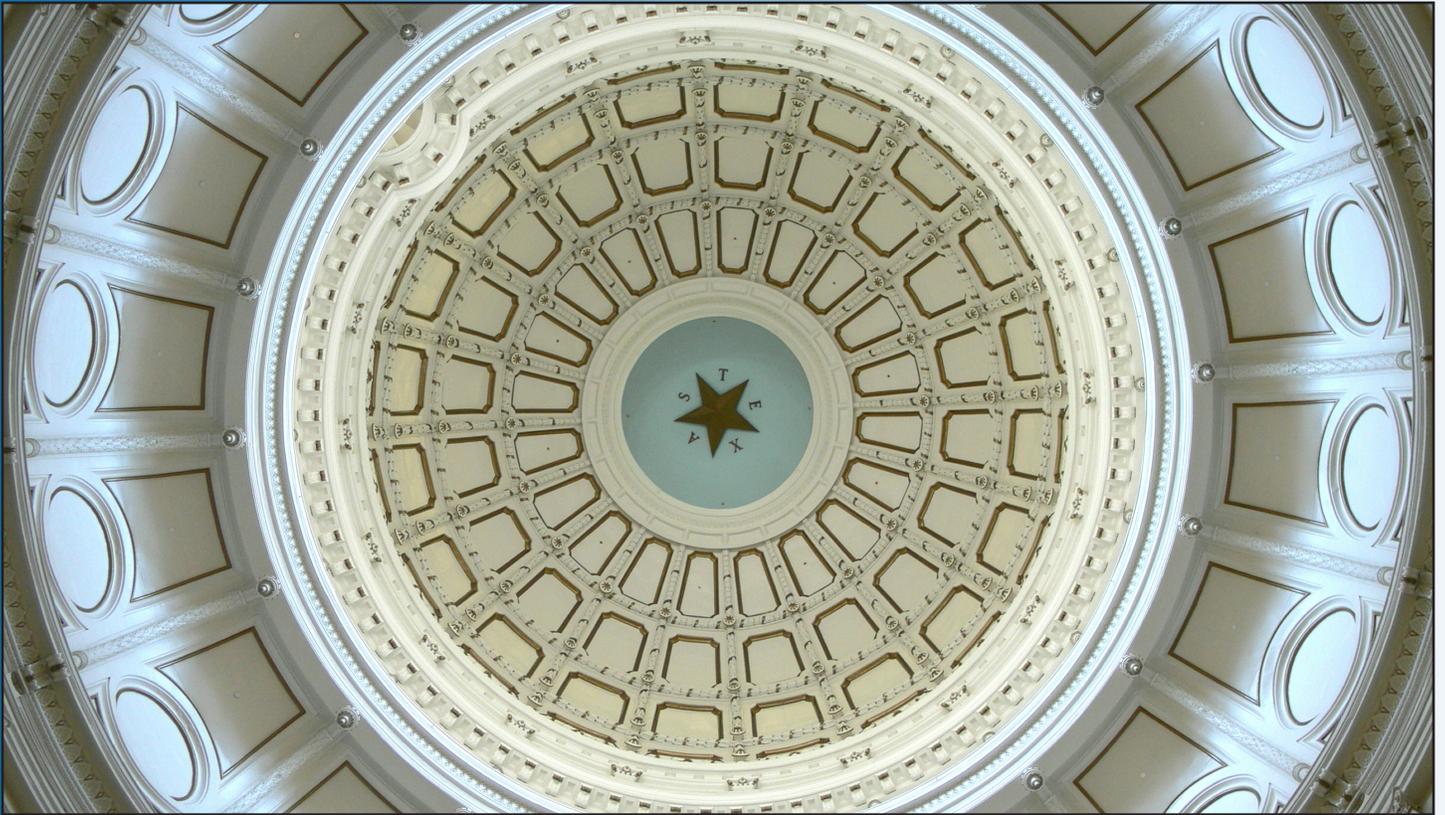


TEXAS HEALTH AND HUMAN SERVICES COMMISSION
INSPECTOR GENERAL



ANNUAL REPORT
SEPTEMBER 2016





PROFESSIONALISM
PRODUCTIVITY
PERSEVERANCE

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Message from the Inspector General

I am pleased to submit my office's FY 2016 Annual Report to Governor Abbott, Executive Commissioner Charles Smith, the Members of the Legislature, and the Citizens of Texas.

This is our first annual report, after four quarterlies. It provides a comprehensive story detailing the steady progress we have made at the IG over the past year. Our work during fiscal year 2016 produced real results that benefit Texas' taxpayers and the beneficiaries of Texas' health and human services system. Texas taxpayers benefitted because their tax dollars are being spent more effectively to serve millions of Texans in need. The beneficiaries benefitted, because the system is achieving greater efficiencies in effective service delivery.

Governor Abbott's charge to me 20 months ago was to reform and restructure the IG for success, to promote transparency and accountability through independent oversight, and to achieve real results by fighting fraud, waste, and abuse in the delivery of health and human services across Texas. I am pleased to report that the reform and restructuring measures that I and my senior leadership team developed — and that my dedicated staff implemented — have enabled us to meet that charge.

We at the IG continue to pursue oversight excellence by developing innovative ways to strengthen the HHS system. We will continue to provide the most professional and productive insight and advice possible, as we realize our vision to be the leading IG in the nation.

This report comprises six sections. Section One lays out an overview of IG accomplishments for FY 2016. It includes an interview with Cecile Young, the new HHS Chief Deputy Executive Commissioner. The section concludes with an interview with Christine Maldonado, Chief of Staff and Deputy IG for Operations. Christine has been an extraordinary leader in Texas for more than 20 years, and in August she was selected to receive the Governor's Commission for Women 2016 Outstanding Woman in Government Award for Leadership.

FY 16 dollars recovered

Litigation

Provider overpayments and penalties	\$10,213,159
Voluntary repayments	\$362,925
	\$10,576,084

Investigations

Beneficiary collections (SNAP, TANF, Medicaid, CHIP, and WIC)	\$32,435,185
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Medical Services

Acute care provider collections	\$5,053,545
Hospital collections	\$25,494,356
Nursing facility collections	\$6,577,246
	\$37,125,147

Audit and Inspections

Audit and WIC collections	\$4,826,257
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Total dollars recovered	\$84,962,673
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FY 16 dollars identified for recovery

Investigations

MCO overpayments identified by SIUs	\$6,373,798
Beneficiary overpayments identified by IG Law Enforcement (SNAP)	\$2,051,291
Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, WIC)	\$38,492,279
	\$46,917,368

Medical Services

MCO acute care overpayments	\$531,280
Nursing facility overpayments	\$2,390,579
	\$2,921,859

Audit and Inspections

Audit provider overpayments	\$15,529,582
WIC vendor repayments and penalties	\$46,048
	\$15,575,630

Total identified for recovery	\$65,414,857
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FY 16 dollars identified as cost avoidance

Litigation

Providers ordered to pay restitution	\$10,490,710
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Investigations

Beneficiary disqualifications	\$3,947,609
Beneficiary income eligibility matches and other beneficiary data matches	\$3,001,047
	\$6,948,656

Medical Services

Pharmacy Lock-In	\$158,284
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Inspections

WIC vendor disqualifications	\$8,659,828
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Total identified as cost avoidance	\$26,257,478
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Message from the Inspector General

Section Two provides an overview of the Texas Department of Aging and Disability Services, as well as an interview with DADS Commissioner Jon Weizenbaum. Sections Three, Four, Five and Six provide summaries of work accomplished this quarter by the Audit, Investigations, Inspections and our support divisions.

I remain grateful for the privilege of leading nearly 700 professional, productive, and persevering IG personnel who continue to accomplish our critical mission: the rooting out of fraud, waste, and abuse via audits, investigations, and inspections in the delivery of nearly \$50 billion

in health and human services in Texas.

We know that integrity is essential in all we do, and we will uphold that high standard. As Senator Alan Simpson once said, “If you have integrity, nothing else matters. If you don’t have integrity, nothing else matters.” We have integrity; and that matters immensely to me. It’s the right polestar for us to follow, and we will keep true to its course.



Stuart W. Bowen, Jr.

Overview

Section

1

Overview

Year of Results produces success

Fiscal year 2016 proved a fruitful year for the Office of Inspector General. During this the first full fiscal year of Inspector General Bowen's tenure, the office made significant progress by implementing broad-based restructuring and reform initiatives that produced rising results across the board. FY 2017 promises more of the same, as the IG's diverse and dedicated oversight teams continue to strengthen mission performance, protect taxpayer dollars, elevate professional capacities, and establish new communities of integrity across Texas through the IG Integrity Initiative. The IG's core values — professionalism, productivity, and perseverance — shape all it does, guiding the office's steady progress toward realizing its vision: to be the leading IG in the nation.

Inspector General Bowen designated FY 2016 as the Year of Results, following upon FY 2015's Year of Restructuring and Reform. Mr. Bowen recently denominated FY 2017 as the Year of Innovation. Restructuring, reform, and results will continue, needless to say, but the catalyzing element driving IG success during the new fiscal year will be innovation.

Results matter. The IG achieved meaningful results over the past 12 months, recovering \$85 million, a 40 percent improvement over the previous year. These results translate into a nearly 200 percent return on investment for the office. This achievement stemmed directly from the concrete and consistent efforts of IG auditors and investigators; it is undiluted by the inclusion of non-IG results (which previous years' reporting included). A little more than two-thirds of the recoveries involved Medicaid funds, with the balance chiefly comprising Supplemental Nutrition Assistance Program recoveries.

The record improvement in recovery levels arose from critical restructuring and reforms implemented over the past 18 months. During that span, the IG created two new divisions — Data and Technology and Medical Services — and restructured each of the others to achieve focused support for the office's core operations. Importantly, Inspector General Bowen established

a new core leadership team that guides all planning and implementation; it includes Principal Deputy Inspector General Sylvia Hernandez Kauffman, Chief of Staff and Deputy IG for Operations Christine Maldonado, and Senior Advisor for Policy and Publications Olga Rodriguez. These key leaders represent more than 40 years of experience and leadership within the HHS system.

This core team is buttressed by an extraordinary senior staff that includes Deputy Inspector General for Investigations Jay Crowley (45 years of federal inspector general experience); Deputy Inspector General for Audit David Griffith (30 years of public service, including 12 years as the Director of HHSC Internal Audit); Deputy Inspector General

Top FY 2016 results

- Recovered \$85 million, an increase of \$25 million from the previous year.
- Issued 50 audit reports, including 7 audits on MCO SIU performance.
- Launched the IG Integrity Initiative, enrolling many MCOs and other providers in a collaborative effort to strengthen the fight against fraud, waste, and abuse.
- Stood up the Inspections arm of the IG and initiated three inspections on key issues impacting Medicaid: pediatric dental sedation, speech therapy, and opioid prescription utilization.
- Secured settlements totaling more than \$5.7 million.
- Eliminated provider investigations backlog.
- Strengthened the fraud, waste, and abuse hotline, now called the IG Integrity Line, which processed more than 50,000 calls.
- Processed more than 96,000 Medicaid enrollment screenings.
- Implemented a new management system (Theory of Constraints) to improve oversight processes, which will ensure that IG return on investment increases.

for Inspections, Col. (Ret.) Quinton Arnold (six tours in the war zone, with Army IG inspections experience); Deputy Inspector General for Data and Technology Alan Scantlen (15 years of experience in data analytics and data management at HHSC); Chief Medical Officer Dr. Ted Spears (30 years of medical practice in Austin); and Deputy Inspector General for Medical Services Debbie Weems (more than 20 years of experience in health care fields including senior leadership positions in Medicaid at HHSC).

Forming the Division of Medical Services brought together the 80-plus IG nurses and other medical personnel under one aegis to increase the power of applied professional expertise in oversight activities. The division is a locus for the IG's expanding stable of subject matter experts that already includes a pharmacist and a Chief Dental Officer. These experts, in concert with the Chief Medical Officer, will provide professional Medicaid-related advice for investigative, audit, and inspection activities. Most notably, IG medical professionals, along with the data forensics team, undergird the newly inaugurated monthly investigative field operations that target vulnerable Medicaid zones. To date, the office executed three such operations, all in concert with the Centers for Medicare & Medicaid Services, to great effect.

IG success this year also stemmed from a forthright commitment to good strategic planning. With the assistance of Dr. Barry Bales, the foremost authority on leadership and planning at the University of Texas' LBJ School of Public Affairs, the IG committed itself to an iterative and consistent strategic planning process. The first planning retreat occurred in June 2015, which produced the initial plan. Follow-up meetings occurred quarterly, with steady improvements implemented into the plan. The IG drew upon Dr. Bales' expertise in leadership to improve the capacity of the senior team to guide the office's diverse missions. This commitment to planning and leadership paid off handsomely in the form of rising results, increased oversight activities, and good organizational morale.

Systemic evolution requires process

improvement. The IG found this path through a management tool called the Theory of Constraints (TOC). It focuses careful analysis on how teams execute programs with an eye on eliminating drag and deficiency. To date, the IG's Medicaid Provider Integrity and General Investigations processes experienced massive reforms through TOC. For MPI, the reforms organizationally integrated varying IG capacities — investigations, legal, data, and clinical — at case-outset to determine whether a new investigation deserves full-scale engagement. For General Investigations, TOC analysis produced a new intake function, freeing investigators from administrative delays and enabling them to devote their efforts to meritorious case resolution.

An overarching IG goal is to synergize the lessons drawn from our oversight work into best-practice recommendations for the HHS System. Working in collaboration with HHSC experts, the Medicaid managed care organizations, relevant providers, and other key stakeholders, the IG will develop a lessons learned and best practices program that will produce useful reports with usable guidance.

IG leadership and staff are energized and enthusiastic about the path the office is on. As Emerson once said, "Nothing great was ever achieved without enthusiasm." We expect great results in FY 2017.

Developing a professional work force

Training is key to professional growth. The IG provided technical and program training from state and federal experts for all of our teams this year. These events included training on internal affairs and law enforcement, investigative report writing, undercover operations, basic and advanced interview and interrogation, and trends in health care fraud. Further, the IG training staff has been significantly strengthened, fulfilling an important goal identified in the Sunset Report.

Stakeholder outreach

Inspector General Bowen began his tenure in late February 2015 with an explicit commitment to developing strong stakeholder outreach initiatives. Over the past year-and-a-half, the IG established good relationships with state leadership offices,

Overview

key legislators, MCO leaders, major providers, key associations, and federal partners. Most important, the IG built the strongest links in the history of the office with the key leaders at HHSC. Executing the IG mission must be a collaborative enterprise; the HHS system partners are essential to its success.

Good communication is key to success. In the oversight world, transparency embodies good communication. The IG's most important development in this area was the creation of the IG Quarterly Report. Prior to Mr. Bowen's arrival, the last report released by the IG appeared in 2011. This current report is the fifth comprehensive review released since Mr. Bowen began.

The IG's quarterly reports provide succinct reviews of oversight activities during the preceding three months, as well as insight into HHS system activities. All reports appear on the new IG website, which was redesigned to supersede the previously unusable one. The new site will be an enduring resource for the Medicaid community, particularly regarding training videos on fraud, waste, and abuse trends, which are forthcoming.

Good communication also requires personal engagement. Mr. Bowen regularly provides such in a variety of ways. He has testified before the Legislature more than ten times, since beginning his appointment, and has established close relationships with key legislators, visiting a number of them in their districts during travels around the state. Mr. Bowen's travels also took him to the offices of the top ten Medicaid MCOs, the sites of many major providers, to numerous speaking opportunities at the invitation of stakeholders, and to the headquarters of the IG's federal partners. Members of the IG leadership team usually accompanied Mr. Bowen on stakeholder engagements.

Meeting with the provider stakeholder community vastly improved IG relationships with key players in the Medicaid space. Significantly, it was a stakeholder engagement that provided the forum for the creation of the new IG Integrity Initiative. This culture-changing endeavor builds upon the axiomatic premise that establishing a

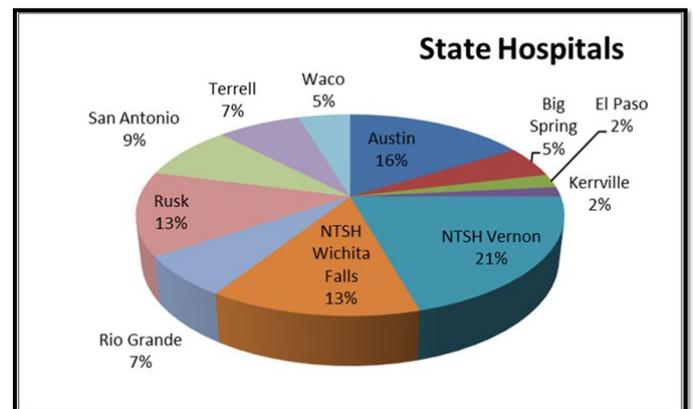
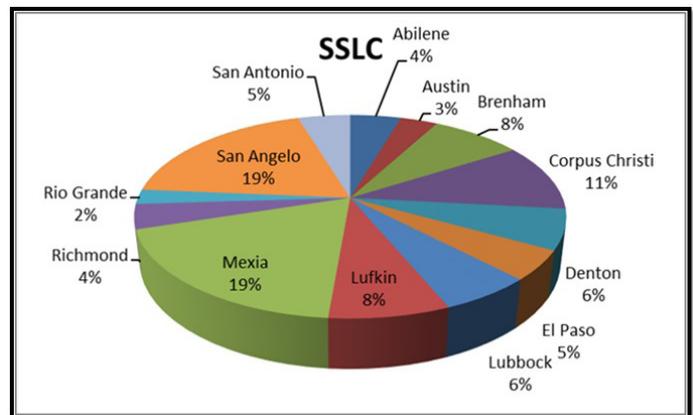
coherent community of integrity across Texas will improve the Medicaid program. There are now over a hundred members of the IGII, with all major MCOs participating.

Investigations accomplishments

Fiscal year 2016 brought dynamic changes to the Investigations Division. A new organizational structure sharpened the focus of IG investigative resources on those zones most vulnerable to fraud, waste, and abuse. To strengthen accountability and transparency, the IG implemented an internally developed electronic dashboard that monitors the progress of investigations throughout the life cycle of a case.

Despite undergoing significant organizational, personnel, and process changes, the Investigations Division attained substantial results during FY 2016. Specifically it recovered \$32 million and identified \$46 million more for recovery. The division accomplished this while eliminating the

FY 2016 SCIT completed investigations



enormous Medicaid provider case backlog and massively reducing the SNAP beneficiary referral backlog.

As noted above, the Theory of Constraints tool invigorated the MPI case management process. Today, MPI investigators conduct four MPI case-presentation meetings per week, enabling them to quickly identify and pursue meritorious investigations. The MPI team also developed unprecedented collaboration with other investigative agencies such as the Department of Justice, the Texas Attorney General’s Medicaid Fraud Control Unit, the AG’s civil medicaid fraud division, CMS, the federal Department of Health and Human Services OIG, and the Federal Bureau of Investigation.

Consolidation of the IG’s law enforcement investigative units (State Centers Investigative Team, Electronic Benefits Transfer, and Medicaid Law Enforcement Unit) continued in FY 2016. All three now use the same reporting and case tracking system and report along the same performance measures.

Like other areas of the investigations division, the LED and Internal Affairs staff created new partnerships and benefitted from critically needed training. For example, staff received training on internal affairs and law enforcement, undercover operations, border intelligence, constitutional law, crime scene photography, interview and interrogation techniques, contract case investigations, policy and procedures, investigative report writing, firearms qualification, and active shooter response training.

During FY 2016, the Division’s Law Enforcement Directorate received 1,298 complaints, completed 1,183 investigations, and referred 75 cases to district attorneys for prosecution.

Audit accomplishments

The Audit Division met or exceeded the goals set for the fiscal year, including performance and division reform targets. The division issued 50 reports, 10 above its target of 40. The state’s Medicaid Integrity Contractor, which is managed by IG’s Office of Federal Audit Coordination,

issued an additional 15 reports. IG Audit also completed 345 single audit desk reviews. Federal Audit Coordination was permanently transferred from HHSC to IG in February 2016, following a successful six-month pilot.

The IG Audit Division identified \$15,529,581 for recovery. Overpayments totaling \$4,825,947 previously identified by the IG Audit Division were recovered, with the majority of the recoveries completed by the Recovery Audit Contractor.

Inspections accomplishments

The creation of an Inspections Division marked a key moment in IG history. The office’s controlling statute long required the office to conduct inspections (as is the case with all federal IGs), but the IG had never fulfilled this mandate. Shortly after his arrival, Mr. Bowen began the process of creating an Inspections Division. The office stood up in February 2016, with a new Inspections staff, and developed an inspections plan. Three inspections are now under way.

Before initiating these initial inspections, the staff received significant training on topics such as basic and advanced interview techniques, critical thinking in the internal audit process, and completed the National Certified Investigator and Inspector Training. The staff also established coordination points of contact with multiple IG program areas. These developments prepared the staff to develop its initial inspection plan, which uses a risk-based approach.

During FY 2016, the Inspections Division WIC Vendor Monitoring Directorate completed 340 compliance buys and 125 in-store evaluations. They also completed 100 percent of the mandated USDA compliance and in-store evaluation activities and closed 348 cases, resulting in a cost avoidance of \$8,659,829. In the continued spirit of collaboration, this area established new partnerships with the P-WIC vendor community.

Chief Counsel accomplishments

In FY 2016, Chief Counsel prioritized collaboration with HHS to draft and promulgate rules and other actions mandated by Senate Bills

Overview

200 and 207. Rules implemented defined the respective roles and purposes of managed care audits, investigations, and oversight of managed care, including oversight of the special investigative units, and rules for opening and prioritizing cases in field investigations. Other key accomplishments include obtaining peer review certification from the Association of Inspectors General for the IG sampling and extrapolation processes and executing or revising memorandums of understanding between IG and licensing agencies.

Data and Technology accomplishments

The Data and Technology Division was created in the fall of 2015 to enhance the IG's existing data analytics, information technology, fraud detection, and actuarial expertise. The division now comprises a cohesive team of data experts supporting the IG's Investigations, Audit, and Inspections divisions. FY 2016 key accomplishments for the division include implementation of the IG Integrity Line and MPI dashboards, enhanced research support for investigations, and providing data support for multiple audits and inspections.

Medical Services accomplishments

The Medical Services Division was formed in May 2016, combining the former Intake Resolution Directorate, the Research Analysis and Detection unit staff, registered nurses from the Medicaid Provider Integrity unit and Audit, the Medical Director and dental team, and the Targeted Query staff.

The accomplishments of the Quality Review unit in fiscal year 2016 include the implementation

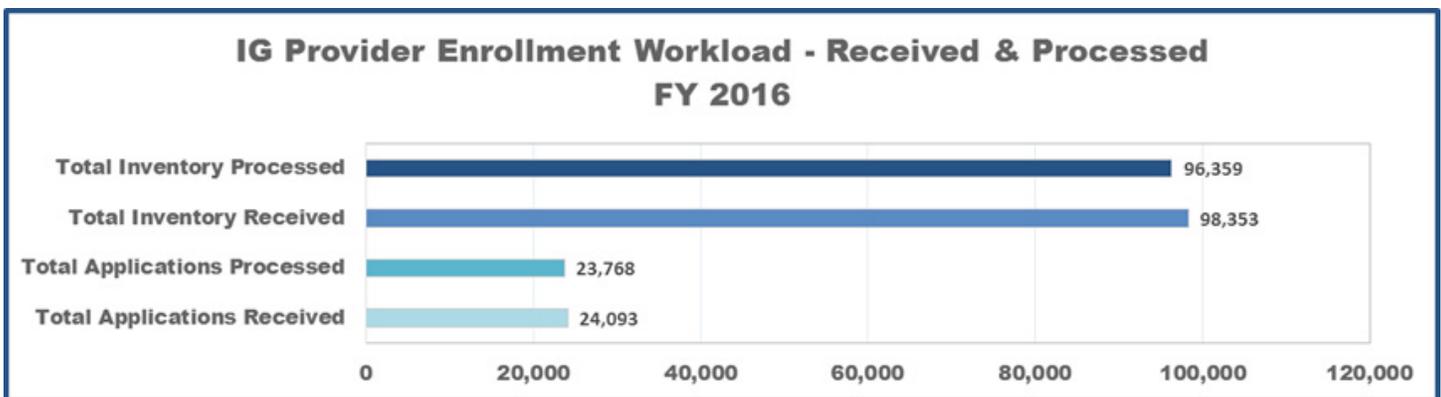
of a Utilization Review Quality Assurance Team, coordinated pilot plans for managed care reviews with Medicaid/CHIP, DADS, and managed care organizations, and working with hospital stakeholders to develop a notice of Diagnostic Record Group change as required by Senate Bill 207. Consistent with other divisions across the IG, this division provided training to staff on managed care, utilization review, the new medical diagnosis coding system, and other HHS programs that they review and monitor to increase their effectiveness in detecting and preventing fraud, waste and abuse.

Operations accomplishments

The Operations Division promotes a culture of collaboration, innovation, and accountability throughout the IG. Its goal is to increase efficiency and effectiveness for the IG, assure responsible accounting for our resources, and promote transparency for our customers.

Key FY 2016 accomplishments include the development of an IG Strategic Plan to promote accountability, strategically restructuring the organization for efficiency, investing in continuous training for each division, and establishing activities and events aimed at promoting morale and retention.

In addition, the division rebranded the Hotline to the Integrity Line, improved operational processes, and pursued technological enhancements with the goal of producing more effective reporting to the investigative staff and increasing the IG's capacity to identify potential cases for investigative action. Calls were processed at an annual rate exceeding 50,000.



Q&A with Cecile Young, Chief Deputy Executive Commissioner, HHS

Tell us about your background.

I have worked in state government for about 30 years. I began my state career as a lecturer and research engineer at Texas Tech University. In 1991, I served as the conference committee clerk for HB 7, which created the Health and Human Services Commission, and came to work at HHSC to implement the legislation. I returned to HHSC in 2007 as Associate Commissioner for Health Coordination and Consumer Services, where I worked until I retired in 2011. I returned as chief of staff in January 2015 and was pleased to be named the Chief Deputy Executive Commissioner in June. In my career in state government, I have served four governors, an attorney general, and a state representative. I have done budget and policy work since 1987.



Cecile Young

You recently became Chief Deputy Executive Commissioner, after serving in the Chief of Staff role for more than a year. How are the roles different?

I was honored and humbled when Governor Abbott named me to serve in this new capacity. I have worked on health and human services issues and budgets for many years and am excited about the opportunities to better our system. It is a serious charge to improve how we serve the people of Texas.

Executive Commissioner Charles Smith envisions great things for HHS, and it is exciting to be a part of that transformation.

What areas of the HHS system will be in your purview? What is your vision for these areas?

By September 2017, I will be responsible for the Medical and Social Services Division and the Facilities Division. We have talented, dedicated employees who want to serve.

MSS brings together all non-facilities client services, including eligibility services, Medicaid services, and community services program. It creates a centralized structure connecting similar programs to make it easier for consumers to locate and access needed services.

The Facilities Division will bring together State Hospitals and State Supported Living Centers to serve our clients in these facilities.

We make a difference in the lives of the people we serve through the delivery of the highest quality services and supports using the funding we receive.

In addition to direct responsibility, I serve as chief administrator of the HHS System in the absence of the Executive Commissioner.

What leadership principles do you think are most important for your position?

The HHS System is one of the most complex government organizations in America. In order to fully understand the challenges, it is important that any executive at HHS has a relentless passion to improve what we do and how we do it. We must constantly strive to find innovative approaches to some of the most challenging and difficult issues for the vulnerable populations in our society. My job is to ensure that our staff understands the priorities of the Executive Commissioner and challenge assumptions for service delivery that will ultimately result in a better experience for our clients.

What do you see as the top priorities for the HHS system over the next two years? What do you think are the biggest challenges facing HHSC today?

There will be many changes over the next two years and these present opportunities to improve the way we do our business. System innovation will be our watchword.

How do you envision collaborating with the Inspector General to root out fraud, waste, and abuse from the HHS system?

My team is dedicated to working with the IG. Our stewardship of the people's resources and our obligation to our clients demand that tax

Overview

dollars pay for their true and intended purposes. Fraudulent and wasteful spending means fewer dollars for services to people.

The IG and our office work hand in hand. We meet regularly to discuss issues and priorities. A recent win for both offices was using data from IG investigations to improve one of our business processes. I foresee many more wins with this collaboration.

Q&A with Christine Maldonado, Chief of Staff and Deputy IG, Operations

Please tell us about yourself and what experiences have prepared you to be an effective leader.

Family has played a critical role in the early development of my leadership skills, as I was raised by some natural leaders who inspired me at an early age. Growing up in a large and loving family from Uvalde, Texas, taught me about the importance of strong collaboration, helping each other through good times and hard ones, and the importance of working hard and ensuring everyone is doing their part to help meet the larger needs of the family and community.

Specifically, my grandmother Carolina taught me humility and how to always understand that you are here to serve others selflessly, which involves ongoing sacrifice of my own desires and goals. She demonstrated on a daily basis how to be truly present with anyone around her and show unconditional love even while sitting side by side in silence. She was such an incredible listener who simply loved me and wanted me to thrive.

My mother Anna taught me how to always stay positive. When something negative happened, she'd encourage me to learn the lesson involved and expect that something better would come in the future. Both my grandmother and mother worked extremely hard, and it's rare I ever observed them sitting down and relaxing; they



Christine Maldonado

always felt the need to contribute to everyone's needs and keep the family functioning. In fact, I remember my mom working two jobs during a rough period in her life, and she demonstrated perseverance balancing her workload while raising three children. My grandmother Carolina raised nine children and became a widow in her 40s, which led to her being a single mother who worked really hard to make ends meet day to day. From these experiences, I learned the value of hard work and how you just need to do whatever it takes to support and serve all of those who rely on you.

This upbringing led to my passion for serving others. As a result, my first job opportunity right out of college was to work for Child Protective Services, where I was an advocate for abused and neglected children; I worked tirelessly, day and night, to investigate cases and ensure that children were protected. After this initial experience, I was completely committed to the Department of Family and Protective Services for 20 years and served in multiple leadership positions within this critical organization. I managed contracts for the Prevention and Early Intervention division, specifically Services To At Risk Youth, and served in multiple leadership roles within the Contract Oversight and Support division. During my tenure with DFPS, I was fortunate to have learned from many effective and caring leaders, such as Kim Wedel and Liz Garbutt, who contributed to my development as a leader. They taught me that leading a work team is just like leading a family in that you must be kind and compassionate, empower people to believe in themselves and make decisions, and work hard to serve the needs of the entire team and not just your own. Even though I was building a Policy Handbook, designing a Quality Assurance process, and developing training plans for the organization, I learned that you could still conduct business effectively while also caring about each of your individual team members. In fact, I learned that caring for and developing each team member is the most important work. Recognizing people's strengths and helping them learn valuable lessons from mistakes inspired them to stay committed to my team and the organization

at large, ultimately making us more effective and carrying us through the tough spots, since each individual felt valued and enjoyed the team environment and one another.

What do you believe to be keys to effective leadership?

- Establishing trust with those you serve, including all of your team members. Everyone around you knows whether you are a person who does the right thing and follows through on your promises. Allow your team members to make mistakes and learn valuable lessons from them, empower their decision making, and trust them to represent you and be by your side during critical meetings. Believe in your team and trust that they are doing their best to meet performance requirements. Know that they rely on leadership to help them grow so they can do better, so it's important to advocate for the resources and training they need to be successful.
- Inspire commitment to the organization's mission and those we serve by advocating for their needs. Understand that everything you do is for them and keep the team's focus there. Establish specific goals and metrics that serve as a compass to ensure the team understands the destination and outcomes we are seeking to achieve. When they meet these goals, recognize and value them for their hard work and customer service.
- Always treat the clients and team you serve with respect, kindness, and understanding. If you don't, no one will be willing to follow your lead and respect you as a leader.

How are you currently applying your leadership skills?

I currently serve as the Chief of Staff and Deputy of Operations at the Inspector General's Office and transitioned to this role nearly a year ago in November 2016.

I am grateful to the Inspector General, Stuart W. Bowen, Jr., for entrusting me to help him lead the organization along with Principal Deputy Sylvia Kauffman. Mr. Bowen believed in my ability, more than I believed in myself, to take on this critical role, and it's been an honor and incredible challenge to help operationalize his vision and begin the process of developing a positive and trusting culture at the Inspector General's Office. As soon as I arrived, Mr. Bowen was in the process of visiting the top 10 managed care organizations to build trust, establish a collaborative partnership, and to better understand them. I quickly followed his lead. Mr. Bowen has been an incredible advocate in obtaining all of the necessary resources for the organization to be successful. His commitment to our mission, vision, and values has been inspiring and a breath of fresh air to all of us whom he serves.

I see my role as a facilitator in promoting communication, developing positive relationships and effective partnerships, spearheading morale and retention initiatives, helping inspire others to connect with the personal side of the IG mission, and working to make the IG's office a place that staff enjoy coming to every day while giving it their all. I try to lead by example, and my goal is to provide excellent customer service to everyone that my team and I encounter. Tying back to what my family and leaders have taught me, I always try to make time for staff, even if it means that I have to sacrifice what I originally had planned for a given hour, day, week. I truly believe that investing in people is the most important part of leadership, so I always try to make that my top priority.

Program Insight: Department of Aging and Disability Services

Section

2

Program Insight: Department of Aging and Disability Services

Overview

The Texas Department of Aging and Disability Services (DADS) was created to administer long-term services and supports for people who are aging as well as for people with intellectual and physical disabilities. DADS also licenses and regulates providers of these services. DADS began formal operations on Sept. 1, 2004.

DADS operates State Supported Living Centers, which provide campus-based direct services and supports to people with intellectual and developmental disabilities at 13 locations — Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, Rio Grande, San Angelo and San Antonio. (The Rio Grande State Center is operated by the Texas Department of State Health Services and provides services through a contract with DADS.)

The State Supported Living Centers serve people with intellectual and developmental disabilities who are medically fragile or who have behavioral problems.

In addition, the DADS Regulatory Services division helps protect the health and safety of Texans by ensuring that regulated facilities and agencies comply with federal and state rules. This division also provides federal certification for health care facilities offering long-term services in the Medicaid and Medicare programs; state licensure for facilities providing licensed health care services; and licensure of home and community support services agencies that provide home health, personal assistance, and hospice services. Two important units within DADS work closely with Regulatory Services: the Consumer Rights and Services area, which operates a complaint intake call center, and Educational Services, which provides training both for providers and DADS regulatory teams. DADS services also include the state Office of the Long-Term Care Ombudsman, which advocates for the rights of residents in nursing homes and assisted living facilities.

Key facts about DADS

State Supported Living Centers

Facility	Enrollment	Average age
Abilene	298	52
Austin	184	58
Brenham	267	46
Corpus Christi	222	50
Denton	455	53
El Paso	106	47
Lubbock	196	46
Lufkin	294	49
Mexia	264	37
Richmond	326	51
Rio Grande	63	43
San Angelo	215	43
San Antonio	232	48

Figures as of June 30, 2016

Regulatory Services

Facilities/agencies regulated (FY 15)

Nursing facilities	1,223
Intermediate care facilities	847
Assisted living facilities	1,829
Adult day care facilities	481
Home/community support services agencies	6,343

Facility inspections completed (FY 15) 4,237

Facility investigations completed (FY 15) 18,827

Source: DADS

Insight from Jon Weizenbaum, Executive Commissioner, Department of Aging and Disability Services

Please tell us about your background.

I grew up in Tucson, Arizona, but have lived in Austin for more than 31 years. I'm a social worker by training and have worked in a variety of clinical settings, including child protective services, private nonprofit foster care and HIV/AIDS services. On the public policy side, I've served as committee director at the Texas Senate Committee on Health and Human Services and as director of communications and government relations with

Program Insight: Department of Aging and Disability Services

the Texas Commission on Alcohol and Drug Abuse.

I joined DADS at its inception in 2004 as director of the Center for Policy and Innovation and then served as deputy commissioner. I've been in the DADS Commissioner role since 2012. I have an undergraduate degree from Brown University and master's degrees from the University of Texas School of Social Work and the LBJ School of Public Affairs. My wife, Nancy, and I are proud parents of two awesome daughters, Emma and Camille (ages 25 and 21, respectively). Like IG Bowen, I'm a big music fan and an enthusiastic (if not exactly professional) guitarist, and I enjoy bicycling and hiking whenever I get the chance.



Jon Weizenbaum

What is your vision for the agency over the next year?

As part of the health and human services system transformation, DADS will continue to be a stand-alone agency only until September 1 of next year, when the remaining two large DADS divisions will become part of the Health and Human Services Commission. That puts us in a unique position. But for this next year, DADS must remain focused on ensuring that these two divisions – Regulatory Services and the State Supported Living Centers – continue to carry out their critically important mission of protecting the health and safety of older Texans and those with intellectual and developmental disabilities. Working with HHSC and other key partners, my vision is that our staff will have all the tools and supports they need to provide seamless service to clients, providers and other stakeholders as our transformation plays out.

What are your strategic priorities for 2017?

For DADS Regulatory Services, our chief priority will be to continue ensuring that long-term care providers such as nursing facilities, assisted living facilities, home health care agencies and others comply with laws, rules, and regulations and provide the highest quality of care possible to the

individuals they serve. As the population of older Texans continues to increase dramatically, so too will the demand for these services. All of us have had a friend or family member who has needed these services at some point, and it's our job to help ensure they are available and provided in a way that keeps vulnerable individuals safe.

To achieve that, we will continue to focus on improving the consistent enforcement of regulations across the state, ensuring that our survey teams in one region are applying the rules in the same way as the teams in other regions. As part of this effort, we've implemented new training for our regulatory investigators and worked closely with providers and other key stakeholders to improve communication and collaboration. This division is also undertaking a variety of important initiatives to help long-term care facilities provide higher quality of care to their residents.

For the SSLC division, our top priority is to continue our efforts to better serve the individuals who reside in these 13 state-operated facilities, including those with complex behavioral or medical needs. One prominent example of this effort was the launch earlier this year of a system-wide electronic health record that allows the centers to collect more robust, consistent data on the health and care of every resident. In addition to improving efficiency and accuracy, the system will allow clinical and other staff to more readily identify trends or concerns and address these issues more quickly. We've also stepped up our efforts to ensure that individuals who move out of an SSLC have the services and supports they need to thrive in a community setting. DADS is entrusted with the task of serving some very vulnerable individuals, and I'm proud of how innovative we've been in improving the quality of services provided to them.

What are your top three challenges?

I would say that recruitment and retention of staff at our SSLCs continues to be a challenge, particularly with certain clinical positions, such as nurses, as well as the direct care professionals who work most closely with residents. Having a stable, well-trained staff is vital to our efforts to provide high quality services. We are continually

Program Insight: Department of Aging and Disability Services

taking a lot of creative steps to address turnover, but it remains a persistent challenge, particularly in certain areas of the state.

Another challenge in a system as geographically widespread as ours is internal communication – getting relevant information to the thousands of our staff who work in our regional offices and SSLCs. We want to always be sure we’re providing these critical front-line workers with the information and tools they need to carry out their work.

The third challenge I would say is addressing the state’s booming aging population in a way that’s both effective and fiscally prudent. By 2026, the number of people over age 60 is expected to increase by 44 percent and make up more than 20 percent of our state’s population. We’re always working to find new, efficient ways to meet the growing needs of older Texans, even in a tight budget environment.

What are your priorities for the 85th Legislature?

One priority for me will be to effectively and accurately communicate with lawmakers about the needs of the populations we serve. Our goal is to provide policy-makers with all the information and data they require as they make difficult choices about how best to spend limited resources. For example, we will share information about the growing caseloads in many of our programs, as well our ongoing need to recruit and retain staff. My vow is that we will be helpful partners as we work with lawmakers and their staff to address these issues. Before the session starts, we also want to provide any needed assistance to legislative committees as they develop interim reports and

recommendations. These can be an effective platform for highlighting the critical issues facing these populations.

What has been your most personally rewarding experience as commissioner of DADS?

In a job that carries a lot of rewards, I would have to say I have most enjoyed getting out in the field to meet with our staff and the individuals they serve. DADS staff members are public servants in the truest sense, and it’s deeply moving to see how the services they provide directly improve people’s lives in tangible ways. You can see it in the SSLCs, where I have met direct care workers who have worked the overnight shift for years in the same home, serving residents who have become like family to them. I can see it when I visit nursing facilities, where our staff has made it possible for these providers to start innovative programs that directly benefit residents. Running a large agency is a challenge that will always carry its share of crises and complexities, but witnessing these efforts in the field helps me stay focused on why we do what we do. We have a critical mission, and I am honored every day to be entrusted with it.

How does your office collaborate with the Inspector General to identify fraud, waste, and abuse?

If, during the course of a regulatory investigation, DADS staff find evidence of possible fraud, the information is referred to the IG. DADS staff at the SSLCs also work closely with IG staff as they investigate allegations of waste, fraud or abuse in these facilities. We’re grateful for the energy and integrity that IG Bowen and his team have brought to these efforts.

Investigations

Section

3

Investigations

Overview

The IG's Investigations Division works to protect the integrity of the Texas Medicaid system and other health and human services programs by investigating allegations of provider or recipient fraud, waste, and abuse.

It conducts personnel investigations at State Supported Living Centers and State Hospitals to ensure the safety of residents in these facilities. Additionally, the IG carries out personnel investigations across the entire HHS System.

The Division comprises five Directorates:

- General Investigations
- Intake Resolution
- Medicaid Provider Integrity
- Law Enforcement
- Internal Affairs

Theory of Constraints streamlines Medicaid Provider Integrity investigations

On July 27, MPI Investigators began regular meetings with critical business areas (Litigation, Data and Technology, and Medical Services) to collaborate and develop strong, strategic approaches to provider investigations. The effort to collaborate in the early stages of investigations is a result of a new management and problem-solving philosophy based on the concept of Theory of Constraints. IG leadership initially embarked on this project beginning in May 2016 to help identify and correct processes and procedures in the investigations workflow that hindered efficient and effective outcomes.

TOC improves General Investigations process

With the early success of the Theory of Constraints applications in Medicaid Provider Integrity, IG leadership quickly moved to implement this strategy with General Investigations. On August 15 and 16, Theory of Constraints consultants met with IG leadership and GI management. HHSC executive management had the opportunity to observe the process in action. GI management is currently drafting a

streamlined investigative method applying the principles of the Theory of Constraints. Although General Investigation has consistently been successful in terms of dollars recovered, the potential exists to identify and correct inefficiencies to enhance and achieve greater results. Designing a better investigative process will allow GI to build on its past success. A pilot process applying Theory of Constraints principles will be launched in September 2016.

General Investigations

The General Investigations directorate 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 Women, Infants, and Children program, as well as other health and human services programs. The GI directorate also assists Internal Affairs and conducts other special investigations.

During this quarter, 106 GI investigators referred 97 cases for prosecution, received 52 court dispositions, identified \$10,601,278 for recovery, and collected \$4,273,222 in overpayments. GI and the HHSC Office of Eligibility Services (OES) began to lay the foundation for the new joint SNAP integrity initiative that will promote collaboration between the OES and the Inspector General to strengthen the fight against fraud, waste, and abuse in SNAP. The initiative focuses on improving communication between the teams and identifying innovative practices to fight and prevent fraud, waste, and abuse.

GI continues to work with tech programmers, managers, deputy inspectors, directors, and subject matter experts to improve the accuracy and timelines of reporting in our archaic case management system.

Top GI accomplishments this quarter

- Identified \$10,601,278 for recovery.
 - Collected \$4,273,222 in overpayments.
 - Referred 97 cases for prosecution.
 - Obtained 52 court dispositions.
-

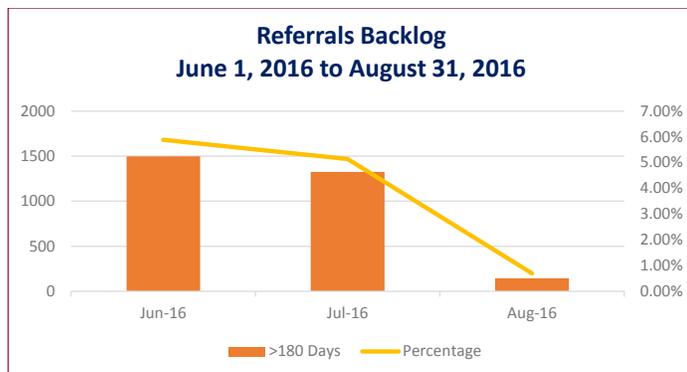
This quarter, GI staff participated in essential trainings including interview and interrogation techniques.

During this quarter, GI reduced backlog cases and referred cases for prosecution to district attorneys throughout Texas, including:

- SNAP and Medicaid fraudulent overpayment of \$80,000 due to a recipient not reporting his earned prize money from participating in sports marathon events.
- SNAP and Medicaid fraudulent overpayment of \$60,000 reported through the IG Integrity Line where a recipient failed to include her husband and his income.
- SNAP and Medicaid fraudulent overpayment of \$83,000 referred by an OSS Texas Works Advisor who suspected the absent parent was living in the home and earning income.

Medicaid Provider Integrity

MPI Intake opened 461 cases and completed 324 cases this quarter while maintaining an average preliminary case processing time of 22 days. After preliminary investigation, Intake transferred 24 cases for full-scale case development and 13 to other divisions of the Inspector General for further development. MPI Intake made additional referrals to Medicare, Managed Care Organization Special Investigative Units, various regulatory licensing boards, and other HHSC agencies including the Department of State Health Services and Department of Aging and Disability Services for review, information sharing, and resolution. The number of pending MPI full-scale investigations has been reduced from 171 to 80 since June 1, 2016. All cases greater than two years



old have been resolved.

MPI conducted joint field operations with the Centers for Medicare and Medicaid Services during this quarter in Houston and the Rio Grande Valley. These collaborative efforts focused on home health and speech therapy providers. During these data-driven operations, intelligence was gathered by MPI to determine whether a full-scale investigation or inspection is warranted. Two cases were opened after the Valley Speech Therapy Operation. IG is planning to conduct these types of operations on a regular basis in fiscal year 2017.

Law Enforcement

The Law Enforcement Directorate comprises commissioned and non-commissioned investigators who conduct criminal and other investigations on violations involving State Supported Living Centers and State Hospitals, Supplemental Nutrition Assistance Program Electronic Benefits Transfers, and Medicaid fraud. The three units in this directorate are the State Centers Investigative Team, Electronic Benefit Transfer Trafficking Unit, and Medicaid Law Enforcement Unit.

State Centers Investigative Team

Allegations of abuse were investigated at a State Supported Living Center after a client was found to have multiple bruises and abrasions on his head, arms, back, and legs. Forensic evidence developed through the investigation substantiated the allegation. Five staff members of the State Supported Living Center were identified, determined to be responsible, and referred to a local district attorney for prosecution.

An allegation of abuse was investigated at a State Hospital after a patient was discovered with puffiness to the right eye and reported that a staff member had pushed the patient into a wall. Subsequent investigation and forensic evidence substantiated that one staff member was responsible for the injury and four other staff members failed to report the incident. This case has been referred to a local district attorney for prosecution.

This quarter, State Centers opened 255 cases and

Investigations

completed 261.

Medicaid Law Enforcement Unit

The Medicaid Law Enforcement Unit comprises five commissioned peace officers who conduct high-level criminal investigations of suspected fraud, waste, and abuse in the Medicaid program. These investigators work with various local, state, and federal law enforcement agencies.

An investigator attached to the FBI's Rio Grande Valley Health Care Fraud Task Force assisted in the investigation of a durable medical equipment (DME) business. The allegation was forgery of prescriptions and submission of fraudulent claims to Medicaid for unauthorized equipment. The owner and six former employees were indicted and subsequently arrested. The DME business submitted fraudulent Medicaid claims totaling \$2.5 million and received Medicaid payments totaling \$1.8 million.

During another investigation involving the FBI's Rio Grande Valley Health Care Fraud Task Force, the unit assisted in the investigation of a subject who purported to be a licensed vocational nurse. The subject used another person's nursing credentials to obtain employment at a local health care company. From January 2015 through July 2016, the subject conducted patient home visits and provided medical services using the false identity. The subject was subsequently arrested and charged.

The FBI, Department of Health and Human Services Office of Inspector General, Texas Attorney General's Medicaid Fraud Control Unit and IG participated in a joint investigation resulting in the arrest Dr. Pedro Garcia of Mission on August 31, 2016. A federal grand jury in McAllen returned an indictment under seal on August 30, 2016, in which Garcia was charged with soliciting and obtaining cash in exchange for referrals of Medicare beneficiaries to prospective home health agencies. Garcia allegedly signed patient forms for patients he did not treat or provide services to and conveyed the forms to

home health agencies, claiming he had treated or provided services to the patients. Some of the patients were deceased on the dates Garcia claimed to have provided treatment or services. During the investigation, it was determined that Garcia also billed Medicaid and was paid a total of \$20,256 in Medicaid benefits from 2011 through 2016.

This quarter, the Medicaid Law Enforcement Unit opened three cases, completed ten cases, and referred ten cases.

EBT Trafficking Unit

Allegations a retailer was exchanging cash for SNAP electronic benefit transfer benefits were investigated. Undercover transactions resulted in more than \$1,500 cash being exchanged for multiple Lone Star cards valued at \$3,500 in SNAP benefits. The investigation was referred to the local district attorney for prosecution.

This quarter, the EBT Trafficking Unit opened 15 cases and completed 26 cases.

Internal Affairs

Internal Affairs conducts investigations of fraud, waste, abuse, employee misconduct, and contract fraud within the HHS system. Internal Affairs Program Investigations conducts investigations of allegations brought against employees, vendors and contractors associated with the Health and Human Services System throughout Texas.

For the period of June 2016 to August 2016, IA conducted 177 investigations, substantiating 26 of those. The cases involved vital statistics fraud, contract fraud, employee misconduct, privacy breaches, computer misuse, and Child Protective Services and Adult Protective Services death cases.

IA conducted an investigation involving an employee of the Department of State Health Services Office of the Texas State Registrar based on an allegation she failed to report the loss or misplacement of a ledger containing personally identifiable information of approximately 500 individuals. The investigation revealed the State Registrar knew of the missing ledger and failed to report it as required by policy.

Audit

Section

4

Overview

The IG Audit Division conducts risk-based audits of contractors, providers, and Health and Human Services (HHS) programs to reduce fraud, waste, and abuse throughout the HHS system. These audits examine the performance of medical service providers and HHS agency contractors, and provide independent assessments of HHS programs and operations.

Audit Division reports issued

MCO special investigative units

The IG issued six reports of Managed Care Organization (MCO) special investigative units' (SIU) performance. The reports, part of a series of reports on MCO SIUs, indicate a wide variance in the implementation of SIU fraud, waste, and abuse plans.

Cigna, Community Health Choice (Community), Cook Children's Health Plan (Cook), DentaQuest, El Paso First Health Plans (El Paso First), Scott and White, Seton, Superior, Texas Children's Health Plan (TCHP), and UnitedHealthcare Community Plan of Texas (United) paid approximately \$15.8 billion in medical claims in fiscal years 2014 and 2015. During this two-year period, the MCOs' SIUs recovered \$2.3 million.

The IG offered recommendations to strengthen

MCO SIU recoveries

MCO	Medical claims	SIU recoveries
Cigna	\$889,257,147	\$107,424
Community	\$1,273,544,989	\$44,609
Cook	\$504,968,813	\$139,142
DentaQuest	\$1,249,372,629	\$458,826
El Paso First	\$278,632,838	\$102,401
Scott & White	\$205,897,191	\$0
Sendero	\$82,321,946	\$0
Seton	\$88,326,283	\$0
Superior	\$7,040,614,775	\$16,094
TCHP	\$1,597,604,863	\$1,439,505
United	\$2,572,939,637	\$0
Total	\$15,783,481,111	\$2,308,001

Top Audit accomplishments this quarter

- Identified approximately \$2.7 million in MCO overpayments for recovery.
- Adopted audit topics for the new rolling audit plan.
- The Recovery Audit Contractor, which is managed by Federal Audit Coordination, identified approximately \$5.4 million in potential Medicaid hospital overpayments for recovery.

SIU fraud, waste, and abuse detection, investigation, and reporting activities. The Medicaid/CHIP Division and audited MCOs were provided the opportunity to study and comment on the recommendations.

The Medicaid/CHIP Division concurred with the IG's recommendations, and will facilitate the development of corrective action plans designed to improve SIU functions. In the first quarter of fiscal year 2017, the IG will issue a final summary report to the Medicaid/CHIP Division offering overall recommendations for SIU improvement.

Delivery supplemental payments

The IG issued its report of delivery supplemental payments. The audit evaluated the effectiveness of processes and controls intended to ensure delivery supplemental payment claims and appeals were processed timely and accurately, and claim adjudications and appeal decisions were valid and adequately supported.

MCOs submit delivery supplemental payment claims to the Health and Human Services Commission (HHSC) to cover hospital expenses for the delivery of a child. From fiscal years 2013 through 2015, MCOs received approximately \$1.5 billion in delivery supplemental payments. Audit results indicate that although delivery

Delivery supplemental payments

Errors	Overpayment	Underpayment
Claims	\$2,079,632	\$773,857
Appeals	\$1,367,801	\$6,298
Total	\$3,447,433	\$780,155

supplemental payment claims were processed with an overall accuracy rate of 99.84 percent over the three-year period, claims and appeals processing errors resulted in MCO overpayments totaling \$3,447,433 and MCO underpayments totaling \$780,155.

The IG recommended that the Medicaid/CHIP Division should recover the identified MCO overpayments and pay the identified MCO underpayments. Additionally, the IG recommended that the delivery supplemental payment function be moved from Strategic Decision Support to the Medicaid/CHIP Division, and that additional processes and controls should be put in place to strengthen the management and administration of delivery supplemental payment activities.

HHSC management concurred with the IG's recommendations and has planned actions to address MCO overpayments and underpayments and strengthen the delivery supplemental payment function.

Acute care utilization management in MCOs

The IG issued an informational report of acute care utilization management in MCOs. The report will be followed by a series of reports detailing the results of the IG's audit to evaluate the effectiveness of MCO acute care utilization management practices in ensuring that health care services are medically necessary and efficient, and that services comply with state and federal requirements.

Through utilization management, MCOs assess the medical necessity, efficiency, and appropriateness of health care services and treatment plans on a prospective, concurrent, or retrospective basis.

MCOs perform prospective utilization reviews before recommended health care services are provided. Prospective utilization reviews include practices such as pre-certification, pre-admission screenings, and prior authorization of certain medical services. MCOs varied in the percentages of prior authorization requests denied and appealed, but the widest variance MCOs reported

was related to reversals on appeal of denied prior authorization requests. MCO reversals of appealed prior authorization denials ranged from as low as 5 percent to more than 80 percent.

Concurrent utilization reviews evaluate ongoing health care or requests for an extension of treatment beyond previously approved health care. Retrospective utilization reviews evaluate health care services that have already been provided to a member and have not been reviewed for medical necessity.

The IG Audit Division will issue four MCO-specific audit reports on acute care utilization management as it continues audit work over the next several months. The series will conclude with a summary report planned for February 2017.

Projects selected for rolling audit plan

The IG implemented a new two-year rolling audit plan that will be updated each quarter. In addition to detailing the scope and objectives of audits that are in progress, the first plan will include a list of audits the IG plans to initiate in the first six months of fiscal year 2017, and a list of audit topics the IG will consider initiating over the next two years through fiscal year 2018.

Audits the IG plans to initiate during the first six months include topics related to dental service organizations, managed care pharmacy benefit manager compliance, hospital credit balances, MCO third party recovery performance, and provider types such as pharmacy and durable medical equipment. While the IG anticipates it will complete the audits listed in the plan, changing risks and priorities could result in some of the planned audits not being started, or in other audits not listed being added to the plan.

Potential audits the IG will consider initiating through fiscal year 2018 include topics related to managed care, eligibility, IT security, foster care, and Medicaid programs. The plan will be updated and issued quarterly to include the most current list of scheduled audits, and to reflect adjustments to scheduled audits resulting from changing risks and priorities.

Audit Division report progress

The Audit Division issued 50 reports in fiscal year 2016, well over its target of 40 reports for the year. Of the 50 reports, 8 reports were issued in the fourth quarter. The Audit Division plans to issue eight to ten reports each quarter in fiscal year 2017.

New Audit Division projects underway Assessment and evaluation practices at a long-term care nursing facility

Objective: To determine whether services at a selected long-term care nursing facility are provided consistent with physician orders and in accordance with resident assessments and evaluations.

Background: Long-term care nursing facilities were introduced into the managed care environment in March 2015. The audit will verify whether services are medically necessary, are provided and billed in accordance with physician orders, state rules and Medicaid requirements, and the level of care for authorized and eligible services.

Council of governments

Objective: To review a selected council of governments' compliance with contractual requirements, and determine whether state funds for fiscal year 2015 and 2016 were used as intended and in accordance with contractual requirements.

Background: The council of governments selected for audit provides disaster relief, youth counseling, assistance with submitting online applications for social service programs, and other services to HHS clients through multiple contracts and grants funded by the Health and Human Services Commission, Department of Aging and Disability Services, and the Department of Family and Protective Services. The council of governments received approximately \$1.5 million from HHS agencies in fiscal years 2015 and 2016.

Selected speech therapy providers

Objective: To review a sample of providers associated with specific MCOs and providers' patients to evaluate provider enrollment and the process for discontinuing treatment.

Background: The Centers for Medicare and Medicaid Services (CMS), MCOs, and the IG recognize speech therapy providers as a high-risk provider group. In fiscal years 2014 and 2015, approximately \$745 million in state funds were spent on speech therapy services in Texas.

Audit Division projects in progress

The following projects from the fiscal year 2016 audit plan are currently in progress:

- Managed care organization SIU performance.
- Acute care utilization management in managed care organizations.
- Performance of contractors selected through non-competitive procurements of more than \$10 million.
- Pharmacy audits.
- Recovery of overpayment amounts identified in federal audits.
- Claims Management System IT interfaces.

Federal Audit Coordination

PERM cycle begins

In August 2016, Texas's fourth Payment Error Rate Measurement (PERM) review began with pre-cycle activities. CMS developed the PERM program to implement legislative requirements for federal agencies to estimate improper payment amounts made in the programs they oversee, report those estimates to Congress, and submit a report on corrective actions to reduce payment errors.

PERM reviews are normally conducted in three component areas (fee-for service, managed care, and eligibility) to validate the accuracy of claims payments in the Medicaid and CHIP programs. CMS uses the results of these reviews to produce both national and state-specific program improper payment rates. CMS contracts with two vendors, a statistical contractor and a review contractor, to conduct the data collection, processing, sampling, and review of the fee-for-service and managed care components of the PERM program, and to calculate state and national error rates. The eligibility component of PERM is on hold while

CMS revises its review methodology. As a result, Texas’s state-specific error rates for the current PERM cycle will include only fee-for-service and managed care components.

Federal Audit Coordination serves as the single point of contact and liaison with CMS and its contractors for PERM-related activities, and is responsible for PERM coordination within all HHS agencies. The current PERM cycle will review Medicaid and CHIP payments made in federal fiscal year 2017, which covers October 1, 2016, through September 30, 2017. Following the conclusion of the PERM cycle in November 2018, HHSC will develop corrective action plans to improve the systems and processes that contributed to any payment errors identified during the review.

RAC update

In May 2016, contract management of the Recovery Audit Contractor (RAC) contract was transferred from the HHSC Medicaid/CHIP Division to Federal Audit Coordination for a six-month pilot period. RAC audits identify and recover Medicaid overpayments made to providers.

Since management of the RAC contract

transferred to the IG, approximately \$5.4 million in potential Medicaid hospital overpayments have been identified for recovery by Health Management Systems, which has provided RAC services for the state since 2013. The dollars identified for recovery added a new component to the performance measures IG reports each quarter.

In addition, Federal Audit Coordination is coordinating with HHS program areas to develop potential review topics in an effort to reduce fraud, waste, and abuse in Medicaid programs.

Federal audit recoveries

Approximately \$4.5 million in Medicaid overpayments previously identified by the Medicaid Integrity Contractor and RAC contractor were recovered in the fourth quarter of fiscal year 2016. The overpayments were recovered by entities other than IG Litigation.

Federal audit recoveries

Contractor	Overpayment recovered
Medicaid Integrity Contractor	\$63,862
Recovery Audit Contractor	\$4,408,156
Total	\$4,472,018

Inspections

Section

5

Inspections

Overview

The Inspections Division conducts inspections and reviews of health and human services programs, systems, or functions focused on systemic issues and providing practical recommendations to improve effectiveness and efficiency to prevent fraud, waste, and abuse, and to ensure the greatest benefit to the citizens of Texas.

The Division comprises two Directorates:

- Inspections
- Women, Infants, and Children Vendor Monitoring Unit (WIC VMU)

Inspections Division progress

As one of the newest divisions of the IG, the Inspections Division's focus since February 2016 included these key priorities:

- Hiring Inspections team personnel.
- Creating and implementing an inspections process.
- Developing and conducting essential core skills training.
- Developing key policies and procedures for the conduct of inspections.
- Developing an initial inspection plan and conducting the first set of inspections.

The division made notable advances toward all of these priorities. Hiring was completed for the initial new positions and is currently under way for the additional positions.

The division developed a 16-step inspections process that outlines how an inspection will be conducted and its organization into three phases: preparation, execution, and reporting. The process describes key deliverables for each phase, key research to be accomplished based on the inspection topic, necessary coordination to be conducted, and incorporation of critical inspection quality standards. The division also developed training modules and trained the inspection teams on the process.

Training is a critical component for success of the Inspections Division. The division leadership

Top accomplishments this quarter

- Initial Inspections Plan developed.
- Policies and procedures created.
- Three inspections initiated: Medicaid pediatric dental sedation, speech therapy, and opioid prescription utilization.

identified core skills required for each team member and developed training plans. The division also conducted training on several of the core skills areas, the inspections process, critical thinking, and interviewing techniques.

The division leadership worked diligently to develop policies and procedures that will guide the conduct of inspections. The policies and procedures are based on the standards found in the Council of the Inspectors General for Integrity and Efficiency Quality Standards for Inspections and Evaluations.

A key accomplishment of this year is the development of an initial inspection plan. The leadership developed a list of potential topics through discussions with the IG and multiple health and human services program areas. The team researched the topic list in order to craft a risk-based approach to select initial inspection topics.

Most notably, three new inspections were initiated this quarter to examine Medicaid pediatric dental sedation, speech therapy, and opioid prescription utilization.

Medicaid pediatric dental sedation

Purpose: Are the pediatric dental procedures with sedation performed on Medicaid beneficiaries medically necessary and within the standard of care?

Objectives: This inspection will look at the medical necessity of sedation procedures of Medicaid beneficiaries, how medical necessity is met, the standard of care associated with the sedation procedures, how dental offices are equipped, and how staff are credentialed and trained to perform sedation procedures in accordance with Texas Administrative Code,

Medicaid, and the appropriate governing boards. The appropriate governing boards will be consulted on the standard of care of the sedation procedures.

Speech therapy

Purpose: Are the procedures used by Managed Care Organizations to determine eligibility for speech therapy services effective in preventing fraud, waste, and abuse?

Objectives: This inspection will look at what controls the MCOs are using to ensure proper authorization of speech therapy services and their effectiveness in preventing fraud, waste, and abuse. It will also determine if the MCOs are using a uniform criteria for medical necessity to authorize speech therapy and determine best practices.

Opioid prescription utilization

Purpose: Does Texas Medicaid have programs effective at reducing prescription opioid abuse, and are there alternative programs that may further reduce opioid abuse?

Objectives: This inspection will assess whether the Texas Medicaid program has implemented effective programs/processes to identify and reduce prescription opioid abuse, and identify alternative and/or additional programs that have proven effective at reducing opioid abuse and can be adopted by Texas Medicaid.

WIC Vendor Monitoring Unit

This unit conducts in-store evaluations, covert compliance buys, and invoice audits to monitor vendors participating in the WIC program.

During this reporting period, the unit conducted 55 compliance buys and completed 31 in-store evaluations. The unit closed 57 cases during the quarter resulting in a cost avoidance of \$280,776.

Q&A with Quinton Arnold, Deputy IG, Inspections

Why did you choose to join the agency?

I was asked to act as the Interim IG until Mr. Bowen was appointed, because of my background as an Army IG. I learned a great deal about the organization and its mission in that time, and knew I could be an asset to the entire HHS System

helping to make this organization the best that it can be. Once Mr. Bowen was appointed, I discussed staying on as his Chief of Staff to help him implement necessary changes. I love his vision for the organization, and his values. As we made progress, Mr. Bowen wanted to create an Inspections Division, and asked me to lead it because of my inspections background as an Army IG.

What positives do you see in this division?

This is a new division, and everyone is excited about this new thing called inspections. It's never been done here before, so we are breaking new ground. That and the impact this division can have across the HHS System excites people. We have put together a great team to start this division.

What goals do you have for your division?

First and foremost, we want to help make the Medicaid system the best that it can be for the citizens of Texas. We do that by conducting quality inspections that adhere to five key principles: they are well coordinated, purposeful, focused on feedback, instructive, and followed up. We also want to produce recommendations that are practical, executable, and that make the inspected entity better. Then we want to follow that up with quality, well-written reports that have a positive impact across the HHS System. Lastly, I want to train our Inspectors to be the best, build a team that can accomplish any task it is given, and live out the values that Mr. Bowen has set for us.



Quinton Arnold

What is your guiding philosophy?

I have had to lead many different ways in the Army. My preferred method is to power down. I empower my Directors, Managers, and Inspection Team Leaders to make decisions and get things done to successfully complete inspections. That means I have a responsibility to remove obstacles from their path, train and equip the team to accomplish the mission, and give direction and

Inspections

guidance to keep us moving in the right direction. I also have the responsibility to listen to my team members and take action when they need help. We are also part of the bigger IG and HHSC teams. Everything we do should help both of those teams be the best.

What are your top priorities?

We have several priorities, but the top priority is conducting quality inspections that result in practical recommendations and are followed up with well-written reports that help make the HHS System better. That means we have to get out and

engage and coordinate with the other agencies and programs in the HHS System to help them understand what inspections are and how they can help the system. The next priority is creating and sustaining a team that can successfully conduct the Inspections mission. The last one I will mention is to create a positive work environment for the team and for those we work with in the conduct of inspections. I want people to be excited and proud to work here and to be able to have a positive impact on our HHS System.

Support Services

Section

6

Data and Technology

Overview

Since coming aboard in April 2016, Deputy Inspector General for Data and Technology Alan Scantlen consolidated all information management and technology support functions into one cohesive area. The new organizational structure aligns with the IG's vision to be the leading state-level IG office in the nation. The Data and Technology Division supports the IG Audit, Investigations, Inspections, and Operations divisions by implementing tools, solutions, and innovative data analytic techniques to streamline operations and increase the identification of fraud, waste, and abuse in the Texas health and human services programs.

The Data and Technology Division comprises the Data and Vendor Operations Unit, Data Research and Intelligence Unit, Data Analytics Unit, and Statistics and Actuarial Services Unit. Working together, these units have made significant strides in improving support through targeted selection of areas most at risk of fraud, waste, and abuse.

The Data and Technology Division has already implemented some quick wins to reform and restructure, effecting more efficient use of data across all its lines of business, and is quickly moving toward innovation.

Data and Vendor Operations

The Data and Vendor Operations unit is responsible for implementing technology solutions and providing support to the IG organization. During the fourth quarter of FY 2016, the unit implemented a technology solution that streamlined operations through enhancements to the electronic Personnel Action Form, which allows IG management to submit and obtain approval on all employee selections, separations, vacancy postings, and position budget and salary changes. This replaces a paper-based process that was cumbersome and time consuming.

The Data and Vendor Operations unit also expanded the current datasets that feed into the

Medicaid Fraud and Abuse Detection System, which has allowed data analysts greater access to create queries and identify patterns of fraud, waste, and abuse.

Data Research and Intelligence

The Data Research and Intelligence unit is responsible for conducting policy research and analysis and analyzing data results. This unit successfully completed investigative data research and intelligence projects, resulting in the completion of 13 Investigative Analysis Reports. These reports were referred to the IG Investigations Division for further research and investigation.

Data Analytics

The Data Analytics unit is responsible for creating complex algorithms to identify trends and patterns of behavior and billing. The Data Analytics unit created algorithms for several initiatives to support the Investigations, Audit and Inspections divisions. These included initiatives related to speech, physical, and occupational therapy; pharmacy; mental health providers; high-billing/high-volume providers; and electronic benefits transactions. The unit uses its sophisticated programming and coding expertise to ask complex questions, develop multiple algorithms with the help of clinical experts for the divisions, to identify outliers across Medicaid services and program areas, and automate reports to facilitate business functions at the IG.

Statistics and Actuarial Services

The Statistics and Actuarial Services unit is responsible for providing sampling and extrapolation support to the Investigations, Audit, and Inspections divisions. This unit is also responsible for data visualization and supporting the compilation of performance metrics for the IG organization.

Overview

The Medical Services Division was formed in May 2016. It combined the Research Analysis and Detection unit staff, registered nurses from across IG, the Chief Medical Director, the Chief Dental Officer and dental team, the utilization review team, and the medical staff from the Medicaid Lock-In program with the goal of creating a pool of clinical subject matter experts who can consult on audits, inspections, and investigations. The IG plans to expand the subject matter expertise by adding a pharmacist and additional subject matter experts representing the vulnerable areas for fraud, waste, and abuse.

A comprehensive cross-training program was initiated to ensure all the nurses had back-up for their respective areas of expertise. This intense training means that staff must stay abreast of medical/dental policies, Medicaid program requirements, changes to the Medicaid Management Information Systems claims payment system, and quality standards of care.

Quality Review

The Quality Review Team consists of Utilization Review and the Lock-In program.

Utilization Review

Utilization review is conducted for nursing facilities and hospital providers. During this quarter the program piloted nursing facility reviews for ten nursing facilities focusing on the impact of managed care since residents were enrolled in STAR + PLUS. In addition to the resource utilization group review, processes considered during the review were the nursing facilities' experience with service coordination, prior authorization, claims management, and quality of care.

The program met with hospital stakeholders

in July to seek input and update providers and representatives on activity related to the revised Diagnosis Related Group validation process. A revised Notice of DRG Change that provides feedback with documentation based on medical record review and coding support received stakeholder comment and input. The hospital community provided input with coding scenarios. This quarter nurse reviewers received a full week of training based on the American Health Information Management Association ICD-10-CM Academy for ICD-10 coding.

During this quarter, the Utilization Review Quality Assurance team performed both onsite and desk reviews of nurse reviewers performing hospital and nursing facility reviews. Quality controls have been performed by a team of three experienced utilization review registered nurses since February 2016. The goal is to improve compliance and inter-rater reliability in utilization review. The team met with the senior management team to review the policy for the Quality Control Monitoring Process. In addition, the team provided feedback on hospital and nursing facility policy and procedures making recommendations to clarify the review processes. Trends identified while performing quality controls provide focus for annual and ongoing training for new and senior nurse reviewers.

Lock-In

The Lock-In program focuses on recipients and abuse of Medicaid services including prescriptions and acute care services. The Lock-In program intervenes by locking a recipient into one pharmacy location, and for fee-for-service recipients a primary care provider. The majority of recipients are managed care members. The program initiated research on other states' activity and drafted a survey to seek managed care organizations' input.

Chief Counsel

Overview

The IG Chief Counsel Division consists of the General Law and Litigation units. Additionally, Chief Counsel provides dedicated attorneys to Investigations, Audit, Inspections and the Medical Services divisions. The General Law unit is responsible for advising and providing legal support to the IG divisions on a wide array of complex topics. Additionally, the General Law unit has primary responsibility for responding to open records requests directed to the IG; review and drafting of procurement documents, memorandums of understanding and other contracts; and supporting other IG units on human resources issues. The Litigation unit is responsible for determining and imposing administrative actions and sanctions based on the enforcement activities of the Investigation and Audit divisions. Following the imposition of some sanctions, the provider has a right to an informal resolution meeting or an appeal. In those cases, the Litigation unit will conduct the informal meeting and will prosecute any appeal before the HHSC Appeals Division or the State Office of Administrative Hearings.

Bankruptcy training

In August, representatives from the Office of Attorney General Bankruptcy and Collections division presented a bankruptcy seminar to the Inspector General attorneys and legal staff who comprise the Chief Counsel division. The training focused on issues which arise when an individual or entity provider commences bankruptcy proceedings during the pendency of an IG audit

or investigation. The division learned generally about the impact of the bankruptcy automatic stay on their active cases as well as the existence of an exception to the stay for “law enforcement and regulatory” activity. The team also was educated about the priority assigned to monies owed by a provider for both overpayment and penalty determinations. Finally, the OAG attorneys detailed the variety of circumstances where federal bankruptcy law would allow a provider to discharge a debt to the state based on overpayments and penalties stemming from their Medicaid participation.

Successful settlements

Attorneys with the Litigation unit have engaged in settlement meetings geared towards enhancing provider understanding of the Medicaid rules and the investigative and audit process. Through these meetings the IG has actively sought input from providers to make the relationship more transparent. The providers attending the meetings have all remarked that they have found the experience to be productive and respectful. Many have remarked that they now see the IG as a partner in the process of applying Medicaid rules to their practice in spite of the fact that the IG must ensure that providers return any overpayments, even if such overpayments were claimed as innocent mistakes. The IG is working through the Litigation unit, in tandem with Audit and Investigations, to educate the provider community to insure that the taxpayers get the best value for their dollars and Medicaid recipients receive high-caliber care.

Program Integrity Research

In the fourth quarter of FY 2016, the Program Integrity Research (PIR) team worked closely with HHSC's Medicaid/CHIP Division to prepare for a significant increase in volume of provider enrollment screenings in anticipation of the September 24 revalidation deadline established by the federal Centers for Medicare and Medicaid Services. PIR staff conducted the same number of provider screenings in the fourth quarter as in each of the previous quarters of FY 16 — about 30,000. While the expected increase in volume did not occur, PIR worked diligently with both internal and external stakeholders to develop processes for conducting FBI fingerprint check requirements. Under federal requirements, such fingerprint checks must be implemented for all high-risk providers by April 2017.

IG Integrity Line

The Integrity Line answered approximately 9,500 calls, about 300-400 more calls than the first and second quarters. Additionally, Integrity Line staff worked with HHSC and our telephony partners to define requirements for improved reporting in FY 17 and collaborated with the IG Data and Technology Division to produce Phase I of the Integrity Line Executive Dashboard, which includes information about referrals that are generated based on phone calls and reports received by the Integrity Line.

Support and Solutions

Operations Support and Solutions continued work to improve the health and culture of the IG organization throughout the fourth quarter of FY 2016. The team deployed a second morale and retention survey designed to measure the perceived

outcome of initiatives established after the initial survey in spring 2016 and to collect information on what could still be improved. Also, the team implemented a process to conduct standardized exit interviews with departing staff, in an attempt to gather objective and candid feedback on what the organization has done well and to identify growth opportunities.

Policy and Professional Development

During the final quarter of fiscal year 2016, the Policy and Professional Development (PPD) team provided multiple professional development and training opportunities to IG employees and leadership. PPD staff directed leadership development events including The 7 Habits of Highly Effective People by Stephen Covey and Strategic Planning and Leadership Development by the Governor's Center for Management Development. PPD also provided multiple opportunities for collaboration and understanding through training events which involved staff from the Medicaid/CHIP Division, Managed Care Organizations, and IG.

The PPD team also began reviewing and consolidating existing IG policies and procedures to create a centralized internal repository. IG policies and procedures relevant to external stakeholders will be placed on the external IG website to further promote transparency with health and human service program stakeholders, and the provider and contractor community.

The IG policies and procedures provide clarity, guide IG employees in how to conduct their responsibilities, and promote transparency and consistency in process and practice across the IG organization.

Appendix: 4th quarter results

Dollars recovered

Litigation

Provider overpayments and penalties	\$2,750,295
Voluntary repayments	\$75,478
	<u>\$2,825,773</u>

Investigations

Beneficiary collections (SNAP, TANF, Medicaid, CHIP, and WIC)	\$4,273,222
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Medical Services

Acute care provider collections	\$3,436,669
Hospital collections	\$8,172,940
Nursing facility collections	\$1,108,933
	<u>\$12,718,542</u>

Audit and Inspections

Audit and WIC collections	\$4,472,139
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Total dollars recovered \$24,289,676

Dollars identified for recovery

Investigations

MCO overpayments identified by SIUs	\$291,629
Beneficiary overpayments identified by IG Law Enforcement (SNAP)	\$1,942,358
Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, WIC)	\$10,601,279
	<u>\$12,835,266</u>

Medical Services

MCO overpayments identified by IG	\$93,342
Nursing facility overpayments	\$436,753
	<u>\$530,095</u>

Audit and Inspections

Audit provider overpayments	\$8,098,457
WIC vendor repayments and penalties	\$67
	<u>\$8,098,524</u>

Total identified for recovery \$21,463,885

Dollars identified as cost avoidance

Litigation

Providers ordered to pay restitution	\$5,796,820
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Investigations

Beneficiary disqualifications	\$1,130,373
Beneficiary income eligibility matches and other beneficiary data matches	\$761,961
	<u>\$1,892,334</u>

Medical Services

Pharmacy Lock-In	\$62,177
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Inspections

WIC vendor disqualifications	\$280,776
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Total identified as cost avoidance \$8,032,107



PROFESSIONALISM
PRODUCTIVITY
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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 Integrity Line

800-436-6184

