own costs.

Recoupment of overpayment or debt

HHSC or the IG must now give a provider

Senate Bill 207 Summary and Implementation

written notice of any proposed recoupment of an overpayment or debt related to Medicaid services and any damages or penalties related to a fraud or abuse investigation. The notice must include the specific basis and calculation of the overpayment or debt, facts and supporting evidence, a representative sample of the documents used as a basis for the overpayment or debt, the extrapolation methodology and related information, the amount of damages and penalties, and a description of due process remedies, including informal resolution. A provider can request an appeal of a recoupment or overpayment of debt within 30 days of the date the provider was notified.

Rules on operation and duties

The Executive Commissioner, in consultation with the Inspector General, will adopt rules detailing the Inspector General's investigation procedures and criteria for enforcement and punitive actions.

These rules will include direction for categorizing provider violations according to the nature of the violation and for scaling resulting enforcement actions, taking into consideration the seriousness of the violation, the prevalence of the provider's errors, financial harm, and mitigating factors. The rules also must include a specific list of potential penalties.

SB 207 specifies that the Inspector General will consult with HHSC regarding

- Investigations of possible fraud, waste, and abuse by certain managed care organizations.
- Training and oversight of special investigative units established by managed care organizations.
- Requirements for approving managed

care organizations' plans to prevent and reduce fraud and abuse.

- Evaluation of statewide fraud, waste, and abuse trends in the Medicaid program.
- Assistance to managed care organizations in discovering or investigating fraud, waste, and abuse.
- Providing ongoing, regular training to appropriate HHSC and Inspector General staff concerning fraud, waste, and abuse in a managed care setting, including training related to service providers and recipients.

Extrapolation review

The bill requires the Inspector General to review its use of sampling and extrapolation to audit provider records. The review will be performed by staff who were not directly involved in Inspector General investigations.

The bill also requires the Inspector General to arrange for the Association of Inspectors General or a similar third party to conduct a peer review of the office's sampling and extrapolation techniques. Based on the review and generally accepted practices among other states' offices of inspector general, the Executive Commissioner of HHSC, in consultation with the Inspector General, will adopt sampling and extrapolation standards to be used by the Inspector General in conducting audits.

Implementation note

The extrapolation model previously utilized by the IG was replaced in March with the RAT-STATS algorithm method, a nationally accepted extrapolation tool.

Senate Bill 207 Summary and Implementation

Reports and transparency

The Inspector General is required to submit a report to the Executive Commissioner, the Governor, and the Legislature. The report would be published on the Inspector General's website and would include information on the office's activities, performance measures, fraud trends, and recommendations for policy changes to prevent or address fraud, waste, and abuse in the health and human services system.

MCO audits

The Inspector General must consult with the Executive Commissioner regarding the adoption of rules defining the Inspector General's role in and jurisdiction over audits of Medicaid managed care organizations and the frequency of those audits. By September 1, 2016, rules will be adopted defining the roles of HHSC and the Inspector General and their jurisdiction over audits of Medicaid managed care organizations.

The Inspector General must coordinate all audit and oversight activities related to providers, including external oversight activities, to minimize the duplication of activities, including those of Medicaid managed care plans. The Inspector General will seek input from the Commission in coordinating these activities.

Pharmacies subject to audits

A pharmacy now has the right to request an informal hearing before the HHSC appeals division to contest an audit finding. The bill requires staff of HHSC's appeals division, assisted by vendor drug program staff, to make the final decision on whether

an audit's findings were accurate. It prevents the Inspector General's staff from serving on the panel that makes that decision.

By March 1, 2016, the Executive Commissioner, in consultation with the Inspector General, will adopt the necessary rules to implement these changes. Provisions related to pharmacies would apply to the findings of an audit made on or after September 1, 2015.

Performance audits and audit coordination

The Inspector General may conduct a performance audit of any program or project administered by or agreement/contract entered into by HHSC or any state health and human services agency. This includes audits related to contracting procedures or the performance of the HHSC or a health and human services agency.

In coordinating audits with HHSC, the Inspector General is required to seek input from the commission and to consider previous audits for purposes of determining whether to conduct a performance audit and to request the results of an audit conducted by HHSC if those results could inform the Inspector General's risk assessment when determining whether to conduct a performance audit or its score.

Reports on the death of a child

SB 207 allows a confidential draft report on an audit or investigation that concerned the death of a child to be shared with the Department of Family and Protective Services.

IG Strategic Plan

Section

2

IG Strategic Plan

During a three day strategic planning retreat in last June that included more than 80 staff, the Inspector General and his staff developed a Strategic Plan to guide the agency's work over the next two years. The plan lays out five goals with accompanying objectives and implementation strategies. This section provides an overview of that plan.

IG Goal 1

Identify and eliminate fraud, waste, and abuse through timely and high quality audits, investigations, and inspections.

IG Objective: Conduct comprehensive audits, inspections, and investigations that include recommendations for and recovery of monetary benefits, enhance HHSC programs, and refer violators for prosecution.

IG Strategy: Increase deterrence by improving IG profile across the state of Texas.

Division breakdown

Chief Counsel

- Ensure processes are in place to refer self-reports to MPI, Audit, or Inspection.
- Participate in development of case strategy early in the process to improve outcomes.

Investigations

- Increase deterrence by improving IG profile across the state of Texas by conducting outreach to stakeholders by the Investigations Division to educate them on who we are and what we do.

- Eliminate the backlog of current cases within the Investigations Division.
- Improve the quality of investigations through increased collaboration between Medicaid Provider Integrity, General Investigations, Internal Affairs Data Analytics and Fraud Detection, and HHS partners and external stakeholders.
- Identify and assign viable referrals through improved screening to conduct investigations in a timely manner.

Operations

- Develop and implement process to complete provider applications within newly mandated 10-day timeframe.
- Refer self-reports to MPI, Audit, or Inspection.
- Develop criminal history criteria for provider application process.
- Develop technology to track provider enrollment applications.

Audit

- Perform timely and quality audits and reviews that produce meaningful results.

Policy and External Relations

- Create and distribute public service announcements for media outlets and agency website.
- Create and distribute posters with Hotline phone number to provider offices.
- Increase social media use.

IG Goal 2

Generate and disseminate excellent work products.

IG Objective 1: Develop an outstanding Quarterly Report production team.

IG Strategic Plan

IG Strategy: Produce a report that goes to the Governor, Executive Commissioner, and each legislator each quarter.

Division breakdown

Audit

- Produce timely, accurate, well-written, meaningful, and concise summaries of audit and review audits.

Operations

- Develop and maintain division-specific expectations and policies and procedures, including desk references.
- Develop quality assurance and performance measures.

Policy and External Relations

- Obtain quality information from divisions; develop standardized and consistent metrics; tie process to mission implementation.
- Develop quality assurance and performance measures.

IG Objective 2: Generate a schedule and template for audit and inspection report production.

IG Strategies: Produce 8-10 audits per quarter; produce 4-6 inspections per quarter.

Division breakdown

Audit

- Establish an audit schedule designed to complete the audit plan and achieve quarterly production goals.
- Develop management methods to assign work to staff and monitor achievement

of Utilization Review and Lock-In Program workload goals.

Policy and External Relations

- Initiate audit schedule and template tied to Quarterly Report.

IG Objective 3: Develop new strategies for dissemination of information including the use of social media.

IG Strategies: Improve public website; develop media list.

Division breakdown

Chief Counsel

- Produce better litigation results by participating in development of case strategy early in the process. This will be done in conjunction with adopting best practices.
- Improve Chief Counsel work products.

Audit

- Use the IG website, and other applicable media, to communicate with providers, contractors, stakeholders, and the public about Audit Division plans, processes, and results.

Investigations

- Define and establish clear guidelines for the development and production of all work products for the Investigations Division.

Policy and External Relations

- Develop improved OIG website; tie-in with HHSC Communications to provide an IG Corner to disseminate IG information in HHSC outreach materials.

IG Goal 3

Adopt and model best practices including cutting-edge technology and data analytics.

IG Objective: To be recognized as the most efficient and technically proficient IG in the country.

IG Strategies: Research and obtain an effective data analytics tool and other technologies; conduct an ongoing review of other state IG best practices; implement clear policies and procedures.

Division breakdown

Chief Counsel

- Ensure policies and procedures are appropriate.
- Retool the case management system and process.

Investigations

- Research and obtain new data analytics and case management tools to achieve better, faster data results for investigations and streamline operational workflow processes.
- Conduct an ongoing review of other state IG best practices and incorporate effective models and processes into the Investigations Division.
- Design, develop, and implement clear and concise policies and procedures for each area within the Investigations Division.

Operations

- Obtain monthly premium payments file for data analytics.

- Obtain denied and rejected vendor drug transactions.
- Increase encounter data reliability and accuracy.
- Leverage existing technologies to enhance IG business processes.
- Procure a new Medicaid Fraud Abuse Detection System.
- Develop the best practices for sampling and extrapolation process in the actuary.
- Educate IG divisions on the services provided by the actuarial department.
- Contract with outside sources for continuing education.

Audit

- Use data analytics and data visualization to improve the accuracy and reliability of risk assessment results, effectiveness of audit and review processes, and management of resources and workload.

Policy and External Relations

- Create a best practices workgroup.
- Continue development of Policy Workgroup which coordinates policy development in all IG divisions.
- Establish a central collection and review of all IG policies and procedures.

IG Goal 4

Develop and maintain outstanding internal and external relationships.

IG Objective: Encourage open communication with provider community and external stakeholders through provider training, Stakeholder Outreach Initiative, forums. Improve internal communication: Drive and track regular contact with HHSC, IG supervisors model the values of the agency.

IG Strategic Plan

IG Strategy: Treat all stakeholders with dignity and respect at all levels of IG.

Division breakdown

Chief Counsel

- Explore possibility of mediation at the State Office of Administrative Hearings.
- Improve communications and collaboration with HHSC Legal.

Operations

- Implement video conferencing for all IG offices.
- Research and analyze managed care trends, issues, and best practices to provide assistance and recommendations to IG divisions.

Audit

- Expand the quality and frequency of communications with the provider community and other external stakeholders.
- Actively reach out to HHS agency program and administrative support areas to learn more about agency operations, tell others about what we do at IG, and collaborate on identifying potential audit topics and initiatives for improvement.

Policy and External Relations

- Schedule regular briefing from the IG with Governor's Office and HHSC Executive Commissioner.
- Schedule staff-level briefings with IG Policy, Speaker, Lieutenant Governor, and media.
- Increase legislative outreach through Champions program, contacting key lawmakers; meetings in-district; and regular legislative staff briefings at the

Capitol coinciding with release of Quarterly Report.

- Increase provider outreach by attending professional meetings and conferences, visiting medical/dental schools, and increased digital outreach.

IG Goal 5

Create and maintain a high-quality and professional staff.

IG Objective 1: Establish a system that provides relevant and timely development.

IG Strategies: Have personnel dedicated to training and development; establish a training and development delivery system; develop curriculum; develop a feedback mechanism.

Division breakdown

Chief Counsel

- Develop staff through a tailored training program.

Investigations

- Develop and implement a plan which will include employee performance development requirements, mandatory and optional training opportunities, parity, and a process for staff to provide feedback to management.

Audit

- Develop training requirements and expectations, and facilitate staff development and professional growth.

Policy and External Relations

- Establish "IG University".

IG Strategic Plan

IG Objective 2: Conduct relevant and high-quality training.

IG Strategies 100 percent of personnel complete core skills training; 80 percent of personnel complete job-specific training; 10 percent of personnel conduct leadership development training.

Division breakdown

Chief Counsel

- Cross-train staff and ensure people hired are qualified and adequately trained.

Investigations

- Design and develop training materials and job-specific curriculum for all staff.

Audit

- 100 percent of audit staff will complete job-specific training every year as required by Generally Accepted Government Auditing Standards, and 100 percent of nursing staff will complete job-specific training at least every two years as required by the Texas State Board of Nursing.

Policy and External Relations

- Identify needs for components of core HHSC and IG job skills, job-specific skills, and leadership skills.

- Develop individual learning plans.

IG Objective 3: Reduce vacancy rate to 7 percent.

IG Strategies Increase pay for new hires; increase use of recruiting/retention bonus; develop improved pay scale.

Division breakdown

Investigations

- Create and maintain a culture that attracts and retains quality employees.
- Develop career ladder and offer training to increase knowledge and abilities of existing staff.

Chief Counsel

- Perform ongoing evaluation of employees.

Audit

- Retain and reward individuals who are excellent performers.

Policy and External Relations

- Define recruiting process with specific goals across divisions, and identify and utilize internship opportunities.
- Create opportunities for all staff to participate in regional and national training.



Investigations

Section

3

Investigations

Reform

Among Mr. Bowen's first new hires was Jay Crowley, a 44-year federal investigative leader who worked with Mr. Bowen at the Special Inspector General for Iraq Reconstruction as a deputy for investigations. Mr. Crowley started in March immediately identifying existing weaknesses and vulnerabilities including:

- An autocratic management style that stifled creativity.
- A general disregard of policies and procedures.
- No cohesive or consistent application of basic investigative guidelines.
- A general lack of investigative focus especially within the Medicaid Provider Integrity Directorate.

Mr. Crowley found managers and investigative staff who were reluctant to make decisions, because they had been previously prevented from or chastised for doing so. Morale throughout the (formerly designated) Enforcement Division (now renamed Investigations) was in a trough.

Mr. Crowley has since accomplished the following:

- Empowered managers and investigative staff to make timely investigative decisions resulting in better utilization of staff and resources and improving results.
- New training regimes have been conducted to continuously improve the investigative skills required to effectively and efficiently conduct investigations.
- Established new and usable investigation policies and guidelines.
- Created a culture of teamwork and cooperation to overcome previous impediments.

- Reduced the large backlog of cases in MPI. There were a total of 1,740 cases identified as open in MPI of which many were more than three years old. To date, the current inventory has been reduced to 9% which, a (7") percent reduction, and the ID will continue to reduce that number.

Mission and Structure

The Investigations Division protects the integrity of the Texas Medicaid and other health and human services programs through investigations of provider and recipient fraud, waste, and abuse. It also analyzes trends and patterns of behavior and billing and refers cases for sanctions or prosecution to appropriate state or Federal regulatory and law enforcement authorities.

Additionally, the Investigations Division conducts personnel investigations at the State Supported Living Centers as well as within HHSC agencies.

The Investigations Division has six separate directorates: Medicaid Provider Integrity; Intake Resolution; Law Enforcement; General Investigations; Data Analytics and Fraud Detection; and Internal Affairs.

Medicaid Provider Integrity Directorate (MPI)

MPI investigates allegations of fraud, waste and abuse committed by Medicaid providers. Some referrals come through the IG Fraud Hotline or complaints from the Inspector General's online Waste, Abuse and Fraud Electronic Referral System. Referrals are also received from the 21 Managed Care Organizations (MCOs) throughout the state.

The directorate develops cases through data analytics of Medicaid billing, evidence

Investigations

acquired through contacts with Medicaid recipients and through liaison within the Medicaid provider community. MPI has approximately 64 investigators and 11 nurse reviewers to conduct investigations with offices in Dallas, Houston, Pharr, Austin, Laredo and San Antonio.

Since February 2015, MPI referred 39 cases to Chief Counsel to seek recoupment of Medicaid overpayments totaling \$8,033,688. An additional 46 cases are scheduled for referral seeking recoupment of Medicaid overpayments totaling \$7,259,385.

Four settlement agreements were reached resulting in recoveries totaling \$987,230. The dollar amount of cases presented to Chief Counsel for recoupment and the dollar amount of recoveries presented above, reflect actual dollars identified as overpayments through investigations and review of records. Moving forward, all investigations requiring sampling will rely upon the newly adopted industry standard.

Investigations received 19 MCO referrals this quarter with estimated overpayments of \$2,390,969. These referrals resulted in 17 ongoing MPI investigations with an estimated MCO overpayment of \$1,935,794.

The number of pending MPI full-scale investigations has been reduced from 694 to 425. Of the 694 investigations, 314 were greater than two years old and considerable effort continues to reduce the remaining backlog.

Older cases are being reviewed for closure due to the following issues, including but not limited to: utilizing expert witnesses that are no longer affiliated with MPI; concerns with the older statistical sampling tools that were previously utilized; and with cases consisting of substantial administrative errors rather than substantive Medicaid

violations. All MPI investigations that are greater than two years old will be resolved before the end of the first quarter of Fiscal Year 2016.

Sample MPI Investigative Accomplishments:

- MPI initiated an investigation based on a complaint regarding a hearing aid provider. It conducted an investigation, discovering that the recipients did not meet the guidelines for provision of hearing aids under the Medicaid hearing aid program. Records review confirmed that out of a total of 660 cases reviewed, 647 had errors related to the required policies, procedures or documentation. As a result of this investigation, IG secured a \$750,000 settlement agreement on July 2, 2015.
- A majority of comprehensive orthodontic treatment plans submitted to Texas Medicaid Healthcare Partnership by a dentist failed to meet Medicaid scoring criteria. Of the 600 cases tested, 491 had one or more errors related to the required Medicaid policies, procedures, and documentation. As a result of this investigation, the IG secured a \$136,985 settlement on July 7, 2015.

Intake Resolution Directorate (IRD)

Investigations created IRD this quarter, a newly created directorate within the Division. It consists of the former Research Analysis and Detection unit and the former MPI Preliminary Intake unit.

The Research Analysis and Detection unit identified inappropriate Medicaid payments. The unit is comprised of nine registered nurses and seven research staff who conduct a variety of research activities designed to identify potential fraud, waste,

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and abuse within the Medicaid program. They are responsible for the Center for Medicare and Medicaid Services' Surveillance Utilization Review requirements and they monitor various sources of information such as Medicare Alerts, Medicaid Integrity Institute newsletters, as well as the U.S. Health and Human Services Office of Inspector General reports and audits to identify patterns of potential aberrant billing. The information is used to comparatively analyze Texas Medicaid claims and encounter billing data to ensure compliance.

Between February 1, 2015 and August 26, 2015, the RAD unit completed 1,834 cases, opened 813 cases and recovered \$8,558,614 of inappropriate payments (this includes \$483,382 to be reported by the end of FY16 for a special project in process).

The Intake Unit, which handles complaint intake and resolution activities, is comprised of 18 investigators. They improve processes, resolve aging cases, address backlogs and implement legislative mandates. They also meet with internal and external stakeholders to refine referral criteria requirements and to improve communication.

Sample IRD accomplishments:

- The RAD unit conducted a special project regarding a high dollar breast cancer medication. The Federal DHHS/OIG issued a report in 2012 alerting states to improper billing of Herceptin in the Medicare arena. RAD reviewed the rules, regulations and policies regarding the use and billing of the drug in the Medicaid population. RAD identified the top billers, conducted medical record reviews and recovered \$615,590 of inappropriate payments. Approximately a year later, DHHS/OIG conducted an audit of this issue. RAD assisted them

with their reviews.

- Since February 10, 2015, the Intake Unit has reduced the total number of cases in intake from 1,046 to 572.

Effective September 1, 2015, the Intake Unit will be required to complete preliminary investigations within 45 days of receipt, a guideline it will meet.

Law Enforcement Directorate (LED)

LED is a newly created directorate within Investigations and consists of both commissioned and non-commissioned investigators who conduct criminal investigations surrounding violations involving State Supported Living Centers and State Hospitals, Electronic Benefits Transfers, and Medicaid Fraud.

The three units comprising this directorate are:

- State Centers Investigative Team
- Electronic Benefit Transfer Trafficking Unit
- Medicaid Law Enforcement Unit.

State Centers Investigative Team (SCIT):

Between February 2015 and July 2015, SCIT completed 615 cases and filed criminal charges in 20 cases.

Sample SCIT Investigative accomplishments:

- At the Mexia State Supported Living Center, an initial allegation charged that a client left without authorization and was injured in the nearby woods. During the course of the investigation, IG investigators determined the resident had been beaten. Four suspects were ultimately identified as having been involved. The case was completed on March 27, 2015, and forwarded to the Limestone County District Attorney's office. On June 17, 2015, a grand jury

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returned indictments on the four defendants.

- IG received an allegation about a male staff member at the Waco Center for Youth communicating with a minor female resident in an attempt to develop a sexual relationship. The suspect failed a polygraph and the McClennan County District Attorney is prosecuting.

EBT Supplemental Nutrition Assistance Program (SNAP) Trafficking Unit

The unlawful use of SNAP benefits is a major concern of the Food and Nutrition Service at the United States Department of Agriculture, which designated the Inspector General as the state Law Enforcement Bureau on this issue.

The unauthorized use, transfer or possession of EBT benefits is a federal and state crime, FNS enlists state and local law enforcement officials to apprehend and penalize persons who violate the Food and Nutrition Act and its regulations.

In February 2015, the Inspector General created the EBT/SNAP Trafficking Unit to conduct investigations into food stamp fraud.

EBT retailer investigations conducted between February 2015 and August 26, 2015, resulted in six arrest warrants, four arrests, and one indictment.

EBT recipient investigations associated with these trafficking investigations resulted in 85 established claims for recovery, totaling \$144,693. This total includes

- 4 non-fraud claims, totaling \$27,774.
- 76 Administrative Disqualification Hearing (ADH) claims, totaling \$115, 330;
- 5 District Attorney (DA) claims, totaling \$1,588.

Sample EBT Investigative accomplishments:

- A North Texas store owner and employee were arrested in a SNAP/EBT trafficking investigation. In July and August 2015, IG investigators conducted undercover operations. The store, an FNS authorized retailer, opened in March of 2015 and immediately produced an average monthly SNAP redemption of \$6,200 per month. The owner and an employee were arrested by the Grand Prairie Police Department on 3rd degree felony warrants, booked on \$10,000 dollar bonds each and are awaiting trial in the Tarrant County District Attorney's office.
- The Terrell Police Department notified IG investigators that owners/employees of a store were trading SNAP benefits for credit and beer from SNAP recipients. Further investigation confirmed two suspects trafficking in EBT benefits. IG conducted the investigation jointly with the Terrell Police Department, obtaining evidence of the two suspects making illegal purchases using SNAP benefits. Both were arrested, one was charged with a 3rd Degree Felony and the other a Class A Misdemeanor. The Kaufman County District Attorney's Office will prosecute them.
- During the course of a joint investigation with USDA/IG, investigators found a retailer in Cameron County was trafficking in EBT benefits. An IG forensic investigation conducted by the Data Analytics and Fraud Detection Directorate showed that over the past two years the store had questionable EBT transactions amounting to \$50,602. A Cameron County grand jury indicted a store employee on August 19, 2015, with addi-

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tional charges pending against the store's owner.

- Operation LONESTAR is a joint EBT/SNAP investigation involving USDA-IG, IG investigators, the Texas Department of Public Safety and the U. S. Department of Homeland Security. The operation identified multiple retailers trading SNAP benefits for cash. Two arrest warrants were issued. Federal and local prosecutors will handle the cases. The investigations include suspects from Texas, New Mexico, and Mexico.

Medicaid Law Enforcement Unit

The Medicaid Law Enforcement unit comprises five commissioned peace officers authorized by the Legislature to assist with Medicaid Fraud investigations.

Sample Medicaid Law Enforcement investigative accomplishments:

- IG investigators proved allegations related to an unlicensed individual conducting illegal medical examinations, assessments, and treatments. The investigation revealed a business owner who hired a 29 year old female to perform, without prior authorization, various medical procedures. The suspect conducted these procedures and prescribed medication from a pre-signed prescription pad, even though she was found not to be licensed as a medical professional in Texas or any other state of the United States. A federal grand jury issued indictments on the following counts: conspiracy to commit health care fraud; health care fraud, and aggravated identity theft.
- In June 2015, IG investigators participated in the largest national healthcare fraud investigation in history, conducted across the United States in 17 cities, in-

volving charges against 243 individuals, including 46 doctors, nurses, and other licensed medical professionals, for their alleged participation in healthcare fraud schemes involving approximately \$712 million in false billings. This coordinated effort was the largest healthcare "takedown" in history, both in terms of the number of defendants charged and recoveries. The IG assisted the Rio Grande Valley Health Care Fraud Prevention & Enforcement Action Team, serving sealed indictments against defendants around McAllen. A total of eight defendants were arrested.

General Investigations Directorate (GI)

GI conducts investigations of state publicly funded health and human services recipients. Specifically, it pursues allegations of overpayments made to recipients in the Supplemental Nutrition Assistance Program; Temporary Assistance for Needy Families; Medicaid; Children's Health Insurance Program; and the Women, Infants, and Children program.

Referrals to GI come from data analysis performed by GI staff, referrals from the Office of Eligibility Services, other HHSC entities, and the general public. Referrals come either through calls to the Fraud Hotline or online complaints to our website. Any dollars identified for recovery are referred for collection to HHSC's Fiscal Division through the Accounts Receivable Tracking System. Additionally, GI conducts criminal investigations of the above recipients, which are referred to district attorneys throughout Texas for criminal prosecution.

During this reporting period, GI had approximately 114 investigators in Texas offices including Dallas, Houston, Pharr, Austin,

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El Paso, Abilene and Beaumont. Accomplishments included 786 cases referred to district attorneys, 668 court dispositions, more than \$21 million identified for recovery, and more than \$30 million collected. We expect an increased number of cases referred to district attorneys, since training has increased IG understanding of what evidence specific prosecutors prefer to move forward on our cases.

Sample General Investigations accomplishments:

- On June 30, six women were arrested and charged in Hidalgo County with various levels of theft totaling more than \$250,000 in SNAP and Medicaid fraud (for not reporting spousal income). The cases resulted from a “sweep team” formed by GI and came from referrals by various sources, including HHSC eligibility workers and public complaints. The “sweep team” consisted of 14 investigators and a manager, and resulted in the referral of 51 cases for prosecution and 54 cases for Administrative Disqualification Hearings.
- GI completed an investigation, initiated on a Hotline referral, regarding a SNAP and Medicaid recipient whose husband was working but was not included on her application for benefits. The suspect was charged with five counts of tampering with a government record, one count of theft, and one count of Medicaid fraud. She received suspended sentences of five years, eight years, and two years, respectively, and served 85 days confinement in the El Paso County Detention Facility. The identified loss was \$32,851.
- An El Paso County investigation, initiated from a referral by a federal parole officer, substantiated an allegation that a

SNAP/Medicaid suspect resided in Mexico. The suspect was charged with four counts of tampering with a government record, one count of theft, and one count of Medicaid fraud and awaits trial in the El Paso County Detention Facility. The identified loss was \$32,777.

- IG Investigators pursued a Webb County case from a referral by a Texas Works Advisor who suspected that an absent parent was actually residing in the household based on vehicle and license renewals. The investigation revealed that the “absent parent” had been living in the home since 2011 and the client had not reported him or his self-employment income as a truck driver, which resulted in the overpayment of \$68,586 in benefits. The client admitted to falsifying her application for benefits. The case was referred to the district attorney for prosecution on July 27, 2015.
- An investigation initiated by a referral from an HHSC eligibility worker found \$74,543 in fraud in SNAP and Medicaid in an El Paso case which was referred for prosecution. The suspect’s husband was working out of town for an energy company and she did not include him on her application for benefits. The investigator obtained verification from a witness, social media posts, vehicle registrations, property ownership, and driver's license, and then obtained a voluntary statement from the suspect.

Data Analytics and Fraud Detection Directorate (DAFD)

DAFD comprises two units: Data Analytics and Intelligence. Both work to seek, identify and remediate suspected fraud, waste, and abuse within the Texas Medicaid

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and other social services programs. They utilize data analytics and investigative research techniques to execute their mission.

DAFD utilizes several different agency and third-party programs to create comprehensive, detailed, and thoroughly vetted products that support investigations.

Sample DAFD accomplishments:

- Vendor Drug Program supported the program and HHSC Legal Services in identifying pharmacy claims billed at a rate higher than allowed under Medicaid program rules. The data analysis assistance has led to the negotiated recovery with several pharmacies amounting to \$12.04 million.
- Duplicate Billing analyzed claims of duplicate Medicaid billings by a group of speech therapy and Comprehensive Outpatient Rehabilitation Facility providers, leading to a recovery of \$20,000.
- Electronic Benefit Transfer Trafficking Support developed and implemented a system to identify suspected trafficking patterns for EBT retailers and recipients. This produced several reports, finding numerous patterns helpful in EBT investigations, including a report detailing the transaction history of a suspicious EBT retailer. On August 18, 2015, the EBT store owner and store clerk were charged with felonies, arrested and released on \$10,000 bond.
- Policy Change Recommendations identified Medicaid policy weaknesses and provided recommended policy changes to the Medicaid/CHIP Division for consideration. The Medicaid/CHIP Division agreed with the recommendations and is implementing these changes.

Internal Affairs (IA) Directorate

IA conducts investigations of fraud, waste, abuse, employee misconduct, and contract fraud within the five agencies comprising the HHSC.

Referrals come from multiple sources including the Hotline, online referrals, email, fax, and other developed sources.

For the period of February 2015 to August 2015, IA had 24 investigators located in nine cities including Austin, Fort Worth, Houston, Lubbock, El Paso, San Antonio, Dallas, Jacksonville and Edinburg. During this reporting period, IA conducted 391 investigations with 196 of those being substantiated.

The cases involved Vital Statistic fraud; contract fraud; employee misconduct; privacy breaches; computer misuse; Child Protective Services -child death; and Adult Protective Services-adult death.

Sample Internal Affairs Investigative accomplishments:

- A former HHSC employee created fraudulent profiles in the Texas Integrated Eligibility Redesign System to obtain benefits for non-existent individuals. This resulted in the loss of approximately \$122,000. Final disposition was reached on July 17, 2015, in Ellis County. The former employee pled guilty, was placed on 10 years probation, and was ordered to pay restitution in the amount of \$77,000.
- A Texas Works Advisor self-generated a Lone Star Card for personal benefit. The worker was observed on retail surveillance video purchasing items and using food stamps when not authorized by law. A Harris County grand jury indicted the suspect, with final disposition pending.

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- In an investigation into a child death, IA found that a CPS Investigator reported they attempted to visit with a child at school, and attempted speaking with the mother by phone as well as speaking with a neighbor. Further investigation revealed that the CPS Investigator never

made such contact and falsified documentation in the CPS IMPACT system. A Harris County grand jury indicted the investigator for tampering with government records and final disposition is pending.

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Section

4

Reform

When Deputy IG David Griffith started in May 2015, he found a staff that had been through significant turmoil and uncertainty. But Mr. Griffith saw that the staff remained positive, demonstrated a willingness to succeed, and continued to recognize the importance of IG mission. There were, however, considerable barriers to achieving success, and performance in many areas of the Audit Division fell far below par.

By June 2015, Audit had issued only 8 of 88 audit projects in the OIG Audit Plan for Fiscal Year 2015. This shortfall included 61 audits from previous years' audit plans. In addition, Audit had issued only 3 of 112 planned Intermediate Care Facility Residential Trust Fund Audits, and only 301 of an estimated 435 single audit reviews had been completed. The Cost Report Review Unit had completed 1,449 desk reviews and 65 field audits of an estimated 1,540 audit projects planned for fiscal year 2015. The division was seriously underperforming.

To aggravate matters, there was no process in place for tracking the results of audit recommendations regarding the collection of overpayments or for implementing improvements to performance, processes, and systems. Consequently, data did not exist to measure whether actions taken to address audit recommendations produced overpayment collections, improved compliance, reduced risk, or strengthened processes.

During Fiscal Year 2015, the Utilization Review work plan indicated nursing facility reviews would examine activity from April 1, 2013 through March 31, 2014. Hospital reviews were lagging several years behind current periods, with reviews during fiscal year 2015 planned to examine claims from the first quarter of 2010 through the fourth

quarter of 2011.

These reviews covered periods of time when fee-for-service was the primary Medicaid service delivery approach in Texas. Managed care expansion escalated in Texas by March of 2013. The managed care service delivery model is now the predominate service delivery approach, with nearly 85 percent of Medicaid recipients in Texas receiving services through managed care organizations.

Nursing facility and hospital Utilization Review staff, however, are not equipped or prepared to perform their responsibilities in a "managed care world." For example, it is not clear whether a managed care organization or the State of Texas would receive the benefit of collected overpayments identified during utilization reviews conducted by the Audit Division.

The previous Audit Director was responsible for management of nearly 150 full-time equivalent employees. This was reduced by 54 FTEs when the Cost Report Review Unit, based on a recommendation from the Sunset Commission report, was transferred to HHSC Financial Services.

Audit expectations for what constitutes acceptable performance had not been clearly defined or communicated to managers and staff. Timeliness and resource utilization targets were not in place to measure and compare actual to planned project performance. Systems were not in place to accurately and readily capture the current status of active audits or to determine the percentage of project completion.

These management challenges limit the IG's knowledge of whether audit performance was on target.

Significant changes are required to address these and other concerns in Audit. Mr. Griffith and his new leadership team

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have been implementing numerous changes and many more in the offing.

Improvements Implemented or in Progress

- Collaborated with the Medicaid/CHIP Division in developing of the Medicaid performance audits, including Medicaid managed care audits, contained in the Fiscal Year 2016 IG Audit Plan, coordinated with HHSC agency internal audit divisions before finalizing performance audits of HHSC agency programs included in the plan.
- In a collaborative effort including IG, DADS, and the State Office of Administrative Hearings, 66 of the 471 appeals pending in February 2015 were resolved by August 31, 2015. The agencies are working on a global solution for this backlog.
- Organized a multi-divisional workgroup jointly with the Medicaid/CHIP Division to develop options for implementing a managed care utilization review process.
- Created an Audit Operations Directorate, which is responsible for quality assurance for audits and utilization reviews, federal external audit coordination, audit risk assessment, information technology application support, performance management reporting, and other support activities designed to reduce the burden of administrative activity on operational units and give managers and staff in those units more time to perform primary duties.
- Collaborating with HHSC Legal to develop a standardized audit appeal process for Audit Division audits and CMS Medicaid Integrity Program audits.
- Developing a formal referral process be-

tween the Audit and Investigation divisions.

- Implementing Audit Division requisition approval and purchasing tracking processes.
- Developing processes for managing, tracking, and reporting the progress of audit projects.
- Revising administrative and direct time codes for auditors, and requiring audit teams to develop due date targets and staff utilization goals for each phase of the audit process.

Improvements planned for FY 2016

- Implement a Utilization Review Quality Assurance Program.
- Improve the IG and Audit Division reputation and relationship with HHS agency management and staff, and with external stakeholder groups and individuals.
- Increase transparency of activities occurring in the Audit Division with both HHS agencies and external stakeholders.
- Improve the usefulness and effectiveness of Audit Division policies and procedures by implementing revisions, updates, and consolidating where appropriate.
- Implement an audit position career ladder, as an IG pilot, to improve staff quality and retention.
- Based on the results of the audit career ladder pilot, implement a career ladder for Utilization Review Unit nurses.
- Expand Audit Division opportunities for internships and initiate a new college graduate recruitment program.
- Improve the Audit Division staff development program.
- Implement a SharePoint division-wide intranet as a tool to improve document

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management, task workflow management, and communication.

- Track and report on the implementation status of prior audit recommendations.
- Maximize the use of TeamMate to manage, monitor, and report on the progress of audits.

Organizational changes during FY 2015

Recent organizational changes in the Audit Division include the transfer of the Cost Report Review Unit to the HHSC Financial Services Rate Analysis Department, and the transfer of the Texas Women, Infants, and Children (WIC) Vendor Monitoring Unit to the IG Inspections and Evaluations Division. The federal external audit coordination function was transferred from HHS Risk and Compliance Management to the Audit Division in August 2015 as a six month pilot. Additional organizational changes recommended in the Sunset Commission report are being finalized and should be implemented in the next 30 days.

The Audit Division is being restructured with the addition of the Audit Operations Directorate, which will provide support to operational units in the Audit Division. Support will include audit and utilization review quality assurance, audit risk assessment, IT application support, and workload production management. Other Audit Division changes include adding IT audit and performance audit staff positions, and adding a new Audit Director position to reduce span of control to a more manageable level.

Audit Division responsibilities, performance, and workplans

The Audit Division includes three directorates: Audit, Quality Review, and Audit Operations. The information that follows

outlines the responsibilities of these units and their respective fiscal year 2015 performance results. For the Audit Directorate, it includes a list of the audit projects planned for fiscal year 2016. For Utilization Review, part of the Quality Review Directorate, it includes risk assessment criteria, the number of nursing facilities planned for review, and the number of hospital claims planned for review in fiscal year 2016.

Audit Directorate

The Audit Directorate conducts risk-based compliance and performance audits of contractors, providers, and HHSC agency programs. The purpose of these audits is primarily to evaluate:

- The efficiency and effectiveness of programs and operations.
- Whether federal and state funds were used as intended and produced expected results.
- The extent of compliance with federal regulations, Texas statutes, Texas Administrative Code, and contract provisions.

Audits are performed in accordance with Generally Accepted Government Auditing Standards issued by the Comptroller General of the United States, IT Audit and Assurance Standards contained in the IT Standards, Guidelines, and Tools and Techniques for Audit and Assurance and Control Professionals issued by ISACA, and other applicable auditing standards that may apply to a specific audit.

The results of these audits are reported to the auditee and to HHSC agency management. Audits identify overpayments and disallowed costs, and make recommendations to improve performance, mitigate risks, address control weaknesses, and reduce privacy and IT security vulnerabilities.

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Auditors refer any potential fraud they identify or become aware of while performing audit procedures to the IG Investigations Division.

The IG Audit Plan for fiscal year 2015, as amended, included 88 contractor or provider audits. Included in that audit plan were 69 audits that had been identified to be audited in previous fiscal year audit plans: 17 from fiscal year 2013 and 52 from fiscal year 2014. Of the 88 contractor or provider audits, 41 were hospital outpatient Medicaid cost report reviews. When the Audit Division identifies unallowable costs on a hospital cost report, it notifies the HHSC Medicaid claims administrator, which adjusts the applicable cost report by removing the unallowable cost, then recalculates any Medicaid payments that were based on the cost report. At the beginning of fiscal year 2015, 41 Medicaid hospital cost report reviews were in progress or planned.

Contractor and provider audits FY 2015

Audit reports issued: 11
Dollars identified for recovery: \$411,459
Hospital Medicaid Cost Reports Reviewed: 12
Unallowable Costs Identified: \$8,492,325

Highlights of contractor and provider audit results from Fiscal Year 2015 include:

- HHSC contract funds were not spent appropriately by a Mental Health Mental Retardation facility. The medical, social, and safety needs of some patients were not being met and financial transactions were not properly supported with documentation. The facility is currently under investigation.
- An integrated audit of a nursing home

facility identified quality of care concerns and pharmaceuticals that had not been appropriately destroyed.

- Unallowable expenses were included on a Managed Care Organization's Financial Statistical Report. Removal of the unallowable expenses increased net income, which increased the experience rebate owed to the state by \$160,956, including interest.
- The results of a fiscal year 2014 audit reported a high error rate at one pharmacy. The pharmacy appealed the results, resulting in agreement that Audit Division would perform another audit of the pharmacy testing a larger sample of pharmacy claims. Preliminary results of the second audit indicate 137 errors out of a sample size of 609 claims, consistent with the error rate in the original audit.

The Audit Division, in accordance with a Memorandum of Understanding between IG and DADS, reviews ICF Resident Trust Funds after an ICF changes ownership or goes out of business. The objective is to determine whether the resident's trust funds are being accurately accounted for, documentation exists for expenditures from resident's trust funds, and applied income from the resident and compensation from the state is accounted for accurately. At the beginning of Fiscal Year 2015, 60 ICF Trust Fund Reviews were pending. Another 52 reviews were requested during fiscal year 2015.

ICF residential trust fund reviews FY 2015

Review reports issued: 17
Dollars identified for recovery: \$18,349
Recipient refunds: \$62,049

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Single audit desk reviews are non-audit services conducted to ensure subrecipients of HHSC agency funds provide their single audit reports in accordance with applicable grant award, financial reporting, OMB Circular A-133, and the State of Texas Single Audit Circular requirements. During fiscal year 2015, OMB Circular A-133 was replaced with the Uniform Grant Guidance (UGG); the first effective date of UGG was December 26, 2014.

The Audit Division reviews subrecipient single audit reports for completeness, accuracy, and reasonableness. Subrecipients of HHSC agencies take delivery of federal or state funds that are passed through the state agency. The Audit Division performs a desk review on all single audits of subrecipients that receive HHSC agency funding, whether pass through or direct, and evaluates whether applicable compliance requirements were met.

When HHSC agency funds are identified on the subrecipient's Schedule of Expenditures of Federal Awards, the reviews determine whether the funds were appropriately identified under and included the correct Catalog of Federal Domestic Assistance number. The Audit Division reports desk review results to the applicable HHSC agencies that fund the subrecipients. At the beginning of fiscal year 2015, 25 single desk audit reviews were pending. Another 410 single audit reports were received during the year.

Subrecipient single audit report reviews FY 2015

Reports reviewed: 301

Fiscal Year 2016 Audit Plan

To accomplish this audit plan, the Audit Division performed a risk assessment, interviewed key HHS agency management and staff, and coordinated with the HHSC Medicaid/CHIP Division and HHSC agency internal audit divisions.

The plan contains 58 audits from the fiscal year 2015 audit plan that were still in progress on August 31, 2015.

It is possible that some of these audits may be replaced with other audits as the fiscal year progresses, due to changing risks and priorities.

The projects included in the Audit Plan for Fiscal Year 2016 are grouped by type of audit: performance, information, technology, and provider.

Performance Audits

- Managed Care Organization Special Investigative Units Performance
- Quality and Completeness of Managed Care Organization Encounter Data, Including Comparison of Encounter Data with Managed Care Organization Provider Claims Data
- Managed Care Organization Comprehensive Review
- Dental Management Organization Comprehensive Review
- Delivery Supplemental Payments
- Selected Delivery System Reform Incentive Payments
- Cost Effectiveness of the Medicaid Managed Care Delivery Model in Texas
- Managed Care Organization Support for Quality Payments
- Managed Care Pharmacy Benefit Manager Compliance
- Physician Administered Drug Rebate Processes in Managed Care Organizations

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- Medicaid Claims Administrator Prior Authorization Processes
- Effectiveness and Monitoring of Medicaid Claims Administrator Key Performance Indicators
- Utilization Management in Managed Care Organizations
- Performance of Contractors Selected as Sole Source Procurements over \$10 Million
- Effectiveness of Texas Integrated Eligibility Redesign System Workarounds
- Grants Management Processes at the Department of State Health Services
- Support for Selected Electronic Health Record Incentive Payments
- Managed Care Organization Behavioral Health Initiatives Funded With Medicaid Dollars
- Foster Care Psychotropic Medication Utilization and Monitoring

Information Technology Audits

- Review of Eligibility, Payment, and Service Provider Information Technology Interfaces
- Information Technology Security at Selected Contractors and Business Partners

Provider Audits

- Selected Department of Family and Protective Services Client Services Providers
- Selected DADS Home Health Providers
- Selected DADS Consumer Directed Services Providers
- Selected Department of Assistive and Rehabilitative Services Consumer Contracts
- Selected DARS Early Childhood Intervention Services Providers
- Selected Department of State Health Services (DSHS) Mental Health and Substance Abuse Services Providers

- Drug Destruction Practices at Selected Long-Term Care Providers
- Selected Family Violence Program Services Providers
- Selected Vendor Drug Program Pharmacy Providers

Quality Review Directorate

Utilization Review

The Utilization Review Unit conducts nursing facility and hospital utilization reviews to determine, whether Medicaid paid the correct amount for the care of Medicaid recipients.

Utilization reviews are conducted by nurses located in five regional offices across the state and in Austin, and are performed in accordance with nationally recognized inspector general standards.

Nursing Facility Utilization Review

Nurses conduct retrospective medical reviews of nursing facility records that support Resource Utilization Group classifications used to determine payment amounts. They evaluate whether the facility correctly assessed and documented the resident's needs and whether the Medicaid reimbursement was appropriate for the level of care that was provided. They also review the medical necessity of the patient to reside in the nursing facility.

When the Utilization Review Unit identifies instances of overbilling or underbilling during its nursing facility reviews, it refers the results to DADS, which is responsible for recouping overpayments and adjusting underpayments. The Utilization Review Unit planned to perform 501 nursing facility utilization reviews in fiscal year 2015, and successfully completed planned reviews (the numbers in the table include some fiscal year 2014 reviews that were completed

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during fiscal year 2015).

Nursing facility utilization review FY 2015

Facilities reviewed: 558
Forms reviewed: 22,215
Forms with exceptions: 4,572
Dollars identified for recovery: \$5,481,033

Hospital Utilization Review

Nurses also perform retrospective reviews of inpatient hospital claims and services provided to Medicaid recipients to assess the following:

- Medical necessity for inpatient care
- Appropriateness of the Diagnosis Related Group (DRG) assignment
- Quality of inpatient care by providers of medical services

When the Utilization Review Unit identifies instances of overbilling or underbilling during its hospital reviews, it refers its results to the HHSC Medicaid claims administrator, which is responsible for recouping overpayments and adjusting underpayments.

New legislation requires the Inspector General to train hospitals on its DRG validation criteria, so the Utilization Review Unit will present training sessions during fiscal year 2016. The Utilization Review Unit planned to review 58,500 hospital claims in fiscal year 2015.

Hospital utilization review FY 2015

Facilities reviewed: 340
Forms reviewed: 16,754
Forms with exceptions: 5,050
Dollars identified for recovery: \$14,059,154

Lock-In Program

The Lock-In Program is designed to control inappropriate Medicaid recipient use of medical services and promote overall quality care. The Lock-In Program limits Medicaid recipients to a single provider and pharmacy when the recipient is identified as receiving duplicative, excessive, or conflicting health care services, including drugs, or is identified or suspected of misuse or fraudulent actions related to Medicaid benefits.

The Lock-In Program continually assesses recipient risk for misuse of prescriptions and services. While continuing to assess the remaining Medicaid population receiving services through fee-for-service, the Lock-In Program has seen growth largely through managed care members. During fiscal year 2015, the Lock-In Program continued to provide education to managed care organizations about the criteria for recipient referrals for misuse of prescriptions and services, and the documentation required to support those referrals.

During fiscal year 2015, the Lock-In Program performed a pilot effort that allowed a selected managed care organization to lock-in members, using Lock-In Program criteria, without Lock-In Program staff first validating documentation supporting the referral.

Based on the results of the pilot, the Lock-In Program plans to expand this automatic lock-in referral process to additional managed care organizations who demonstrate

Recipients in Lock-In Program FY 2015

Fee for service (prescription or provider): 22
STAR (prescription only): 181
STAR+PLUS (prescription only): 944
Cost avoidance: \$59,882

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appropriate identification of members for lock-in with an accuracy rate of at least 80 percent. Lock-In Program staff will perform retrospective reviews to determine the accuracy of managed care organization lock-in decisions.

Fiscal Year 2016 Utilization Review Work Plans

Quality Review plans to conduct utilization reviews of 235 nursing facilities and approximately 87,000 hospital claims during fiscal year 2016. Information about processes used to select nursing facilities and hospital claims for review follows.

Nursing Facility Utilization Review Plan

Nursing facility reviews evaluate the accuracy of coding on Minimum Data Set (MDS) forms submitted by nursing facilities for Medicaid reimbursement. Reviews will be selected from MDS forms supporting claims for dates of service for the sample period from April 1, 2014 through February 28, 2015. Reviews will also contain a medical necessity component, and will focus primarily on admissions that occur no more than six months before the date the onsite review begins.

IG selects a statistically valid random sample of claims for testing during nursing facility reviews, but the test results are not extrapolated to the entire population of claims from which the sample was selected. During fiscal year 2016, the Utilization Review Unit plans to begin reporting, for informational purposes, the amount of extrapolated results.

Utilization reviews of several nursing facilities will be performed during fiscal year 2016 as part of a managed care utilization review pilot. These reviews will focus on the

period of time during which the facility delivered its services as a Medicaid managed care program provider. Results of this pilot could help inform the discussion about whether the state or the managed care organizations should receive overpayments collected by the state.

The Utilization Review Unit uses a risk-based approach to select nursing facilities for review, but also selects a number of low-risk facilities to ensure a comprehensive level of review within a cross section of nursing facilities. Factors considered in the risk-based process include:

- Historical error rate (error rates currently average about 5 percent)
- Variances in annualized dollars billed
- Type of RUG classifications billed (such as existence of high dollar RUGs)
- Whether or not the facility has received a utilization review since October 1, 2010, when use of MDS 3.0 was first required

Hospital Utilization Reviews

Reviews will be selected from hospital claims for dates of service from the fourth quarter of fiscal year 2011 through the first quarter of fiscal year 2014. The Utilization Review Unit uses a risk-based approach to select hospital claims for review. Factors considered in the risk-based process include:

- High dollar DRGs
- Error prone DRGs
- Short stays
- Readmissions
- Outpatient surgery billed as inpatient
- Cost and day outliers
- Children's hospitals
- Freestanding psychiatric services

Audit Operations Directorate

Audit Quality Assurance

The Audit Quality Assurance Unit is responsible for the Audit Division Quality Assurance and Improvement Program. This program ensures that audit work performed by the Audit Directorate is in conformance with GAGAS and other applicable auditing standards. This unit also assesses the efficiency and effectiveness of activities within the Audit Directorate, including identifying opportunities for improvement.

Utilization Review Quality Assurance

The Utilization Review Quality Assurance Unit is responsible for monitoring the Utilization Review Unit's activities through retrospective reviews of medical necessity, appropriateness, and efficiency of health care services provided by Medicaid. This unit also assesses the efficiency and effectiveness of nursing facility and hospital utilization review activities and identifies opportunities for improvement.

Federal External Audit Coordination

The Federal External Audit Coordination Unit coordinates and serves as the single point of contact for all federal government audits and reviews of HHSC and audits and reviews involving more than one HHSC agency. The unit interacts regularly with federal office of inspectors general, the federal Government Accountability Office, and federal agencies such as CMS.

CMS Medicaid Integrity Program Audits and PERM Program Reviews

The Audit Operations Directorate is responsible for and serves as the single point of contact for CMS Medicaid Integrity Program audits and the CMS Payment Error Rate

Measurement program for all HHSC agencies.

The Deficit Reduction Act of 2005 created MIP and represents a CMS national strategy to combat fraud, waste, and abuse in the Medicaid program. CMS is deploying MIP through the use of contractors procured to conduct audits of Medicaid provider actions, audit claims, identify overpayments, and educate providers and others on Medicaid integrity issues. The CMS Medicaid Integrity Program contractors focused their audit work during fiscal year 2015 on Medicaid fee-for-service pharmacy claims, hospice pharmacy claims, and hospice eligibility.

CMS Medicaid Integrity Program audits FY 2015

Audit reports issued: 6

Dollars identified for recovery: \$3,728,698

The Improper Payments Information Act of 2002 requires federal agencies to annually review programs they administer and identify those that may be susceptible to significant improper payments. To comply with these requirements, CMS implemented the PERM program to measure the improper payments in Medicaid and CHIP programs and produce error rates for each program.

Risk Assessment, Audit Planning, and Resolution

The Audit Operations Directorate coordinates and directs risk assessment and annual audit plan processes involving the identification of risks across all major business processes and programs within HHSC agencies. The directorate leads outreach and coordination initiatives with all five HHSC agencies, as required by S.B. 207, 84th Legislative Session, involving close coordination with

Audit

HHSC agencies relating to the prevention of fraud, waste, and abuse. Also, the directorate tracks, monitors, and evaluates progress on addressing prior Audit Division audit and review recommendations.

TeamMate and SharePoint Administration and Support

The Audit Operations Directorate supports the Audit Division mission by providing resources and expertise in supporting the TeamMate Audit Management Software, which provides an integrated paperless strategy for managing the division's audits and documenting the work performed.

SharePoint is a Microsoft Office web application platform being implemented by the Audit Division to leverage technology and resources to further the division's mission. SharePoint combines various functions which are traditionally separate applications such as intranet, extranet, content management, document management, enterprise search, business intelligence, and workflow management.

Audit Division Budget, Performance Reporting, Policy, and Staff Development

The Audit Operations Directorate supports and monitors the budget and financial resources of the Audit Division to ensure appropriate and prudent stewardship and accountability.

The directorate maintains and updates Audit Division policies and procedures, provides resources and expertise in development of audit and review procedures, and coordinates the overall professional development and training needs of division.

The directorate also provides support to the audit and review reporting process, and reports on key division performance and other metrics to division managers who monitor and direct the activities of the Audit Division and ensure proper alignment with the IG mission and division strategic plan.

Inspections

Section

5

Inspections

Reform

Deputy IG David Holmgren started in June 2015. He was provided with a mandate from Mr. Bowen to establish an Inspections and Evaluations (I&E) Division. During the last quarter of fiscal year 2015, great strides have been made in drafting policy and procedures, identifying fiscal year 2016 project plans, and integrating the Women, Infants, and Children (WIC) Vendor Monitoring Unit into I&E.

Structure and operation

I&E conducts reviews of HHS-enterprise programs from a broad, issue-based perspective. Inspections and Evaluations offers practical recommendations to improve the efficiency and effectiveness of HHS programs, with a focus on preventing fraud, waste, and abuse. I&E has two primary product lines:

- Inspections provide factual and analytical information; monitor compliance; measure performance; assess the effectiveness and efficiency of programs and operations; share best practices; and inquire into allegations of waste, fraud, abuse, and mismanagement.
- Evaluations provide outcome-oriented, practical information for decision-making. The scope and breadth of an evaluation depends on the time allocated and the information available.

Inspections should be completed within 90 days. The ability to complete inspections in an abbreviated schedule is one of the keys to a successful program. Inspection objectives are clearly defined in the planning process, and I&E quality standards allow for expedited report review cycles. Additional-

ly, the I&E staff is in constant contact with the inspected agency, so the findings and recommendations are not a surprise. Inspections are geared to provide agency leadership with all necessary information needed to make informed executive decisions without the long lead times commonly associated with other types of reviews.

Evaluations generally are the result of specific requests from agency executives to examine an emerging issue that has not been included in any project plan. Timelines are contingent on specific objectives but will normally be completed in 120 to 180 days.

During fiscal year 2015, I&E developed a proposed staffing structure that initially requires additional funding for 20 FTEs. This level of staffing will allow I&E to complete the 24 to 30 inspections identified as the goal in the Fiscal Year 2016 Strategic Plan. Until funding issues are resolved, I&E has collaborated with other Inspector General divisions to detail select employees to I&E. This allowed for the initiation of inspections and the development of checklists for additional fiscal year 2016 inspections.

Women, Infants, and Children (WIC) Vendor Monitoring Unit

The WIC Vendor Monitoring Unit consists of nine individuals. The unit focuses on identifying fraud, waste, and abuse by WIC vendors across the State of Texas.

The WIC unit conducts three types of oversight: compliance buys, on-site evaluations, and invoice audits. Compliance investigations are executed by I&E staff at WIC vendor locations to determine whether vendors are properly accepting WIC benefits, following WIC vendor procedures, and have

Inspections

controls in place to prevent the unauthorized purchase of prohibited items.

On-site evaluations are routine monitoring of WIC vendors to determine that all required products and signage are displayed and that grocery items are priced within acceptable limits. Invoice audits are detailed reviews of purchase and sales records to determine if vendors have the proper level of item purchases that match WIC sales.

The United States Department of Agriculture (USDA) requires routine monitoring of at least 5 percent of vendors be conducted by the state agency as of October 1 of each fiscal year. Additionally, the WIC unit conducts invoice audits and compliance buys in number sufficient to satisfy the USDA 5 percent threshold.

Invoice audits and compliance buys are conducted on vendors identified as "high risk" by an annual assessment conducted by the Texas Department of State Health Services (DSHS) as mandated by the USDA. Additionally, compliance activities may be conducted based on referrals from DSHS or other agencies. The I&E WIC unit conducts on-site evaluations on vendors selected from a listing of "no-risk" vendors, which is also prepared annually by DSHS. The "high risk" and "no risk" assessments are based on the federal fiscal year from October through September.

WIC results FY 2015

Compliance buys: 147

On-site reviews: 151

Invoice audits: 51

Disqualification cost avoidance: \$8,729,176

Note: Numbers through August 31, 2015; WIC unit operates on federal fiscal year schedule.

Improvements planned for FY 2016

- Conduct a comprehensive annual risk assessment of HHSC enterprise programs.
- Assess program size and scope, changes to the program, previous findings and recommendations, and legislative interest.
- Involve program stakeholders.
- Coordinate proposed projects with agency Internal Audit staff, IG Audit staff, and federal IG staff.
- Conduct data analytics and best practice research to identify trends and potential fraud, waste, and abuse.
- Analyze investigation and hotline trends.
- Ensure inspections and evaluations are value-added and enhance the efficiency and effectiveness of HHS enterprise-wide.

FY 2016 projects

- Inspect Managed Care Organization Special Investigation Unit compliance with statutory and contract requirements.
- Inspect medical and dental facilities for compliance with Managed Care Organization/Dental Management Organization program requirements.
- Review Texas Department of State Health Services WIC risk assessment.
- Conduct WIC compliance purchases, on-site evaluations, and invoice audits.
- Conduct a review of the IG verification and certification of Legislative Budget Board measures.

Inspections

FY 2015 Inspection

In July 2015, the Medicaid Provider Integrity Intake Unit received an allegation that a wheeled medical device provider was non-compliant with the Assistive Technology Professional qualified rehabilitation professional requirements at delivery of approved medical equipment for clients. The substance of the allegation implied that this left those clients with an ill-fitting device for their ambulatory needs. The Investigations

division referred the matter to the Inspections and Evaluations Division owing to a lack of information that might merit an investigation or audit. The overall objective of the inspection is to determine whether policies the provider is following are the appropriate protocols required for services rendered to Texas Medicaid clients for wheeled mobility systems. A report will be issued in the first quarter of fiscal year 2016.



PROFESSIONALISM
PRODUCTIVITY
PERSEVERANCE

If you suspect a provider or recipient of state benefits
is committing fraud, waste, or abuse
call the HHSC Inspector General Hotline

800-436-6184

