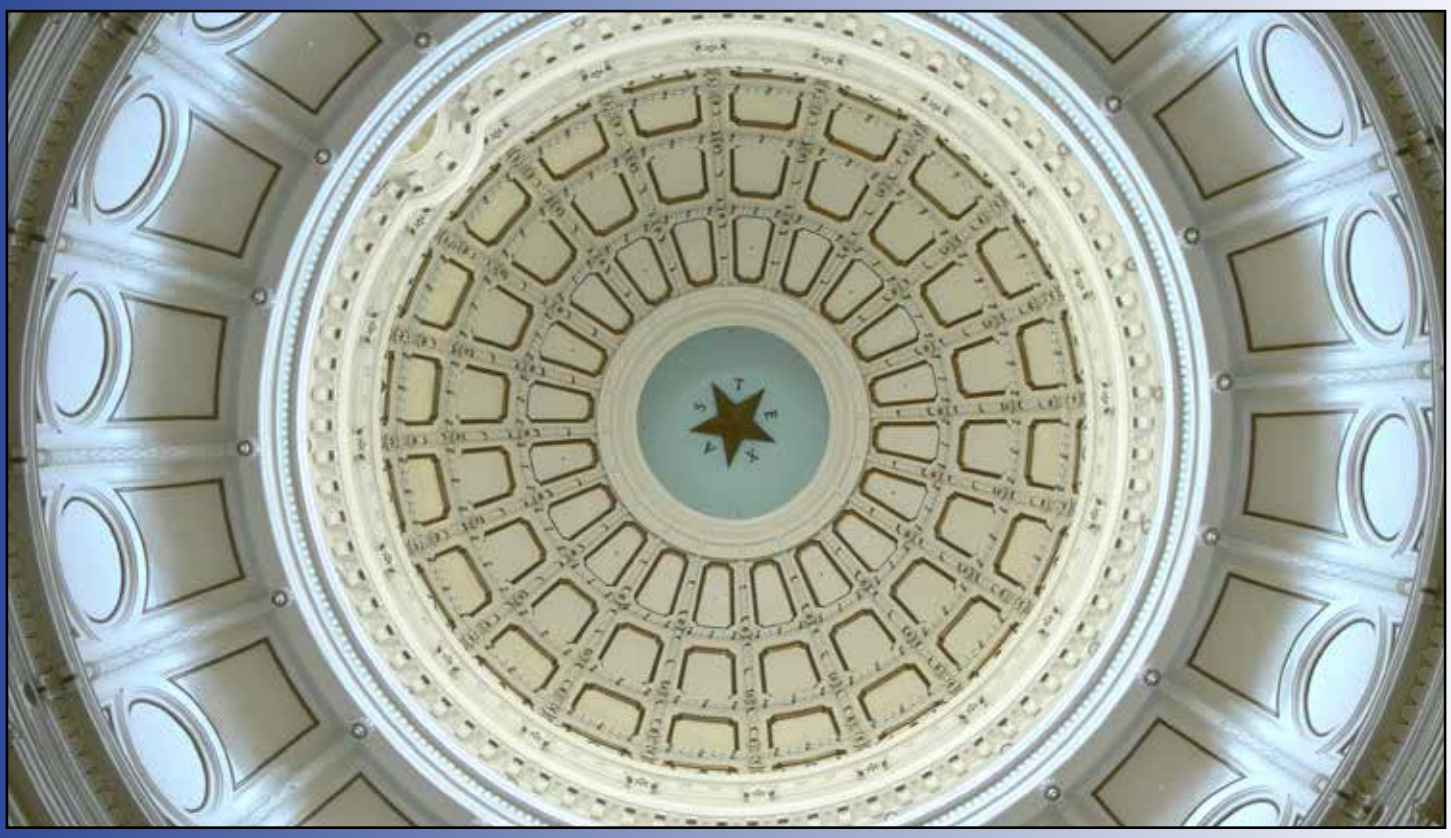
Texas Health and Human Services Commission

Inspector General



Quarterly Report

December 2015

PROFESSIONALISM
PRODUCTIVITY
PERSEVERANCE

Message from the Inspector General

I am pleased to submit to Governor Abbott, Executive Commissioner Traylor, the Members of the Texas Legislature, and the Citizens of Texas my Office's second Quarterly Report, capturing the work my team and I accomplished since September 1.

This report reveals a story of steady progress toward achieving the vision I set for our agency 40 weeks ago when I began my appointment: to be the best Inspector General operation in the country. "To be the best," I told my staff at our agency-wide meeting last week, "we must succeed in hitting our metrics and accomplishing excellent work *while firmly adhering to our values*." The quarter saw key progress in all aspects of our mission fulfillment, as my highly capable and motivated IG team continued to coalesce around our core values: professionalism, productivity, and perseverance.

Section One of this report provides a concise overview of our agency's activities, starting with how we executed our commitment to collaborate closely with HHSC leadership, as the Health and Human Services System moved into major consolidation mode. Notably, the section highlights Executive Commissioner Traylor's auspicious provision of 18 inspectors for our new Inspections and Evaluations Division. Please read the excellent interview with him in Section One; it substantiates the collaborative spirit that has developed between the IG and HHSC over the past 40 weeks. The section also lays out this quarter's wide-ranging mission progress, including our extensive stakeholder outreach engagements, our innovative reform and restructuring agenda, and the establishment of a Data and Technology Division to provide order and expertise to this mission-critical area.

Section Two presents our first Program Insight report, reviewing Medicaid, the largest service delivery component within the System. The section includes a fascinating interview with Gary Jessee, the new State Medicaid Director. Sections Three through Five outline the important progress my Investigations, Audit, and Inspections Divisions achieved during the quarter.

I thank my outstanding IG Team for courage, constancy, and commitment demonstrated consistently throughout 2015, a year of extraordinary change. I look forward to working with all of them in 2016, as we strive to realize our vision, live our values, and fulfill our mission.

Stuart W. Bowen, Jr.

Dollars recovered

Litigation	
Overpayments and penalties	$1,122,799
Investigations	
Research Analysis and Detection reviews	$796,567
General Investigations collections	$4,253,075
Audit	
Hospital Utilization Review	$4,851,472
Nursing Facility Utilization Review	$1,660,598
Total	**$12,684,511**

Dollars identified for recovery

Investigations	
RAD identified MCO overpayments	$168,410
SIU identified MCO overpayments	$2,845,747
LED overpayments identified	$18,966
GI claims in recovery	$8,566,198
Audit	
Provider overpayments	$527,006
Hospital outpatient costs reports	$239,000
Inspections and Evaluations	
WIC vendor monitoring	$33,720
Total	**$12,399,047**

Dollars identified as cost avoidance

Litigation	
Providers ordered to pay restitution	$2,027,525
General Investigations	
GI disqualifications	$898,500
Income eligibility matches	$2,374
Other data matches	$645,568
Audit	
Pharmacy Lock-In	$51,831
Total	**$3,625,798**

Contents

Overview

Section

1

Overview

Consolidation and collaboration

September 1, 2015, marked a momentous turning point for the Texas Health and Human Services System. On that day, Senate Bill 200 became effective, catalyzing a new era of consolidation and collaboration across the System. Under Executive Commissioner Chris Traylor's leadership, Texas aims to be the "best health and human services agency in the country" (as he noted at a recent HHSC all-staff meeting). The Legislature's guidance, embodied by Senate Bill 200, and Governor Greg Abbott's strategic support provide the map and fuel necessary to reach that extraordinary but reachable goal.

Consolidation promises much: new operational efficiencies; significant savings of tax dollars; rational ordering of services; and, ultimately, better care for the millions of Texans for whom the System provides critical health and human services. But those desirable and desperately needed outcomes will only occur if leadership and staff across the System strive for and achieve new levels of organizational and entrepreneurial collaboration. Thanks to the trenchant, disciplined, and reliable guidance of Chief Deputy Executive Commissioner Charles Smith and Deputy Executive Commissioner of Transformation, Policy, and Performance Christopher Adams prospects for success appear not just possible, but very promising, even at this early juncture in the reform and restructuring process.

Over the past three months, Inspector General personnel partook fully in various consolidation activities, participating in a broad spectrum of transformation committees; this reflects, again, the dawn of a new and collaborative day at the IG. These activities embraced a wide range of engagements all intended to help identify, implement, and report on the continuing transformation of how the System supports the delivery of health and human services in Texas. IG progress-points include greater connection and improved coordination with the Health and Human Services Commission on the technology, legal, and budgeting fronts, among others. These diverse activities engendered unprecedented levels of IG communication with programs and personnel from across the System. For example, this quarter, Inspector General personnel met with partners in the Medicaid/CHIP Division (MCD) and the Office of Social Services (OSS) more often and more fruitfully than in any previous quarter in memory.

2016 will bring enormous change to the System. Pursuant to legislative mandate, the Department of Aging and Disability Services (DADS) will consolidate into HHSC, and the Department of Assistive and Rehabilitative Services (DARS) will divide and merge into HHSC and the Texas Workforce Commission. Since beginning his appointment in late February, Inspector General Bowen has enjoyed excellent working relationships with Commissioner Jon Weizenbaum and his staff at DADS, and Commissioner Veronda Durden and her staff at DARS. These salutary connections will continue to pay dividends as the System moves through its new revolutions in 2016.

The Inspector General met regularly this quarter with Executive Commissioner Traylor and Chief Deputy Executive Commissioner Smith, with consolidation, collaboration, and transformation as the common themes of those meetings. The System's leadership incontrovertibly shares a concerted commitment to ensuring that Texas delivers the best health and human services programs possible to those in need, recognizing that achieving this goal requires a diligent and undeterred resolve to ensure transparency and accountability regarding the expenditure of billions of taxpayer dollars.

Interview with Chris Traylor, Texas HHSC Executive Commissioner

What is your vision for Texas' Health and Human Services System?

We are creating a team culture where every employee understands their role in the System's mission and works without regard to agency or division boundaries to improve our services, our accountability, and the value we provide Texans. We will embrace technology, creativity, and old-fashioned hard work to become the model for health and human services delivery. It's amazing how much you can accomplish when you don't care who gets the credit.

What principles guide your leadership of the Health and Human Services System?

Chris Traylor

I think the keys to leadership are honesty, accountability, and trust. You have to let people know what's expected of them and what kind of support they have. You need to tell them how they're doing, where they are falling short and what they are doing well and then step back and let people do their jobs and listen when they find ways to make us better.

What are your strategic priorities for the System as we move into 2016?

We need to make sure everyone is pulling together toward a clear goal, and that means making sure everyone knows what those goals are and what their role is in achieving them. We need to be a team to recognize and break down silos that keep us from giving Texans the best service available, while protecting taxpayers. Acting on direction from the Texas Legislature, HHSC and other state health and human services agencies are moving to implement the most significant reorganization in more than a decade. We have a great team set up to guide us through this transformation which will be a major focus of our attention in 2016.

What are the top three challenges facing the System right now?

There is one top challenge right now, and that's the transformation effort which encompasses many challenges. We're looking at every aspect of our operations, finding what needs to be blended, what's overlapping and the best ways to achieve the mission. That means getting ready for two rounds of consolidation to go into effect in 2016 and 2017, while preparing for the 2017 legislative session where our progress will be reviewed. We need to go into the session prepared to show what we've done to improve and what we plan to do to get even better. The key is making transformation a continuous process. All of us need to think every day about what we can do better and what the system can do better. The state's needs change, technology changes, and clients' issues change. We need to nurture innovation to anticipate those changes and be ready for them.

It's a new day at HHSC, with a new EC and a new IG appointed by Governor Abbott earlier this year. How would you characterize your engagement so far with the new Inspector General?

It's been great. Inspector General Bowen has put in a number of reforms that will make this agency better serve the people of Texas, and I feel fortunate to have him on our team and have his expertise working to protect our clients and taxpayers.

The IG has a mission that demands a certain degree of operational independence. However, the IG is administratively a part of HHSC and, per recent legislative enactment, is part of the System's ongoing administrative consolidation. How is the consolidation going with regard to the IG?

I'm very pleased with the way things are going with the transformation overall and with the Inspector General's efforts in particular. I think we're going to have better communication and a more efficient operation, and that's going to benefit everyone. I want everyone in the System to know the Inspector General is part of this team and is here to support our efforts.

Overview

New activities

Inspectors approved

In mid-December, Executive Commissioner Traylor approved the initial build-out of the IG's new Inspections and Evaluations Division. His allocation of 18 positions will enable Deputy Inspector General for Inspections and Evaluations Dave Holmgren to move forward on his ambitious oversight agenda.

The IG's enabling legislation, passed in 2003, provides that the Inspector General should fight fraud, waste, and abuse through audits, investigations, and inspections. But no previous IG established an inspections division nor used the unique oversight capacity that an inspection can afford. Virtually all federal inspectors general have audit, investigation, and inspections divisions.

Upon his arrival at the IG, Inspector General Bowen addressed the structural gap by creating the Inspections and Evaluations Division. When funding fell through, the capacity to develop the division disappeared. Thanks to Executive Commissioner Traylor's support, however, the new division will produce four to six inspections per quarter in 2016. Commissioner Traylor also approved ten new investigators to close a weakness identified at the IG's first investigations' strategic planning conference in November; and he authorized funding for 15 IG contractors to support the Medicaid provider re-enrollment process, which has a March 24, 2016, deadline.

Data and technology innovation

Last January, HHSC secured the services of a consulting firm to audit and assess the IG's structure and systems. The final report from that firm listed a litany of weaknesses, including a diffused array of information technology systems and a number of serious data issues. The IG has since addressed many of these matters; but, in mid-December, Inspector General Bowen provided a more enduring solution by appointing Senior Advisor Sylvia Kauffman as the new Deputy Inspector General for Data and Technology. The new Data and Technology Division now under her aegis will rationally order and dramatically improve the IG's data analytics and information technology components, while coalescing the agency's actuarial, technology procurement, and fraud detection elements. This innovative evolution further positions the IG for mission success in 2016.

Inaugural Investigations leadership conference

After several visits across the state to conduct town halls with IG personnel, Inspector General Bowen identified a need for an investigations planning event in Austin that would convoke all investigative managers and directors. Deputy Inspector General for Investigations Jay Crowley agreed, and thus a two-day conference occurred in mid-November, producing an extraordinary array of insights, ideas, and new investigative strategies.

The success of the session led Inspector General Bowen and Mr. Crowley to schedule quarterly investigative leadership meetings, with the next one to occur in mid-February. Further, the benefits of this event persuaded Inspector General Bowen and Deputy Inspector General for Audits David Griffith to schedule one for the Audit Division in February 2016.

IG Integrity Initiative

The IG Integrity Initiative took incipient shape this quarter. Its aim is to develop an integrity network across Texas spanning and linking all providers and provider communities that are committed to pursuing the most transparent and accountable Medicaid system possible. Achieving maximum integrity requires comprehensive community commitments. The IG Integrity Initiative will develop, secure, and enforce those commitments, integrating diverse efforts aimed at ensuring clean, consistent, and coherent health and human service programs in Texas.

During a trip to the Rio Grande Valley in late September, the seed for the IG Integrity Initiative was planted. While in McAllen, Mr. Bowen met with Dr. Carlos Cardenas, the CEO of Doctors Hospital Renaissance (DHR), and his staff for several hours, addressing outstanding issues and brainstorming on a variety of solutions. After watching a

17-minute promotional video on DHR, the Inspector General inquired whether Dr. Cardenas would more explicitly express in future videos a clear and convincing commitment to integrity. Dr. Cardenas said yes, auspiciously launching an analytical trend that soon took more formal shape as the IG Integrity Initiative.

To participate in the Initiative, providers must publicly affirm integrity in their mission statement, and they must promise to report any and all fraud, waste, or abuse whenever and wherever they might find it. Further, participating providers must provide integrity training to their employees, prominently post the IG's hotline poster in numerous locations, and provide a link to the IG's website on their websites. The Initiative will formally begin in 2016.

CMS partnership

In mid-November, the IG entered into a novel partnership with the Center for Program Integrity at the federal Centers for Medicare and Medicaid Services (CMS), headquartered in Baltimore. CMS works with all states, including Texas, to fight Medicaid fraud; but the fed-state connection with Texas needed strengthening. The new CMS/IG partnership provides that strengthening, concretizing a critical alliance between our offices and bolstering our mutual commitment to robust and responsive anti-fraud efforts. This synergistic combination will advance the IG's evolution toward implementing an array of more effective oversight technologies oriented to the managed care world. Unfortunately, too many legacy systems within the IG are still structured toward the fee-for-service world. The new Deputy Inspector General for Data and Technology, Sylvia Kauffman, will lead her team in rectifying that imbalance.

The first manifestation of the new IG/CMS partnership was a two-day December conference in Austin that brought CMS integrity personnel to meet with the IG's Medicaid Provider Integrity team. The ensuing exchanges generated a series of key insights that started what will be a continuing and collaborative process to strengthen the "Medi-Medi program". The program enables the analysis of billing trends and other data across the Medicare and Medicaid programs. The impetus for the endeavour arises from the assumption that a provider who commits fraud in Medicare will possibly commit fraud in the Medicaid program. Medi-Medi uses program matching algorithims to identify who the dual violators might be.

IG personnel will travel to Dallas in January and CMS headquarters in Baltimore in February to expand upon the emerging partnership established this quarter with CMS.

CMS Medicaid Program Integrity Review

In late September, senior CMS leader Barbara Davidson brought a team of CMS integrity experts to Austin to conduct a review of the HHSC and IG Medicaid program integrity systems. The four-day engagement included extensive interviews with IG and HHSC Medicaid personnel as well as several Special Investigative Units attached to MCOs.

In late November, Ms. Davidson provided initial feedback on her review, noting that neither the IG nor the Medicaid program had any major deficiencies. This starkly departed from the previous CMS integrity review, which found six major deficiencies. Further, after subsequent discussion and submissions, Ms. Davidson reported that the three minor vulnerabilities identified will also likely not be issues of note in the final report.

Website

The IG launched its new and very much improved website in mid-December. The new portal provides a useful, attractive, and accessible array of information and services to providers, stakeholders, and the Citizens of Texas. Inspector General Bowen firmly committed himself to transparency and accountability when he started his mission last February, and this new website helps further that commitment.

Several key features distinguish the new portal:

- All IG reports will be posted on the site, including quarterly reports, audits, and inspections.
- The site will contain videos that provide training, insights into IG reports, and guidance on Medicaid program issues.

- The site will provide room for the detailed presentation of IG initiatives.

Theory of Constraints

Pursuing efficient systemic reform is a guiding principle at the IG. The search for tools to advance such led Inspector General Bowen to Larry Temple, the CEO of the successful Texas Workforce Commission. Mr. Temple indicated that a particular systems analysis method, called the Theory of Constraints, enabled his agency to save money and achieve better results. After an insightful briefing on the method, Mr. Bowen initiated a competitive procurement to secure the capacity necessary to implement the system at the IG. The award remains pending but is expected in early 2016.

Ongoing activities

Stakeholder outreach

Soon after he took office, Inspector General Bowen established an ambitious stakeholder outreach program to rebuild trust with the provider community, build relationships with the Legislature, and communicate a new collaborative oversight agenda aimed at ensuring that the money appropriated for those in need in Texas gets spent on meeting those needs.

This quarter the IG travelled across Texas to meet with providers and IG personnel in McAllen, Pharr, Edinburg, El Paso, Dallas, and Houston (where he was joined by Chief Deputy Executive Commissioner Smith); he delivered remarks to the following stakeholder groups:

- DADS Regulatory Services Conference
- Texas Medical Association Conference/Border Health Caucus
- Texas Association of Health Plans/CEO Meeting
- Texas Medical Association/MCO Medical Directors Conference
- Adult Day Care Association Conference
- State Bar of Texas Legislative and Campaign Law CLE.

Mr. Bowen had substantive discussions about the IG mission with the following Members of the Legislature this quarter:

- Senator Jane Nelson
- Senator Juan Hinojosa
- Senator Lois Kolkhorst
- Senator Robert Nichols
- Representative Richard Raymond
- Representative Four Price
- Representative Rene Oliveira
- Representative Bobby Guerra
- Representative Joe Moody
- Representative Sergio Munoz
- Representative Elliott Naishtat
- Representative Donna Howard

Settlements

Inspector General Bowen's first directive after he started work last February ordered the replacement of the agency's extrapolation tool with a well-accepted one called RAT-STATS (used by the United States Department of Health and Human Services Inspector General). Due to problems with the previous extrapolation tool, the IG determined it was in the best interests of the State to settle most of the pending cases. This quarter, the IG settled 21 cases amounting to $2,227,892. The Chief Counsel and the Inspector General continue to negotiate the possible settlement of 82 additional cases. Mr. Bowen has settled 43 cases since February, with recoveries amounting to $11,853,614.

S.B. 207 implementation

On September 1, 2015, the Legislature's substantial reform agenda for the IG, embodied by Senate Bill 207, went into effect. The amendments to the IG's enabling authority significantly altered certain aspects of the IG's approach to enforcement.

The top five changes are:

- A very restrictive new standard of proof for credible allegation of fraud payment holds.
- The end of payment holds based only on program violations.
- The creation of restrictive investigative timelines.
- The provision of an independent subpoena power to the IG.
- The authorization for the IG to execute performance audits of any HHS program.

Program Insight: Spotlight on Medicaid

Section

2

Program Insight: Spotlight on Medicaid

Medicaid in brief

The largest program within the Inspector General's purview is Medicaid, a federal-state health care program for indigent persons established by the Congress in 1967.

Among other things, Medicaid pays for physician, inpatient, outpatient, pharmacy, lab, dental, and x-ray services; it also funds long-term healthcare services, home and community-based health care, nursing facility services, health care at intermediate care facilities, and treatment for persons with intellectual disabilities.

In fiscal year (FY) 2014, the federal government funded 58.7 percent of the Texas Medicaid program, while the state funded 41.3 percent.

Combined federal and state Medicaid expenditures on direct services amounted to more than $25.6 billion in FY 2014, which was 26.2 percent of the Texas State budget. This included an estimated $2.4 billion in payments to nursing homes and an estimated $3 billion for prescription drugs. State administration of the program cost $1.7 billion. Disproportionate Share Hospital payments, uncompensated care, and Delivery Services Reform Incentive Payment reimbursements accounted for an additional estimated $6.3 billion in program costs for FY 2014.

The Texas Medicaid program serves low income families, indigent children, related caretakers of dependent children, pregnant women, people aged 65 and older, and adults and children with disabilities (based on income and other factors). Seventy-seven percent of Texas Medicaid clients are under age 21. While non-disabled children comprise the largest segment (67 percent) of Medicaid clients, they account for only 31 percent of total program spending. By contrast, people who are elderly, blind, or have a disability comprise 26 percent of the served population, but account for 60 percent of all expenditures.

The Texas Medicaid program has substantially converted to the managed care model, with 87 percent of the program under managed care. Previously, the system operated on a fee-for-service model, with the state directly paying healthcare providers a set fee for services.

Under the now dominant managed care model, the state pays MCOs a capped (or "capitated") rate to deliver services to a defined cohort. Clients within the cohort receive health care services and long-term services from networks of doctors, hospitals, and other qualified health care providers under contract with MCOs.

HHSC administers the various Medicaid programs in Texas through MCD, which oversees a continued expansion into managed care. Managed care now comprises 87 percent of the state's Medicaid service delivery.

Top 10 key facts about Texas Medicaid

1. Total spent on Texas Medicaid client services and administration, FY 2014	$27.3 billion
Acute Care (non-drug, non-dental)	$12 billion
Long-Term Services and Supports	$8.0 billion
Prescription drugs	$3.0 billion (est.)
Dental and other	$2.6 billion
Administration	$1.7 billion
2. Estimated supplemental health care payments (DSRIP, DSH, UC) FY 2014	$6.3 billion (est.)
3. Division of Medicaid funding	
Federal share	58.7%
State share	41.3%
4. Portion of state budget spent on Medicaid	26.2%
5. Avg. monthly Medicaid enrollment	3.74 million
6. Texas births covered by Medicaid	53.9%
7. Medicaid clients in managed care FY 2015	87%
8. Avg. monthly Medicaid clients under age 21 FY 2014	77%
9. Medicaid recipients by demographic	
Hispanic	50%
Caucasian	19%
African-American	15%
Other	16%
10. Spending on long-term services/support	31%

Source: HHSC System Forecasting.

Program Insight: Spotlight on Medicaid

Twenty-one managed care organizations, each under separate contracts, provide care to millions of needy Texans through the following programs:

1. State of Texas Access Reform (STAR) program, providing primary, acute care, and pharmacy services for pregnant women, newborns, and children with limited income.
2. STAR+PLUS program, providing acute care services plus long-term services and supports for individuals who are age 65 or older or have a disability.
3. STAR Health program, providing medical, dental, vision, and behavioral health benefits for children in conservatorship of the Department of Family and Protective Services, including those in foster care or kinship care.
4. NorthSTAR program, an initiative of the Department of State Health Services, providing integrated behavioral health care in the Dallas service area.
5. Children's Medicaid Dental Services, providing a wide array of dental services to Medicaid eligible minors.

Insight from Gary Jessee, Texas Medicaid Director

Gary Jessee, a 20-year veteran of state service, became Texas' new State Medicaid Director on October 30, 2015. For the previous three years, Mr. Jessee served as the Medicaid/CHIP Division's (MCD) Chief Deputy Director for Program Operations.

What is your vision for the Texas Medicaid and CHIP programs?

I grew up in a family focused on service to others. We frequently spent our Sundays together as volunteers in nursing homes. I learned the difference between having what you need, and not having basic needs met. It instilled in me a deep compassion and concern for the people we serve.

I've been in human services for more than 20 years managing programs from aging to physical, intellectual, and developmental disabilities – the whole gamut. As far as my preparation for this particular position, I credit Kay Ghahremani (former State Medicaid Director) for creating a culture of compassion and dedication, and Executive Commissioner Chris Traylor for nurturing the talent needed to develop new ideas and carry them out.

Gary Jessee

In the new managed care environment, what advantages do you see compared to fee-for-service?

The vision for improved Medicaid under managed care is managed care brings the promise of members having a source to help them navigate the system. They don't have to shop themselves to try to find services. You can integrate acute and long-term services and supports for better care coordination. You can leverage the long-term support and services to reduce expenditures on the acute

MCD/IG audit collaboration

Senate Bills 200 and 207 require HHSC and IG to work together on audits of managed care organizations. Collaboration between MCD and IG auditors this quarter helped generate two audits of great importance: the Utilization Management audit and the Special Investigative Unit audit.

- IG Audit coordinated with MCD staff throughout the audit planning phase to assess risk, select MCOs for review, and prepare audit test plans. As the MCO contract manager, MCD provided IG Audit information about the business of the contractor, the deliverables, and other information needed to design a suitable audit methodology.
- MCD and IG Audit met before the audit work began to ensure a shared understanding about MCO structure and operations.
- MCD will provide data to the auditors, increasing confidence that audit results will accurately relate to the business of the MCO and its relationship with MCD.
- IG Audit will meet quarterly with State Medicaid Director Gary Jessee to brief the status of the current MCO audits and to share preliminary results.

care side and also increase the ability for members to remain in their community or their preferred setting for as long as possible.

My vision for improving Medicaid is to focus on member experience and provider experience. We are looking for opportunities to improve the pathways our members navigate and the supports they receive from their managed care organization. For providers, we are doing everything we can to encourage participation in Medicaid, reduce administrative burdens wherever we can, and really encourage some standardization that reassures them to stay with us for the long haul.

There are efficiencies achieved in managed care that don't exist in fee-for-service. The ability to avoid duplication by not having multiple parties trying to deliver services and having a single point of coordination is a benefit; that is a foundational point in a managed care environment. This leads to better managing of service across providers, to better quality measures, and to holding the MCO accountable. Commissioner Traylor frequently makes the point – if three people are in charge, nobody's in charge.

Please describe how MCD's relationship with the IG is developing.

HHSC and the IG are within the same System. I want to give credit to the new Inspector General for his efforts to improve the perception of what the IG's role entails for this industry. I think providers are beginning to embrace that the Inspector General and the people who work in the IG are there to address the offenders who give the Medicaid system a bad name. They also encourage those doing a good job to continue their efforts and to help others remain compliant. I think one thing that the new Inspector General has done personally is deliver the message of the Inspector General's support of providers endeavoring to do the right thing. There is nothing exciting about running providers out of business, but what is exciting is focusing on the member and ensuring anyone who interfaces with them is a participating provider in good standing, providing good quality health care, and working in the best interests of the state.

Are you planning any changes regarding the administrative work required of providers who participate in Medicaid?

While we can't do anything about provider rates, we can reduce the administrative overhead. This will attract and retain more providers; if we achieve that then we've been successful. We are continuing our efforts to improve the experience for both members and providers by increasing transparency. On the provider side, we know the administrative burden of contracting and doing business with multiple MCOs increases the need for additional office staff for time spent with administrative work. The reality is we are a big Medicaid system and providers must interface with commercial, private pay, Medicaid, and Medicare systems, so we will never alleviate the responsibility they have as a provider and the work they have to do. But where we can, we will try to improve processes to make things more transparent. We need to focus on what we can change and make a note of what we can't, and move forward.

As the HHS transformation begins to unfold, how do you think this will benefit Medicaid or CHIP? What support and resources will become more accessible as a result of the transformation?

I think the promise of transformation is to improve provider experience and member experience. What we are doing within Medicaid/CHIP and the IG is consistent with the whole system's transformation. We have heard that people are confused, providers are unclear as they navigate multiple systems with inconsistent policies, inconsistent processes, and not knowing who is on first, who is on second. So the promise of the transformation is to bring those programs together so providers have one stop; so you don't have to navigate all these different systems. For members in the system, it brings them to one place, too. So it really does have the capacity to achieve efficiency.

Investigations

Section

3

Investigations

The IG's Investigations Division works to protect the integrity of the Texas Medicaid system and other health and human services or assistance programs (e.g., SNAP, TANF, WIC) by investigating allegations of provider or recipient fraud, waste, and abuse. Additionally, the Investigations Division conducts personnel-type investigations at the State Supported Living Centers as well as across the entire HHS System.

Division news

New leadership

This quarter, Juanita Henry became the Assistant Deputy Inspector General for the General Investigations Directorate. Ms. Henry brings 20 years experience in criminal investigations, serving state and federal governmental agencies, including the U.S. Department of Health and Human Services Office of Inspector General (DHHS-OIG), the Texas Attorney General's Medicaid Fraud Control Unit, and the HHSC Inspector General. Additionally, she has many years of managerial experience in the criminal investigations field.

Timothy Menke joined the Investigations Division as the Assistant Deputy Inspector General overseeing the Medicaid Provider Integrity Directorate and the Intake Resolution Directorate. Mr. Menke brings a wealth of knowledge gained from more than 25 years of federal criminal investigative experience conducting and supervising health care fraud investigations in leadership roles for DHHS-OIG, including service as Deputy Inspector General for Investigations.

Leadership conference

On November 18 and 19, 2015, Investigations Division managers came together for a two-day leadership conference. The meeting identified many areas for improvement, which will increase productivity, generate increased investigative results, and make the division more operationally efficient. The Investigations team appreciates the support and insight Mr. Bowen shared with us throughout the session.

Medicaid case backlog reduced

The backlog of Medicaid cases (both full scale and preliminary) has been reduced from 1,118 cases (in February 2015) to 16 cases as of November 30. The remainder will be resolved by the end of the second quarter of FY 2016. The backlog comprised cases that were more than two years old, with most more than four years old.

Collaboration with Medicaid Transportation Program staff

Dimitria Pope, Director of HHSC's Medical Transportation Program (MTP), spearheaded an operation in conjunction with the IG Law Enforcement Directorate that resulted in the cancellation of an MTP contract in Sherman, Texas. Deputy Inspector General for Investigations Jay Crowley noted that, in his more than 40 years of investigative experience, he had rarely encountered a program partner as committed and cooperative as Ms. Pope. This represents a model case for HHSC and IG collaboration.

General Investigations

With 114 investigators across Texas, including offices in Dallas, Houston, Pharr, Austin, El Paso, Abilene and Beaumont, GI pursues allegations of recipient fraud or abuse of state health and human service program benefits. GI staff members met earlier this year with district attorneys around the state to gain a better understanding of what evidence is needed for a prosecutor to move forward with a case. After these meetings, the directorate saw a 77 percent increase in cases referred for prosecution. GI accomplishments this quarter include 145 cases referred to district attorneys, 33 court dispositions, more than $8.5 million identified for recovery, and $4,253,075 collected.

GI also achieved the following:

- Many investigators completed a four-day advanced interview and interrogation training class de- signed to enhance skills for conducting thorough interviews.
- The IG and Social Security Administration jointly investigated suspected fraudulent activ-

ity by a recipient of SNAP, Medicaid, and Social Security income benefits, identifying overpayments of $82,267. This case was filed for federal prosecution in late September 2015.

- An IG hotline complaint led to an investigation of a recipient who allegedly made false statements on an application for benefits. The suspect received $42,861 in excessive SNAP benefits and $63,093 in excessive Medicaid benefits for a total of $105,954 in fraud. This case was filed for criminal prosecution in late September 2015.
- A referral from an HHSC Office of Social Services eligibility worker led to an investigation of a falsified recipient application, which found $51,437 in excess SNAP and Medicaid payments. This was referred for criminal prosecution on October 29, 2015.
- On October 15, 2015, a suspect pled guilty to felony theft, received 10 years of deferred adjudication, was disqualified from receiving benefits for 12 months, and ordered to pay $45,736 in restitution. Over the course of several years, the suspect failed to disclose household information that resulted in improper SNAP and Medicaid payments.

Medicaid Provider Integrity (MPI)

MPI investigates allegations of fraud, waste, and abuse committed by Medicaid providers in connection with services rendered to Medicaid recipients.

Since September 1, MPI referred 66 cases to IG Litigation. Seven settlement agreements were reached totaling $705,369. Another case resulted in penalties imposed by IG Litigation totaling $407,000. Six additional cases resulted in the Medicaid contract and Texas Provider Identification being cancelled, with the six providers being placed on the Exclusion List. During the first quarter of FY 2016, MCOs referred three cases with total estimated overpayments of $922,185. These referrals are now under MPI investigation.

The number of pending MPI investigations has been reduced from 425 to 218 cases since September. Considerable progress was made on closing old or legally insufficient cases. The old cases had problems regarding extrapolation or entailed invalid allegations on administrative errors rather than substantive legal violations.

MPI is participating in a joint operation with a federal partner to target home health care services and medical providers suspected of defrauding Medicare and Medicaid by submitting false claims for services. The operation will lead to the recovery of Medicaid overpayments and the exclusion of providers from the Medicaid program.

Intake Resolution (IRD)

IRD consists of the Research Analysis and Detection (RAD) unit and MPI Preliminary Intake unit.

Preliminary Intake complaints serve as the cornerstone of the initial investigative process in MPI. During this quarter, Preliminary Intake and RAD worked together to eliminate a backlog of 572 preliminary intake cases. They established a process to ensure new complaints are addressed accurately and timely within the legislatively mandated 45-day processing deadline.

Fraud Detection and Investigative Strategy (FDIS)

The FDIS Directorate is comprised of two units: Data Analytics and Intelligence. Both units work to seek and identify conduct that might amount to fraud, waste, and abuse. It uses data analytics and investigative research and analysis techniques to accomplish this.

MPI cases referred to IG Litigation

- An investigation of a speech therapy provider found a 92 percent billing error rate. The dollar-for-dollar overpayment in the case was $814,862.
- Another investigation found a provider had a 97.28 percent billing error rate. Litigation is seeking to recoup $491,053.

This Directorate will move into the new Data and Technology Division in 2016, under the leadership of Senior Advisor and Deputy Inspector General for Data and Technology Sylvia Kauffman.

Among other things, FDIS researches and analyzes claims, retailer information, recipient transactions, and other data, creating Investigative Analysis Reports for the MPI, GI, LED, and IA Directorates. The Directorate uses a variety of analytics to generate comprehensive, detailed, and thoroughly vetted products that develop and support investigations.

Noteworthy accomplishments this quarter include:

- Automated an administrative report, reducing work time by an average of three to four weeks per report.
- Trained federal auditors on a variety of data systems that will be used to conduct au- dit work in Texas.
- Helped the MPI Directorate resolve its backlog cases by reviewing and processing 157 cases. Of these, 16 were referred to external agencies, 3 were referred to MFCU, 11 went to full scale investigations, 7 were referred to RAD for processing, and the rest were closed.
- Completed investigative data analysis and intelligence work, resulting in the completion of 40 Investigative Analysis Reports. Of those, 25 were referred to MPI, 7 were referred to GI, and 8 were referred to RAD for processing.

Law Enforcement (LED)

LED consists of commissioned and non-commissioned investigators who conduct criminal investigations regarding violations regarding State Supported Living Centers and State Hospitals, Electronic Benefits Transfers, and the Medicaid program. The units in the Directorate are the State Centers Investigative Team (SCIT), Electronic Benefit Transfer Trafficking Unit, and Medicaid Law Enforcement Unit.

State Centers Investigative Team

SCIT completed 315 cases this quarter and filed criminal charges on 15 of them. One case, involving two SSLC employees, led to an employee pleading guilty to tampering with a governmental record and receiving six years of probation; the second employee is awaiting trial for injuring a disabled individual.

EBT Trafficking Unit

The growing unlawful use of SNAP benefits in criminal transactions concerns the Food and Nutrition Service (FNS) of the United States Department of Agriculture (USDA) as well as the State of Texas. FNS enlists state and local law enforcement officials to apprehend and penalize violators. An agreement between FNS and IG to investigate SNAP retailer fraud will strengthen joint efforts to fight this criminal conduct.

Medicaid Law Enforcement Unit

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

Medicaid Law Enforcement Unit accomplishments this quarter include:

- IG investigators and HHSC's MTP staff conducted an operation in Sherman, Texas, in which MTP staff canceled a transit agency Medicaid contract. The fraud investigation continues.
- IG investigators participated in a multiagency investigation focused on a Central Texas unlicensed group home and its owner. Allegations include abuse, neglect, and exploitation of clients, along with multiple fraudulent activities by the owner, including the possible receipt of Medicaid and SNAP benefits under fraudulent pretenses. IG investigators helped execute a search warrant of the owner's home and seized evidence and are awaiting subpoenaed financial records to determine the actual amount of fraudulently taken Medicaid and SNAP benefits. Participating agencies include HHSC IG;

Austin Police Department; Belton Police Department; Texas DPS CID; DADS; DFPS; IRS; and HUD. The overall coordination is being conducted by the Attorney General's Office.

- MPI and LED investigators obtained information that a physician, previously indicted as a result of the June 2015 Rio Grande Valley Health Care Fraud Prevention and Enforcement Action Team's National "take down," submitted duplicate billings and billings for services not rendered on deceased patients. The physician was re-indicted on new federal charges of health care fraud.

Internal Affairs (IA)

IA conducts investigations of fraud, waste, abuse, employee misconduct, and contract fraud within the five HHS agencies. The investigations mainly involve vital statistics fraud, contract fraud, employee misconduct, privacy breaches, computer misuse, Child Protective Services child death cases, and Adult Protective Services adult death cases. During this period, IA conducted 290 investigations, with 113 of those substantiated.

Q&A with Glenn Martin, Director, Medicaid Provider Integrity Unit

What does your role as Director for MPI at the IG entail?

The MPI Directorate is part of the IG's Investigations Division. I have held the position as Director for MPI since June 1, 2015. The Director's primary role is to oversee the investigative efforts of the 6 MPI managers and 53 MPI investigators around the state, as well as the nurse manager and 10 nurse reviewers who help investigate fraud, waste, and abuse by Medicaid providers. My role as Director is to provide leadership and support for the MPI staff, translating the vision provided by Mr. Bowen and Deputy IG for Investigations Jay Crowley, to produce high-quality investigative work products in a timely fashion.

What prior experiences have you had that you feel especially prepared you for this role?

My education includes a bachelor's degree in accounting and a master's degree in management. I am also a Certified Public Accountant. I was previously a Special Agent with the Federal Bureau of Investigation for 29 years. During my FBI career, I investigated a great variety of federal crimes, including Medicare and Medicaid fraud violations. I was previously the Manager of the MPI San Antonio Field Office for approximately two years before accepting the position as Director of MPI.

Glenn Martin

What is the purpose of the MPI Directorate?

The main purpose of the MPI Directorate is to investigate allegations of fraud, waste, and abuse by Medicaid providers. MPI investigators also perform other duties under HHSC agency regulations as required by law.

What goals do you have for your Directorate?

My goals for the MPI Directorate include the following:

- To become the best MPI investigation team in the nation through improved investigative productivity while maintaining the highest standards of integrity and excellence.
- To develop fully supported and timely cases through perseverance.
- To retain investigative staff and promote excellence and professionalism.
- To develop new MPI investigations through outreach liaison activities with Medicaid providers, Medicaid recipients, as well as federal and state agencies.
- To initiate and increase participation with federal and state agencies on joint investigations of Medicaid fraud, waste, and abuse in Texas.

What changes have you made or do you anticipate making?

A large number of changes have already been implemented to foster a more effective and efficient MPI investigation organization:

- Assessment of MPI investigator capabilities has begun to determine what training and mentoring are required to generate a competent investigative team capable of handling a variety of allegations concerning fraud, waste, and abuse.
- Providing ready electronic access to investigative staff for MPI policy and procedures that cover the full range of MPI protocol and investigative techniques.
- Equipping and empowering MPI managers and investigators to make decisions concerning how investigations are conducted to achieve a successful conclusion.
- Fostering a culture of teamwork and cooperation to meet the new investigative deadlines
- Targeting fraud cases that will have the greatest impact on Medicaid recipient safety and recovery of Medicaid overpayments.
-

How does the MPI Directorate interact with managed care plans? How does it coordinate with Medicaid? With what other agencies does it coordinate?

The Investigations Division holds quarterly meetings with the MCO/DMO Special Investigative Units (SIU). These meetings are designed to inform SIUs of provider schemes and to foster a free exchange of information regarding fraud, waste, and abuse. MPI investigators also liaise with SIU investigators within each MPI field office territory.

The SIUs are contractually required to routinely provide information to IG regarding any fraud, waste, or abuse they discover. The MPI Directorate, working through the Fraud Detection and Investigative Strategy Directorate, acquires MCO data that is used to develop data populations that target specific billing codes to generate statistical samples as part of the investigative process for most MPI investigations.

The MPI Directorate recently participated with CMS in an investigation targeting home health providers throughout Texas. MPI routinely coordinates investigations with the Attorney General's Medicaid Fraud Control Unit. A plan is under way to participate with DHHS OIG and MFCU on a joint task force to conduct investigations.

How does the transition from fee-for-service to managed care impact your Directorate?

The transition from fee-for-service to managed care organizations has had an impact on the MPI Directorate because data from MCOs comes in a less readable format than fee-for-service data. MCO data has generated fewer new MPI investigations. The IG is working to obtain MCO data in a format that will allow IG to efficiently assess whether MCO providers are following program rules.

Audit

Section

4

Audit

Hospital-specific utilization review and managed care pilot

The Quality Review Directorate of the Audit Division conducts hospital utilization reviews of Medicaid inpatient claims submitted by hospital providers. Reviewers assess quality of care and medical necessity, and perform Diagnosis Related Group validation. Currently, Quality Review selects a sample of claims from a risk-based pool of fee-for-service claims each quarter.

In the coming year, the Quality Review Directorate plans to launch a pilot program designed to review high-risk claims at a selected hospital in addition to the quarterly selection of claims described above. Reviewers will examine a single hospital's randomly selected high-risk claims, including both fee-for-service and managed care, over a period of multiple quarters or multiple years. This will be the first utilization review of hospital claims paid under the managed care service delivery method.

Quality Review may also consider in the future selecting hospital claims from a specific managed care organization for utilization review.

Utilization Review Forum: Adapting to managed care

On November 16th, IG initiated a Utilization Review Forum. During the first meeting, leaders from MCD and IG met to identify issues anticipated to shape the future of utilization review in a managed care service delivery environment. Inspector General Bowen, State Medicaid Director Gary Jessee, and representatives of IG, MCD, and the Managed Care and Actuarial Analysis Unit of the HHSC Financial Services Rate Analysis Department participated.

The UR Forum facilitates collaboration to develop a three-year transition plan for moving hospital and nursing facility utilization review from the fee-for-service environment to the managed care environment.

Outcomes of completed audits

3 Pharmacy audit reports identified $456,609 for recovery. One of the audits identified errors related to invalid claims, refill errors, quantity errors, and Controlled II (C-II) errors, resulting in $414,081 in overpayments.

19 Audit reports issued for Medicaid outpatient hospital cost reports, resulting in adjustments of $28,735,352, which are expected to have an estimated impact to the Medicaid program of $239,000.

2 Performance audits issued for services delivered by HHSC Family Violence Program providers identified $70,396 for recovery. The audits identified unsupported salaries, incorrectly calculated fringe benefit costs, incorrectly allocated salaries and shared costs, and other unallowable charges.

Reducing Audit Division backlog

56 Audits carried forward from FY15 to FY16

24 Audits issued in first quarter of FY16

20 Audits to be issued in second quarter of FY16

7 Audits on hold, pending investigation

5 Audits canceled (no significant issues)

Measuring state payment error rates

IG Audit serves as the single state contact with the Centers for Medicare and Medicaid Services (CMS) for the CMS Payment Error Rate Measurement (PERM) program. PERM measures improper payments in Medicaid and in the Children's Health Insurance Program (CHIP). CMS conducts PERM reviews in three component areas: fee-for-service, managed care, and eligibility. CMS uses PERM results to produce national as well as state-specific program improper payment rates.

The PERM program uses a 17-state, three-year rotation cycle for measuring improper payments.

Texas was measured in federal fiscal year 2014 and will be measured again in federal fiscal year 2017. On November 17, 2015, CMS issued Texas-specific as well as national error rates and review findings from the federal fiscal year 2014 PERM cycle.

Results show that improper payment rates in Texas are lower than the national average for CHIP claims but significantly higher than the national average for Medicaid claims. Texas has no errors in Medicaid managed care payments. The adjacent tables also include rates from the previous federal fiscal year 2011 PERM cycle for comparison.

Of the 17 states measured in the federal fiscal year 2014 PERM cycle, Texas has the second-highest Medicaid improper payment rate. The relatively high error rate results primarily from a change in federal guidelines. The new guidelines, which had not been fully implemented at all affected Texas agencies, require the inclusion of the attending provider's National Provider Identifier on the institutional claim form.

Texas had the sixth lowest of the 17 states measured with regard to the CHIP improper payment rate in the federal fiscal year 2014 PERM cycle. The majority of the CHIP improper payments involved one of two types of errors: failure to list the attending provider as required on the institutional claim, or delayed implementation of a new provider screening process required by the Affordable Care Act.

Training and coordination with federal OIG auditors

IG's Federal Audit Coordination unit facilitated and coordinated two on-site training sessions in Austin for 16 federal OIG auditors based in Texas and neighboring states. The sessions offered training to the federal auditors about how to access and use Texas data to identify fraud, waste, and abuse in the Medicaid program. This initiative between IG and the federal Department of Health and Human Services OIG sets a new mark in collaboration between our respective agencies and prepares the path for many more state-federal collaborative efforts to come.

Medicaid improper payment rates

	Texas 2011	Texas 2014	National 2014
Overall	6.5%	23.9%	11.0%
Fee-for-service	0.9%	46.2%	18.6%
Managed care	0.1%	0.0%	0.1%

CHIP improper payment rates

	Texas 2011	Texas 2014	National 2014
Overall	10.8%	2.0%	3.2%
Fee-for-service	0.3%	9.6%	13.1%
Managed care	0.3%	1.7%	0.6%

New Audit Division projects under way

Managed Care Organization Special Investigative Units' performance

Objective: Determine the effectiveness of Managed Care Organization Special Investigative Units' performance in detecting and investigating fraud, waste, and abuse; and in reporting reliable information on SIU activities, results, and recoveries to HHSC.

Background: In fiscal year 2015, Medicaid MCOs received more than $20 billion of federal and state funds from the State of Texas in capitated services. State law requires Medicaid MCOs to establish or contract with a qualified entity to provide "special investigative units" to investigate suspected fraud or abuse by MCO members or their participating providers. HHSC MCD administers MCO contracts and maintains oversight responsibility over MCOs. The IG approves annual SIU fraud, waste, and abuse plans submitted by MCOs, and has oversight of MCO SIU performance.

Delivery supplemental payments

Objective: Evaluate the effectiveness of processes and controls intended to ensure delivery supplemental payments are paid timely and accurately, and are valid and adequately supported.

Background: Delivery supplemental payments reimburse MCOs for high costs associated with providing prenatal, delivery (births), and postpartum care to eligible Medicaid members. The payments supplement the capitated payments MCOs receive from the state for each of their Medicaid members. In fiscal year 2015, MCOs received approximately $400 million in delivery supplemental payments. HHSC Strategic Decision Support receives, reviews, adjusts, and submits all delivery supplemental payment claims and administers the appeals process for rejected claims.

Acute care utilization management in Managed Care Organizations

Objective: Evaluate the effectiveness of acute care utilization management practices at selected MCOs in ensuring that health care services, procedures, and facilities are medically necessary, appropriate, and efficient; and evaluate whether they achieve intended client outcomes, including those related to timeliness, availability, and quality of care.

Background: Utilization management evaluates medical records for medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. MCOs use utilization management to review requests for approval of future medical or service needs. This could include pre-admission screenings, prior authorization for certain medical services, and concurrent utilization reviews, which are usually conducted during hospital confinement to assess the need for a member's continued stay or release. MCOs may also use utilization management to comprehensively monitor and evaluate the appropriateness of past medical treatments or health care services provided to members. The MCD is responsible for managed care policy and oversight of MCOs.

Performance of contractors selected through non-competitive procurements of more than $10 million

Objective: Determine if selected non-competitive contractors are meeting the deliverable deadlines and performance measures stated in the contract.

Background: HHS agencies enter into formal agreements with contractors to perform needed services. An agency may award a contract through a non-competitive process for a variety of reasons (for example, emergency situations, proprietary services, sole source services) and bypass formal bidding or competitive request for proposal processes. This audit will review the performance of selected contractors with non-competitive contracts over $10 million.

Pharmacy audits

Objective: Determine whether the vendor accurately billed the Texas Medicaid Vendor Drug Program and complied with contractual requirements and Texas Administrative Code rules.

Background: The three pharmacies selected for audit are "closed shop" pharmacies that fill prescriptions for specific facilities and are not open to the public. The claims to be tested are fee-for-service claims from the period of September 1, 2011, through August 31, 2014. Claim amounts for the pharmacies during this period were about $47 million, $13 million, and $9.6 million, respectively. The Vendor Drug Program is administered by the MCD.

Inspections and Evaluations

Section

5

Inspections and Evaluations

Structure

The Inspections and Evaluations (I&E) Division conducts reviews of HHS System programs from a broad, issue-based perspective. The inspections and evaluations reports will offer practical recommendations to improve the efficiency and effectiveness of HHS programs and contractors, with a focus on preventing fraud, waste, and abuse. I&E has two primary product lines: inspections and evaluations.

I&E has proposed a staffing structure that requires 18 FTEs, which Commissioner Traylor approved in mid-December. The Division's work will thus quickly expand in size in 2016, because the new staffing will allow I&E to complete 24 to 30 inspections in the upcoming year.

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

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides supplemental foods and nutrition education, including free breastfeeding promotion and support. The program supports good health care during critical times of growth and development. The federal government provides 100 percent of WIC's funding. The Texas Department of State Health Services administers the program. The I&E WIC Vendor Monitoring Unit reports on WIC activities.

As of October 1, 2015, 322 vendors, with a total of 2,191 outlets, provide WIC benefits in Texas. DSHS conducts risk assessment of vendors annually. Criteria include cost containment, dollar volume, flat-rate pricing, and percentage of business volume that WIC comprises. An assessment score of ten or above constitutes "high risk." In federal fiscal year 2016 to date, 196 vendors are categorized high-risk.

Vendor Monitoring Unit activities for federal FY 2015

120 On-site evaluations conducted. From those, 280 sanctionable and 180 non-sanctionable violations were found; 16 of the 120 vendors had no violations. The most noted violations: 72 prices not prominently displayed; 54 labeling food items not authorized as WIC items; 52 not labeling three or more declared least expensive brand items.

116 Vendor-specific compliance buys conducted. There were 178 sanctionable and 65 non-sanctionable violations cited; 37 of the 116 vendors had no violations. The most-cited violations: 33 not labeling three or more declared least expensive brand items; 26 prices not prominently displayed; and 24 labeling food items not authorized as WIC items.

43 Follow-up compliance buys on open cases. There were 63 sanctionable and 28 non-sanctionable violations cited; 14 of the 43 vendors had no violations. One vendor was disqualified for trafficking food benefits and is appealing the decision. The most cited violations: 12 not labeling three or more declared least expensive brand items; 10 labeling food items not authorized as WIC items; and 8 prices not prominently displayed.

58 Vendor outlets which had invoice audits performed. Of those vendors, 5 had no disallowances; 47 were found to have disallowances, but no pattern of disallowance; 2 were disqualified for not submitting invoices with their audits; and 1 quit the program after preliminary findings of a pattern of disallowance. One was disqualified, with the action upheld after a fair hearing; two others that were disqualified appealed and have fair hearings pending.

PROFESSIONALISM
PRODUCTIVITY
PERSEVERANCE

Produced by IG Policy and External Relations
Rebecca Komkov, Deputy Inspector General for Policy and External Relations
Denise Donnelly, Director, Center for Policy and Outreach
Aelia Akhtar, Manager, Center for Policy and Outreach

Report design and editing: Art Moore

HHSC Inspector General
11501 Burnet Road, Building 902
Austin, Texas 78758
512-491-2000
OIGCommunications@hhsc.state.tx.us

To report fraud, waste, or abuse
800-436-6184

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