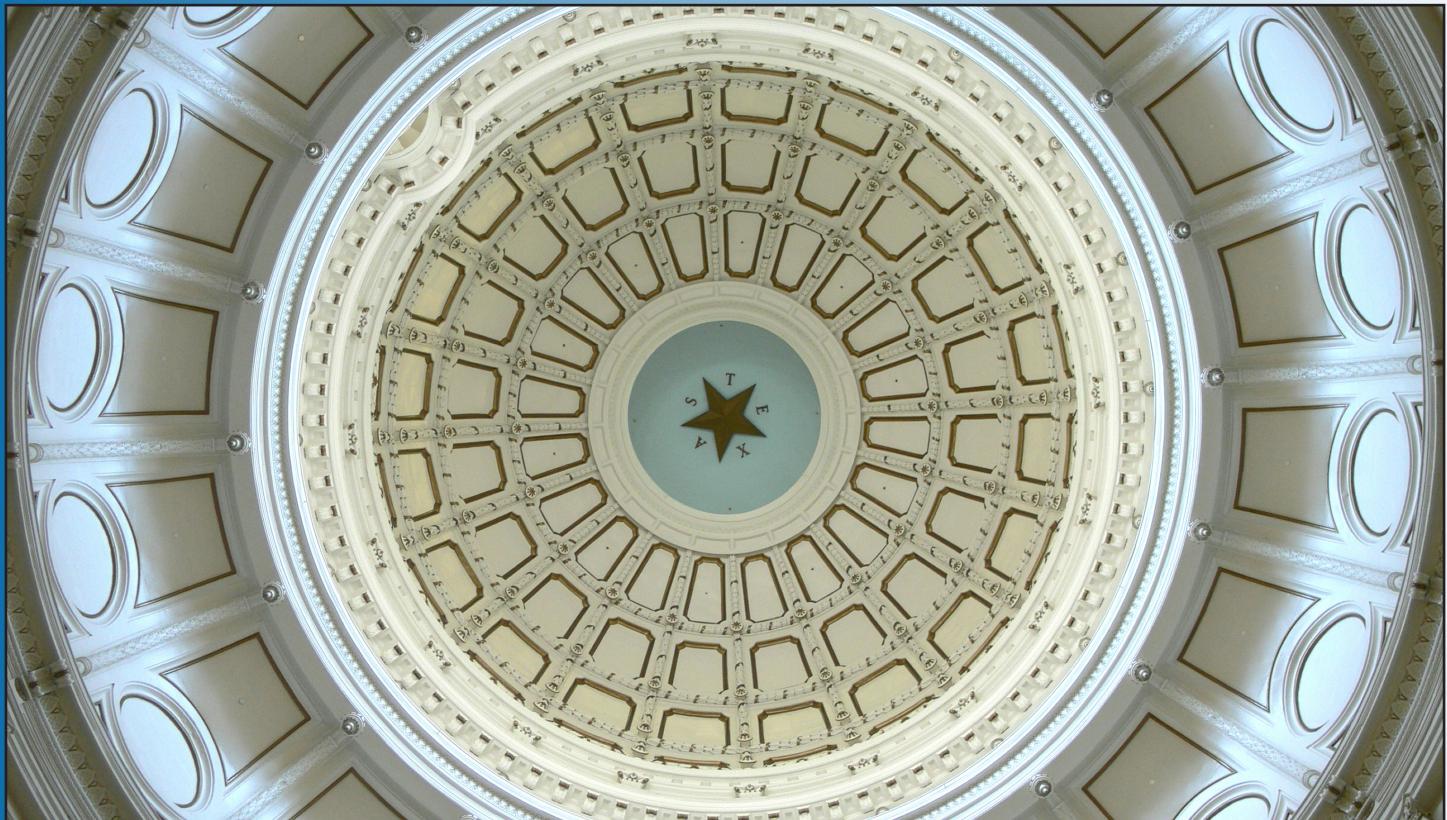


TEXAS HEALTH AND HUMAN SERVICES COMMISSION
INSPECTOR GENERAL



**QUARTERLY REPORT
MARCH 2016**





**PROFESSIONALISM
PRODUCTIVITY
PERSEVERANCE**

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Message from the Inspector General

I am pleased to submit this quarterly report to the Governor, the Executive Commissioner, the Members of the Legislature, and the Citizens of Texas.

Just over a year ago, I began my tenure as the Inspector General at the Texas Health and Human Services Commission. I thank Governor Abbott for appointing me to what has proved to be an enormously challenging, thoroughly engaging, and immensely fulfilling leadership position.

I and my outstanding IG team oversee about \$40 billion in public funds expended annually for the delivery of health and human services in Texas. We fight fraud, waste, and abuse across the state by vigorously exercising our audit, investigation, and inspection powers.

This report provides a wide range of data-points underscoring the continuing progress my team and I have made in building a new culture of integrity, transparency, and success at the IG. This new culture arises from our core values: professionalism, productivity and perseverance.

As I told my staff at the last IG all staff, 2015 was the Year of Reform and Restructuring; 2016 is the Year of Results. The progress outlined in this report reveals substantial evidence that the reforms and restructuring we inculcated over the past year generated genuine positive results: for example, our financial recoveries are up 76 percent from the previous quarter.

Restructuring and reform continued this quarter, of course, as we pursue organizational and leadership excellence, the achievement of which will guide us to our vision of being the leading IG in the nation. Organizational reforms included the full operationalizing of our new Data and Technology Division, the money-saving merger of the Policy and External Relations Division into the Operations Division, and the productivity-inducing strengthening of the Inspections Division. Leadership restructuring included the appointment of Sylvia Kauffman as Principal Deputy Inspector General, Christine Maldonado as Chief of Staff (dual-hatted as Deputy IG for Operations), Frank Bryan as Counselor to the IG, and Quinton Arnold

Dollars recovered

Litigation

Provider overpayments and penalties	\$3,984,446
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Investigations

Acute care provider collections (SNAP, TANF, Medicaid, and WIC)	\$571,597
Voluntary Repayments	\$84,461
Beneficiary collections	\$10,122,681

Audit

Hospital collections	\$6,040,736
Nursing facility collections	\$1,546,066

Total

\$22,349,987

Dollars identified for recovery

Investigations

MCO overpayments identified by SIUs	\$598,679
Beneficiary overpayments identified by IG Law Enforcement (SNAP)	\$35,810
Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, WIC)	\$9,354,591

Audit

Provider overpayments	\$1,654,617
Nursing facility overpayments	\$766,532

Inspections and Evaluations

WIC vendor repayments and penalties	\$7,555
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Total

\$12,417,784

Dollars identified as cost avoidance

Litigation

Providers ordered to pay restitution	\$1,079,112
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General Investigations

Beneficiary disqualifications	\$779,228
Beneficiary income eligibility matches	\$7,484
Other beneficiary data matches	\$778,160

Audit

Pharmacy Lock-In	\$29,017
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Inspections and Evaluations

WIC vendor disqualifications	\$6,115,009
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Total

\$8,788,010

Message from the Inspector General

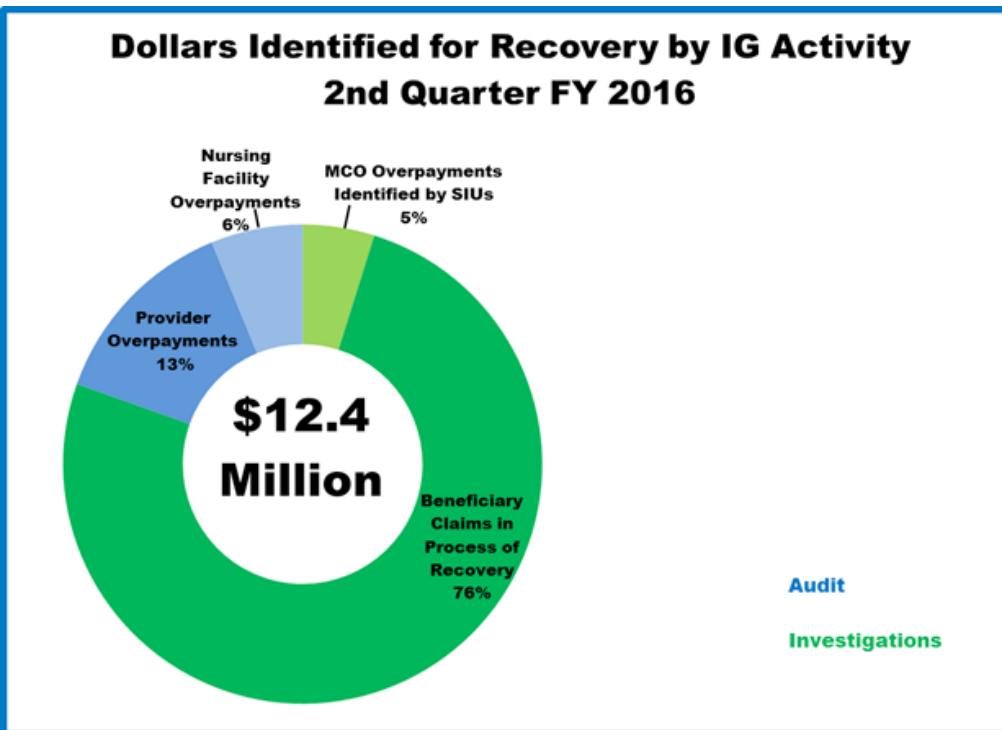
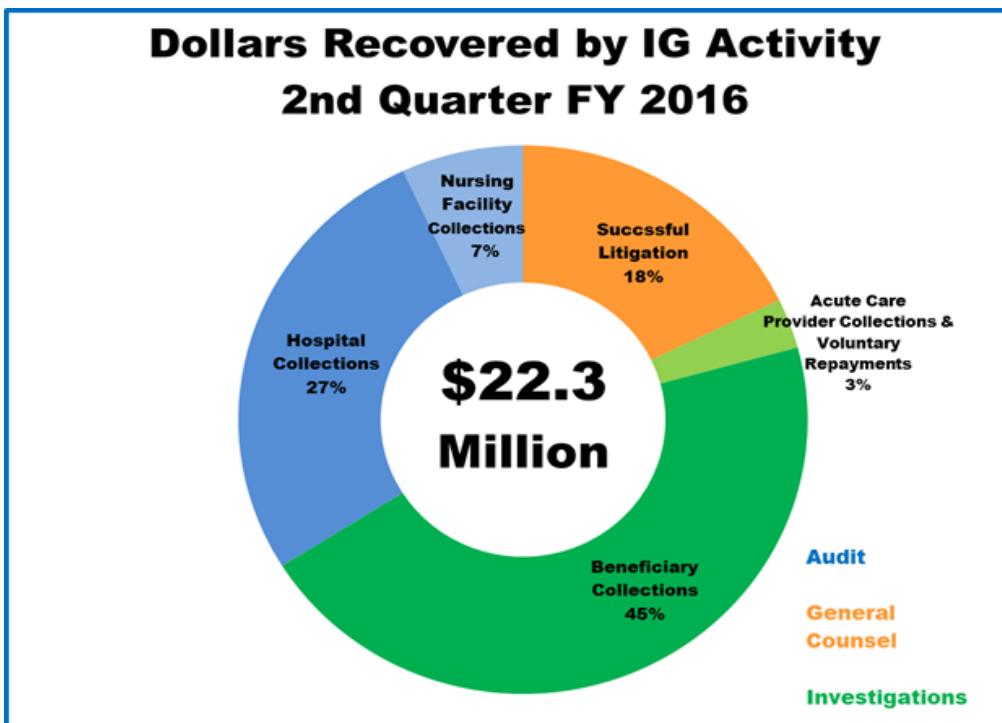
as Deputy Inspector General for Inspections.

I remain grateful to the nearly 700 IG public servants who strive every day to improve our mission performance. And I am resolutely confident that our team of auditors, investigators, and inspectors will continue to succeed as we execute our role in ensuring that millions of Texans in need

across our state receive the health and human services they should.



Stuart W. Bowen, Jr.



Overview

Section

1

Overview

Stakeholder outreach program introduces new IG Integrity Initiative

This quarter, the IG advanced its unwavering commitment to effective stakeholder outreach through a series of deep and productive engagements with key stakeholders, including the leadership teams of large MCOs, various significant Medicaid providers, key members of the Legislature, selected representative associations, and essential federal partners.

The stakeholder outreach program, which kicked off last summer, fills a pre-March 2015 void wherein such engagement was deficient, as noted by the Sunset Commission, with the consequent effect of a loss of trust and credibility. The program's growth has built new levels of relational trust between the IG and all engaged stakeholders.

The stakeholder outreach program's overarching theme is "effective partnerships produce excellent results benefitting all." In every program engagement, the IG emphasized the importance of the agency's new culture-changing innovation: the IG Integrity Initiative. The Inspector General will formally roll out the initiative on April 21 before the Senate Committee on Health and Human Services. A top Medicaid provider will testify about the initiative's promise, along with Mr. Bowen.

Based on the community policing model, the new Initiative provides a framework for a paradigm shift in Medicaid oversight. It rests upon the core premise that the vast majority of Medicaid providers either comply with program rules or try to comply. These providers, along with the MCOs, want the same thing that the IG wants: the best Medicaid system Texas can have, with as little fraud, waste, and abuse as possible. Though most providers are law-abiding, a small cohort seeks to take advantage of the system for improper personal gain.

The IG Integrity Initiative aims to partner with complying providers to identify and root out bad actors from the system. It fundamentally depends on partnerships that will generate an integrity network across Texas creating powerful links between the IG and all Initiative members.

To become a member of the Initiative, a provider or MCO must:

- Publicly affirm integrity in its mission statement.
- Commit to reporting any and all fraud, waste, or abuse to the IG whenever and wherever they might find it.
- Provide Medicaid integrity training to their employees.
- Prominently post the IG's Integrity Line poster in high-traffic areas.
- Provide a link to the IG's website on their websites.

The IG conducted key meetings with the CEOs

Key quarterly results

- Recovered \$22 million, a 76 percent increase from the previous quarter.
- Identified \$8.8 million in cost avoidance, a 132 percent increase from the previous quarter.
- Conducted 28,255 background checks for providers enrolling or re-enrolling in Medicaid, a 71 percent increase from the previous quarter.
- Completed 23,954 beneficiary investigations, a 14 percent increase from the previous quarter.
- Reviewed more than 13,500 hospital claims, an 8 percent increase from the previous quarter.
- Collected more than \$7.5 million from hospital and nursing facility utilization reviews, a 14 percent increase from the previous quarter.
- Fully complied with new statutory 45-day and 180-day requirements for reviewing preliminary and completing full-scale investigations. Preliminary investigations averaged 24 days.
- Settled 7 cases for \$327,741.

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and staffs of two of the largest MCO in Texas. Tom Wise and Don Langer, the CEOs of Superior and United Healthcare, respectively, each participated in initial visits with Mr. Bowen; the follow-up half-day convocations between IG staff and each MCO's leadership team generated understanding and insights that promise much joint productivity and progress on the fraud, waste, and abuse front in the near future.

Houston was the site of two other excellent MCO visits this quarter, where the IG met with Chris Born, the CEO of Texas Children's Health Plan, and his senior staff, and with Ken Janda, the CEO of Community Health Choice, and his leadership team. Both full-day engagements produced outstanding results, including identifying key areas of coordination on investigations of suspect providers.

The Inspector General travelled to Dallas in January to meet with the leadership team at Amerigroup, another top MCO in Texas. The visit proved productive, setting the stage for deeper engagements with our respective full staffs later this spring in Austin.

Mr. Bowen visited the Rio Grande Valley again this quarter, continuing his commitment to this region where the state spends a substantial portion of its Medicaid dollars. In the Valley, the IG and his leadership team sat down with numerous providers in Brownsville, Harlingen, and McAllen, as well as the President of UT- Rio Grande Valley and his staff from the new School of Medicine. Mr. Bowen committed to return this summer to speak to the inaugural class at the Medical School.

The trip to the Valley included productive engagements with numerous IG personnel in Pharr, where Deputy IG for Investigations Jay Crowley joined Mr. Bowen for a staff-wide open forum. Subsequent to this visit, investigative leaders in the Pharr office presented a training session to more than 100 providers in the Valley entitled "Dental 101," hosted by the South Texas Dental Society. This event stemmed from a oversight strategy meeting the Inspector General had in the Valley with local dental leadership.

State leadership, including legislators, are the paramount stakeholders for the IG. They provide us our mission, appropriate the resources necessary to accomplish it, and review our performance. Mr. Bowen committed the IG to total transparency and accountability a year ago; keeping leadership and legislators informed about the office's work is essential to fulfilling that commitment. To that end, the IG met this quarter with the following legislators:

- Senator Jane Nelson
- Senator Juan Hinojosa
- Senator Eddie Lucio, Jr.
- Senator Charles Perry
- Senator Brandon Creighton
- Representative Richard Raymond
- Representative Four Price
- Representative Eddie Lucio, III
- Representative Bobby Guerra
- Representative Toni Rose
- Representative Sergio Munoz, Jr.
- Representative John Otto
- Representative Armando Martinez
- Representative Ryan Guillen
- Representative Oscar Longoria
- Representative Terry Canales

The Inspector General also engaged regularly with the staffs of the Governor's Office and the legislative leadership.

In February, Mr. Bowen and his senior leaders travelled to Washington, D.C., for a week to build and strengthen partnerships with the IG's key federal counterparts. All of the federal programs that the IG oversees receive substantial federal funding, and the U.S. Government financially supports significant parts of IG operations. Thus, maintaining strong connections with our federal counterparts is key to ensuring that we steward well our oversight resources and responsibilities.

The IG leadership team had a very productive meeting with the healthcare fraud attorneys at the U.S. Department of Justice, which led to prospects for the IG gaining traction toward participating in federal strike force activities in Texas. Thanks to a strong relationship with the Comptroller General for the United States, the IG team had a very

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productive half day of meetings at the Government Accountability Office, gaining valuable guidance from the GAO's senior health care auditors who cover Texas.

Perhaps the most productive meetings of the week occurred with the leadership teams at the Office of Inspector General for the U.S. Department of Health and Human Services and the Center for Program Integrity at the Center for Medicare and Medicaid Services. These visits generated great joint operational possibilities for Medicaid investigations in Texas. On the beneficiary oversight front, the IG enjoyed an excellent discussion with the leadership at the Inspector General for the U.S. Department of Agriculture, establishing firm connections for future collaborative work on SNAP audits and investigations.

On the final day in D.C., Mr. Bowen and his team met with Senator John Cornyn and Representative Dr. Michael Burgess. Both members expressed strong support for our mission and opened the door for any future assistance they might be able to provide to strengthen our oversight efforts.

Strategic planning deepens operations

From the outset of his service, Mr. Bowen emphasized effective strategic planning as essential to organizational success.

Last June, the IG leadership team spent three days developing an initial strategic plan, with the support of Dr. Barry Bales, Assistant Dean at the LBJ School. Since then, with Dr. Bales' continuing advice, the team has met quarterly to review, revise, and refine the plan, updating it to address experiential lessons learned and ensuring that it serves a useful purpose as the roadmap for our key operational activities.

In concert with the strategic plan, the Inspector General launched quarterly business planning events for the Audit and Investigations divisions to ensure that their work aligns with the strategic plan's priorities. The Investigations two-day meeting in December generated enormous progress, as did the February Audit event.

These quarterly planning convocations complement the larger strategic planning process, securing an integrated connection between the organization's strategic commitments and its operational workflow. The respective processes have had the salutary effect of deepening the engagement and commitment of mid-level management in the Audit and Investigations divisions, with staff playing key roles in shaping each divisions' operational business plans.

IG supports transformation of Health and Human Services System

Governor Abbott's signature on Senate Bill 200 inaugurated a new era of transformation, fiscal efficiency, and collaboration across the Health and Human Services System.

Executive Commissioner Chris Traylor led the way by creating the Transformation, Policy, and Performance Division. Under Deputy Executive Commissioner Chris Adams' leadership, this crucial entity rapidly executed a series of critical tasks:

1. Established an Interagency Transition Steering Committee to manage and monitor the transformation.
2. Conducted a functional analysis of all systemic operational areas to support developing a comprehensive plan for the rational consolidation of numerous critical functions.
3. Developed milestones to drive progress and designated 13 workgroups to manage functional area transformation projects. Seven focused on systemic structural reform, while six sought solutions for improving the operational delivery of administrative support services.
4. Established a Stakeholder Input Plan that provided eight regional hearings across Texas where numerous stakeholders and citizens testified regarding the transformation.

IG personnel participated actively in transformation activities this quarter, with the Chief of Staff serving on the Transition

Overview

Steering Committee and other senior IG personnel participating in various functional workgroups. In mid-January, the Inspector General and key members of his leadership team travelled to Harlingen to participate with the Executive Commissioner, Chief Deputy Executive Commissioner Charles Smith, and Deputy Executive Commissioner Adams at a transformation stakeholder hearing.

The IG organizationally committed to transformation by conducting a deep review of its technology operations, which generated an efficiency inducing transfer of part of the IG's technology team to HHSC's Information Technology Department. The move strengthened IT system architecture and expanded the technology resources available to IG operations.

Interview with Charles Smith, HHSC Chief Deputy Executive Commissioner

As the Chief Deputy Executive Commissioner, what are your top three priorities for the Health and Human Services System?

First, I would like to say how honored I am to be working at the Commission. Since coming here last July, I have enjoyed my experience and found many knowledgeable, hard-working, and dedicated professionals across the HHS system.

My priorities are really straightforward and simple. I believe they are the essential elements of any successful organization or business:

1. Establish an organizational culture that emphasizes, thrives on, and rewards continuous improvement in every facet of the organization;
2. Develop SMART (Specific Measurable Achievable Relevant and Timely) performance goals and targets for the various programs and create measurement tools that allow management to make decisions based upon monitoring and reviewing analytical and empirical data; and
3. Create an environment where staff become

experts in their respective areas so they can hold contractors and vendors accountable for delivering the goods and services for which they've contracted.

What leadership principles have you found most relevant to your role here in HHSC?

I have really tried to stay true to two leadership principles. One is the Stephen Covey principle of "seek first to understand, then to be understood." This means that I ask lots of when, where, how, and why questions. I expect our leaders to "know" their business.

The other leadership principle that I follow is to set out clear expectations. My philosophy is that 90 to 95 percent of people "want" to meet their immediate supervisor's expectations. When they fall short, it is usually a result of unclear expectations rather than a lack of concern or ability. Because none of us are mind readers or have infinite amounts of time to do or redo our jobs, I try to communicate effectively up front to avoid rework, unnecessary frustration, and lost productivity. Overall, I believe people have adjusted very easily to my management style.

Transformation is a top priority for the HHS System for the next several years. What are three of your most relevant insights related to managing and leading change that you can share with us?

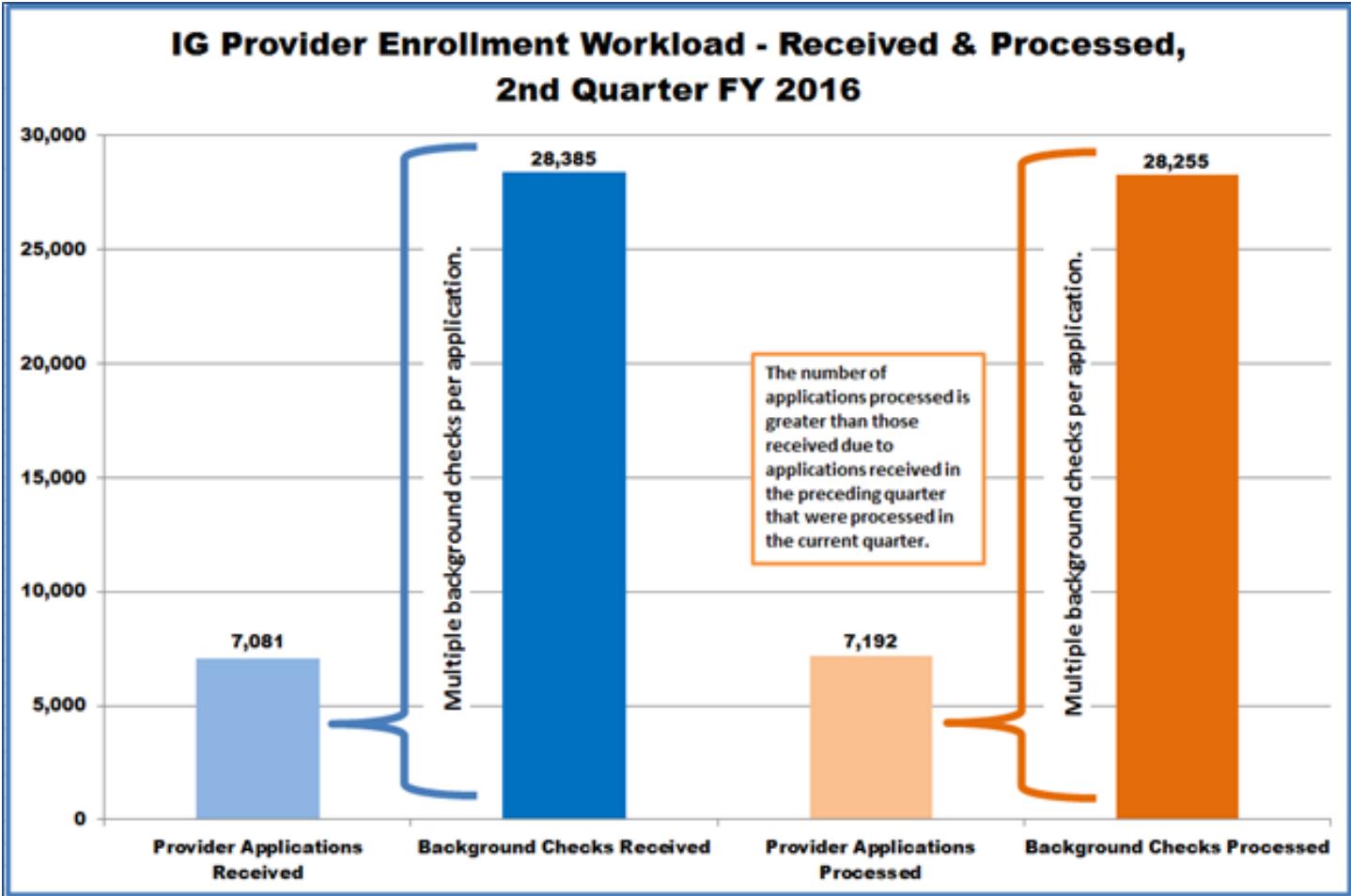
I believe effective leaders build a need for change. They articulate a clear vision of what the future state will be and why it is necessary to the organization and employees to move. They ensure that others have input into as many aspects of the transformation as is possible without forsaking the ultimate goal or vision. They also ensure that lines of communication are open and used frequently to keep staff aware of the changes and solicit feedback.

As the Chief Deputy Executive Commissioner, you work closely with



Charles Smith

Overview



the Inspector General. How would you characterize your engagements with the IG and the organization so far?

I have had the pleasure of meeting and working with all of the executive and senior-level IG staff. I have found all of them to be well credentialed and very dedicated to their mission. I am looking forward to great things from the IG in 2016.

The Inspector General is responsible for oversight of the HHS System and is an integral part of HHSC. How do you see the IG assisting the HHSC leadership through the transformation period by providing oversight that is focused on integrity and transparency?

Inspector General Bowen has done an excellent job of ensuring that both the IG and HHS staff understand that, while responsibilities are different, they do not have to be antagonistic. In this regard, he and his team have done exceptional

work establishing a collaborative relationship for the betterment of the system. In addition to focusing on integrity and transparency, I can see the IG taking an active role in helping to ensure that no important linkages are broken as program areas are transformed.

Integrated audit effort progresses

The quarter saw continued collaborative coordination between the IG and HHSC program staff, which fundamentally improved the IG's approach to auditing providers, contractors, and programs. The IG's new integrative approach will guide all future reviews, including current engagements that range from determining MCO success in preventing fraud, waste, and abuse to ensuring the proper utilization of health care services provided under managed care plans.

The IG's audit of potential state overpayments identified by federal audits exemplifies a new era of collaboration. Several HHSC program

Overview

areas coalesced to provide information about the complex interplay of state and federal activities, which will provide audit recommendations that generate substantial recoveries.

Provider background checks rapidly completed

The IG's Provider Integrity Research (PIR) unit conducts background checks and screening activities for applicants seeking enrollment or re-enrollment as a state Medicaid provider, which include hospitals, doctors, pharmacists, medical transportation providers, and durable medical equipment companies.

When a provider submits an enrollment (or re-enrollment) application to the HHSC Medicaid-CHIP division through the Texas Medicaid and Healthcare Partnership, TMHP directs applications to PIR for review, research, and recommendation. Pursuant to a new statutory requirement, PIR must make a recommendation within ten days to accept, conditionally accept, or deny the provider's application, based on the background check results. This process often requires consultation with attorneys in IG Chief Counsel.

The table on the preceding page reflects the screenings received and completed this quarter.

The Hotline is now the “Integrity Line”

Formerly known as the Hotline, the IG Integrity Line staff receives complaints and referrals alleging fraud, waste, and abuse by providers, recipients of Medicaid funding, or recipients of SNAP, TANF,

or WIC benefits. Integrity Line staff follow up on complaints, gather information, then refer the report to the appropriate IG group. Virtually all referrals go to the Investigations Division, where next steps depend on the specific nature of an individual report. The Integrity Line, which is receiving more than 3,000 calls per month, is an integral component of the IG's investigative work.

Senate Bill 207 update

In 2014, the Sunset Commission reviewed the Inspector General's office, 12 years after it was created by House Bill 2292. Senate Bill 207 codified the Commission's recommendations and reforms. Over the last nine months, the IG has taken action to implement those reforms. Some of the key results are:

1. Improved operational coordination with HHSC:

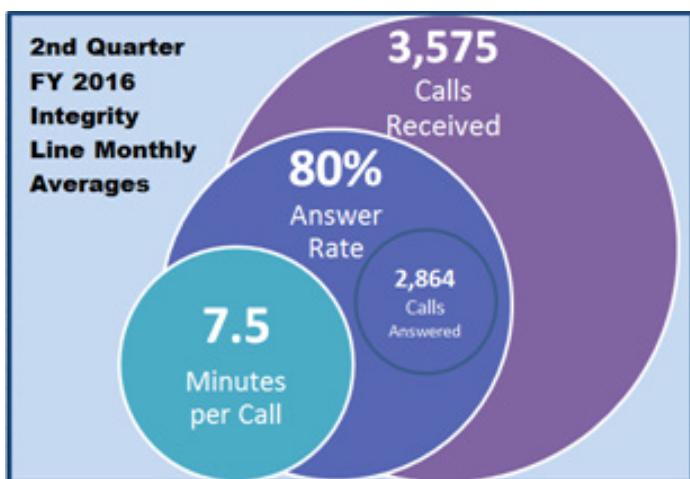
SB 207 required the IG to collaborate with HHSC. Key examples of implementing this include:

- The IG Audit Division works closely with MCD to coordinate audits of MCOs.
- The IG Chief Medical Officer and IG policy analysts participate in HHSC Clinical Policy Development meetings to offer guidance from an enforcement perspective. IG and HHSC conduct regular meetings to improve policy coordination.
- The IG General Investigations team and the HHSC Office of Social Services entered into a pilot program to strengthen beneficiary fraud referrals.

2. More efficient operations:

SB 207 required that the IG focus on improving its audit and investigations operations and reducing backlogs. In response:

- The IG implemented all required timelines into the investigations process. The IG now completes preliminary investigations within 45 days and full investigations within 180 days.
- The Chief Counsel Division settled many old cases, and continues to pursue settlement on other cases that merit such resolution.
- The Provider Integrity Research team



Overview

streamlined enrollment operations to assist providers in meeting the requirements for becoming a Medicaid provider within 10 days.

3. Successful peer review of RAT-STATS: The IG obtained a peer review of the IG's sampling and extrapolation techniques on January 7, 2016, through the Association of Inspectors General.

IG implementing rules required by Senate Bill 207

- The definition of "fraud" now excludes unintentional technical, clerical, or administrative errors.
TAC citation: TAC § 371.1607(28)
Effective: October 1, 2015
- IG can impose payment holds only to compel production of records, when requested by MFCU or when a credible allegation of fraud exists. Prior authorized claims cannot be placed on hold unless IG has evidence of a material misrepresentation by a provider relating to those services.
TAC citation: 1 TAC § 371.1709
Effective: October 1, 2015
- In overpayment notices from fraud or abuse investigations, providers are entitled to information relating to extrapolation and the methods used to determine the overpayment in sufficient detail so that the extrapolation results may be demonstrated to be statistically valid and are fully reproducible.
TAC citation: 1 TAC § 371.1711
Effective: October 1, 2015

- MCOs must refer potential overpayments where the amount exceeds \$100,000, and IG must conduct a preliminary investigation.
TAC citation: 1 TAC § 371.1311
Effective: Currently proposed in Texas Register. Anticipated effective date May 14, 2016.
- IG must consider specific criteria, including aggravating and mitigating factors, when determining the type of sanction or penalty that should be assessed in a given case.
TAC citations: 1 TAC § 371.1603; 1 TAC § 371.1715
Effective: Currently proposed in Texas Register. Anticipated effective date May 14, 2016.
- IG must consider specific types of criminal conduct based on the provider type, when determining whether to enroll a provider. If a provider is licensed by a board, IG guidelines can't be stricter than standards to be licensed.
TAC citation: 1 TAC § 371.1011
Effective: Approved by Medical Care Advisory Committee on February 18, 2016. Scheduled for HHSC Council on February 25, 2016. Anticipated effective date August 21, 2016.

Program Insight: Social Services

Section

2

Program Insight: Social Services

Social Service Programs in brief

The HHSC Office of Social Services (OSS) determines applicant eligibility for Medicaid, the Children's Health Insurance Program (CHIP), the Supplemental Nutrition Assistance Program (SNAP), the Temporary Assistance for Needy Families Program (TANF), and other social services programs.

The United States Department of Agriculture Food and Nutrition Service administers SNAP at the federal level, and HHSC determines eligibility and administers benefits through the Lone Star Card, an electronic benefit transfer (EBT) card similar to a debit card.

The Texas Workforce Commission manages work-related SNAP policy employment and training services.

Recipients can use benefits to purchase eligible food items from participating retailers. SNAP benefits are 100 percent federally funded, but Texas funds 50 percent of the program's administrative costs.

Federal law defines SNAP eligibility criteria, while the state determines certain program options. Legal immigrants who have been legal residents of the U.S. for more than five years, and legal immigrants who are children, elderly, or disabled may receive SNAP, if otherwise eligible. All undocumented immigrants are ineligible for SNAP benefits.

The purpose of the TANF cash assistance program is to provide financial assistance to needy dependent children and the parents or relatives with whom they are living. Eligible TANF households receive monthly cash benefits through the Lone Star EBT Card. To qualify for TANF, one must be a resident of Texas, living with a related child under age 19, a U.S. national, citizen, legal alien, or permanent resident, and meet certain federally mandated income requirements.

TANF provides monthly cash payments to assist with the following:

- Food
- Clothing
- Housing
- Utilities
- Furniture
- Transportation

Top 10 key facts about OSS programs

1. Average number of eligibility determinations (FY 2012-2015)

Ranged from 10.3 to 11.6 million each year, with an average of about 43,000 per workday.

2. Number of recipients

SNAP: 3,787,845 **TANF:** 61,294

3. Applications submitted online

65%

4. Active Your Texas Benefits mobile apps installed

580,918

5. Documents uploaded through app

1,467,140

6. Regional eligibility staff

8,168

7. Eligibility offices

263

8. Clients served

In FY 2015, 7,238,109 individuals received services (TANF, Medicaid, SNAP and/or CHIP).

9. Estimated SNAP program expenditures (FY 2015)

	SNAP	TANF
State:	\$161,977,411	\$12,971,234
Federal:	\$5,433,968,137	\$50,402,130
Total:	\$5,595,945,549	\$63,373,364

10. Child recipients

SNAP: 56.6% **TANF:** 86%

Source: HHSC

- Phone
- Laundry
- Medical supplies not paid for by Medicaid

TANF benefits are time limited. The federal and state governments each have a role in the design and funding of the TANF program. At the federal level, the U.S. Department of Health and Human Services, Administration for Children and Families, regulates the program. HHSC and TWC share administration of the program at the state level. HHSC determines eligibility and administers benefits through the Lone Star Card, while TWC handles work-related policies and delivers employment and training services through local workforce development boards.

TANF comprises both state and federal funds. Federal funds come to the state in the form of a

Program Insight: Social Services

TANF block grant. The block grant has an annual cost-sharing requirement for Texas, referred to as maintenance of effort. The Texas Legislature determines how much state and federal TANF block grant funds go to the TANF cash assistance program and how much goes to other TANF funded programs.

Insight from Stephanie Muth, Deputy Executive Commissioner, HHSC Office of Social Services

Please tell us about your background and what brought you to your current position.

I have been in my current position as the Deputy Executive Commissioner for the Office of Social Services since November 2011, and I've had an unusual path to this position. Just prior to assuming this role, I served as the Chief of Staff at the Health and Human Services Commission and before that I was the Director of External Relations. I also held various positions at the Department of Human Services and the Texas House of Representatives.

At the time I was Chief of Staff, the agency was experiencing serious challenges in our eligibility system. While the federal time limits for rendering eligibility decisions was 45 days (or 30 days, depending on the program), in some areas of the state it was taking as long as six months for an applicant to get an interview for benefits. People were going without needed services, and the state was facing federal sanctions for a high error rate in the SNAP program. The eligibility system spiraled out of control due to a variety of factors, including the increased demand for services following Hurricane Ike. I worked closely with the Executive Commissioner at the time to put in place improvements in the eligibility system, and, because of our dedicated, hardworking staff, we achieved immediate improvements. But I also recognized the need to modernize the system to



Stephanie Muth

prepare for challenges the future would likely bring and was excited by the potential that I saw to improve the system.

What do you enjoy most about leading the Office of Social Services?

The mission of the Office of Social Services is to connect Texans to services — whether that is through the eligibility determinations that more than 8,000 regional eligibility staff across the state perform, or through the contracts with community based organizations that are administered through the Community Access and Services division.

We make a difference in Texans' lives every day and provide necessary services to Texans in crisis. And we do it in a way that is efficient and effective. I am proud of the work that we have done to promote self-service and improve our business process that has helped us reduce our cost per case and manage increasing caseloads without increases in staff. We have been recognized federally for our low error rates in determining eligibility. We have strengthened our contract monitoring and made improvements in the contracting process. Most of all, I am inspired by the staff that I have an opportunity to work with. They work hard, embrace change, and are committed to serving Texans.

Tell us about some of the challenges you have experienced in eligibility and what you are doing to address those challenges.

Texas' population has grown and continues to grow rapidly. The increasing numbers of individuals and families have translated to greater demand for services from the Texas Health and Human Services Commission. Between 2007 and 2012, HHSC experienced a 46 percent increase in its caseload. If the population growth continues as expected, by 2020 there will be an additional 20 percent greater need for public human services.

Population is just one of the impacts on caseload. Less predictable factors such as unforeseen natural disasters and changes in policy can also place a strain on resources. In order to meet current demands and prepare for the future within the confines of current resources, HHSC has taken a

Program Insight: Social Services

proactive approach to redesigning its system for greater efficiency and effectiveness for both its staff and clients.

The reality is that staffing growth does not parallel population growth. Because of this, transformation strategies have been focused on maximizing the capacity of our existing resources. We have done this by implementing process improvements including changes in our business process and improved use of technology. The goal of our business process redesign is to free up lost capacity by eliminating activities that do not add value and to deliver an accurate eligibility determination as quickly as possible. To create this new business process, we turned to our experts, the staff in the field. Forty field workers and first-line supervisors from HHSC offices across the state were brought together to form a workgroup to redesign the eligibility process from start to finish. Currently the new business process is in place in 62 offices and we are working on statewide roll-out.

Effective use of technology can bring large efficiencies. Two technology cornerstones are focused on providing clients with a portfolio of self-service options via the web site, YourTexasBenefits.com, and a Your Texas Benefits smartphone app. The YourTexasBenefits.com app offers clients the ability to apply, renew, and report changes for their benefits at anytime and anywhere. The app focuses primarily on features easily done by a smartphone, such as uploading documents and signing up to receive case alerts via e-mail or text message. The increased use of self-service options helps manage workloads by reducing data entry, client traffic, and calls to eligibility offices or call centers. This allows staff to focus on their core function of making accurate and timely eligibility decisions. Vendor costs are also reduced because fewer documents are imaged and call volume is decreased. We deployed the mobile app in November 2014 and currently have over 580,000 active downloads and have had over 1.4 million documents provided to us through the app.

These tools have proven effective. In 2009, Texas struggled with processing applications on time. Only 58 percent of SNAP applications and 73 percent of Medicaid applications were processed on time. The state had a 7 percent error rate in SNAP – well above the national average. Today, over 96 percent of applications are processed on time, and SNAP error rates are less than 1 percent – an all-time low for Texas and among the best in the nation. HHSC estimates the increased reliance on self-service saved as much as \$41 million in reduced printing, postage, and document imaging costs for the state between January 2012 and December 2014. In addition, payments for call centers and document processing fell \$12.7 million between FY 2012 and FY 2014 while monthly caseload increased by more than 600,000.

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

The Office of Social Services collaborates with the Inspector General in many ways. From an eligibility perspective, the Office of Social Services is responsible for preventing fraud by building an eligibility system that promotes accuracy and integrity. To accomplish this, we rely on information from the Inspector General on the patterns and types of fraud detected relating to eligibility for Medicaid, CHIP, TANF, and SNAP. This helps us build better processes on the front end to prevent fraud from occurring. In addition, Office of Social Services staff provide referrals to the Inspector General staff when they believe that fraud may be occurring with an established case. Another good example of the partnership between the Inspector General and Office of Social Services is the new Lone Star Card EBT procurement. As part of the proposal from the selected vendor, OSS will be able to provide the Inspector General with fraud analytics examining suspicious purchasing patterns with SNAP and TANF recipients and better inform IG investigations.

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-type investigations at the State Supported Living Centers and State Hospitals to ensure the safety of residents in these facilities. The Division comprises five Directorates:

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

Managed Care Special Investigations Unit quarterly meetings show progress

On February 17, 2016, the Investigations Division hosted its quarterly MCO-SIU meeting, providing opportunities for IG staff and MCO investigative staff to confer on numerous investigations, identify new fraud schemes, and engage in partnership development. The meeting featured instructors from the Attorney General's Medicaid Fraud Control Unit, IG-Audit staff, and two MCO-SIUs.

New IG administrative subpoena implemented

The IG finalized the process for exercising its new independent administrative subpoena power, which the Legislature granted during the 84th Legislative Session. The subpoena power allows investigative staff to obtain evidence during investigations, which enhances success rates in both administrative and criminal prosecutions.

General Investigations

The General Investigations (GI) 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.

GI cases produce substantial recoveries of funds, which are returned to the state treasury or agency programs. It coordinates investigative activities internally with other IG sections, HHSC departments, and local, state, and federal law enforcement agencies, and therein the following:

- Conducts recipient fraud investigations in SNAP, TANF, and Medicaid programs.
- Pursues recipient Electronic Benefit Transfer fraud and abuse.
- Enforces SNAP and TANF disqualifications of recipients found guilty in court or administratively of intentional program violations.
- Conducts CHIP recipient fraud investigations.

The GI directorate also assists Internal Affairs and conducts other special investigations.

General Investigations challenged by limited resources

The main challenges facing GI are:

- Federally mandated timeline to complete investigations.
- Increased referrals.
- Need for more investigators.

Mandate plus increased referrals

burgeons caseloads

The GI directorate is federally mandated to complete investigations within 180 days of receipt of the initial referral. For the last two fiscal years, the GI directorate received a monthly average of 7,000 referrals. A large percentage of these came from the HHSC Office of Social Services, which determines SNAP eligibility.

Case leads come from a variety of sources including the following:

- The Waste, Abuse, and Fraud Reporting System (WAFERS), the Integrity Line, IG website, mail, fax, and e-mail.
- State Auditor's Office.
- HHSC Ombudsman.

Investigations

- United States Department of Agriculture whistleblowers.
- Governor's Office/legislative office referrals.
- Referrals uncovered during Fraud Detection and Investigative Strategy analyses.
- Other law enforcement agencies.
- Data match results.

Staffing challenges being addressed

Since early 2014, the number of investigators in the GI directorate dropped from 134 to 112. But GI continued to produce excellent results, recovering more than \$78 million during the last 2 1/2 years, completing more than 49,500 investigations, and making 150,900 referrals. In January 2016, IG began improving the staffing situation by moving investigators into GI to address case backlogs.

Q&A with Juanita Henry, General Investigations Director

What does your role as director for the General Investigations directorate at the IG entail?

I oversee a staff of 165. Of the 165, 112 are investigators. My role is to provide support, leadership, and assistance to staff in performing their duties.

As a longtime investigations professional, I know that two of the most crucial components of good investigations are respect and professionalism. I try to instill those principles in all GI staff. Although it is our duty to determine if a recipient has committed fraud or abuse in a healthcare program, I have found that when you carry out your mission in a professional manner and you treat a person with respect, they may not like that they are being investigated, but they will appreciate how they are being treated and then tend to be more cooperative. Showing respect and professionalism leads to stronger investigations, which results in GI fulfilling its purpose.

What prior experiences do you feel especially prepared you for this role?

I have a combination of more than 20 years conducting cases and significant management

Top GI accomplishments this quarter

- Reduced case backlog by 19.87 percent.
- Referred 322 cases to district attorneys
- Obtained 112 court dispositions.
- Identified \$9,354,591 million for recovery.
- Collected \$10,122,680 from completed cases.

experience in criminal and civil investigations of healthcare programs. I feel the training and experience I gained during those decades of work prepared me well for this role.

What goals do you have for your directorate?

Provide staff with the support, skills, and tools needed to be successful. This would ensure the following:

- Investigations meet federal and state guidelines.
- Investigations conducted in the most efficient and effective manner.
- Investigations conducted in a professional manner.
- Investigations obtain necessary evidence to pursue an overpayment, Administrative Disqualification, or a prosecution.



Juanita Henry

What changes have you made or do you anticipate making?

Due to the large volume of referrals that GI receives from the OSS, GI partnered with OSS to develop a new communication plan, which will strengthen the quality of referrals received, inform OSS of fraud trends, and provide OSS with case status. We will provide ongoing support to OSS on what is needed in a complaint when making a referral.

Intake Resolution Directorate

IRD includes the Intake and Research Analysis and Detection units. These two units perform distinct yet complementary functions. Intake handles Medicaid provider complaints received

Investigations

from a variety of sources, while the RAD unit processes voluntary repayment requests, conducts acute care utilization review activities, and recovers overpayments. IRD staff comprises investigators, research specialists, and registered nurses.

Intake triages Medicaid provider complaints, while IRD conducts complaint resolution, provider education, recoupment actions, and refers cases to the Texas Attorney General's Medicaid Fraud Control Unit, regulatory boards, and other state and federal agencies. Legislative mandates direct Intake staff to assess and act on all complaints within 45 days of receipt.

Medicaid Provider Integrity

Comprising more than 55 investigators, MPI investigates allegations of fraud, waste, and abuse committed by Medicaid providers.

The directorate initiated multiple new lead

developing outreach efforts this quarter, including connecting with local, state, and federal law enforcement agencies, MCOs, and Medicaid providers and recipients. These outreach efforts develop community networks, creating additional new links for obtaining case referrals. MPI currently conducts joint investigations with Texas' medical and dental boards on patient safety issues.

This quarter, MPI referred seven completed cases to IG Litigation and closed 50 investigations; MCOs referred four cases to MPI.

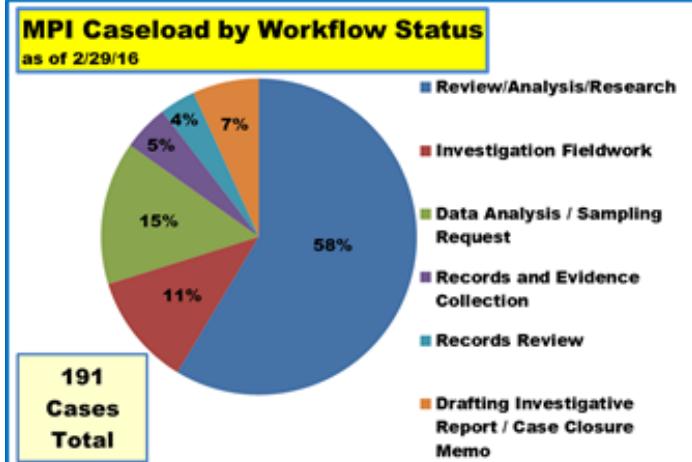
Law Enforcement

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

This unit investigates allegations of abuse, neglect, or exploitation of patients at State Hospitals or at State Supported Living Centers. Texas has 13 State Centers and 11 State Hospitals. During this quarter, the State Centers Investigative Team completed 310 investigations and filed criminal charges against 14 suspects in 12 cases.

The following vignettes shed light on cases



IRD statistics

Research Analysis and Detection

Cases opened	74
Cases closed	49
Dollars recovered	\$571,597
Dollars identified	\$1,433
Voluntary repayment	\$84,461
Cases transferred	24

Intake

Complaints received	463
Preliminary cases opened	379
Preliminary cases closed	291
Average days to complete	24.6
Cases referred	307

Investigations

resolved this quarter:

- A registered nurse admitted to diverting hydrocodone tablets for personal use at a State Supported Living Center.
- Two staff members at a State Hospital used a client's credit card, with violations proved by transaction history and store video associated with the unauthorized use of the card.
- Three SSLC suspects engaged in physical abuse of a client as substantiated by video evidence. Two additional criminal offenses were uncovered: tampering with a government record and interference with an emergency request for assistance.

This quarter, State Center cases produced ten indictments, one guilty plea resulting in three years' probation, and four arrest warrants.

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.

The Medicaid Law Enforcement Unit recently completed a joint investigation with the Austin Police Department, identifying a fraud scheme involving Medicaid and SNAP beneficiaries.

Top IA accomplishments this quarter

- Investigated a grant-funded non-profit entity, finding that the program used funds inappropriately for home remodeling, home furniture purchases, and travel. This investigation was referred to the United States Department of Health and Human Services, Office of Inspector General for further action. The program was ordered to remit \$7,325 to the Department of State Health Services.
- Conducted an investigation involving a former Child Protective Services Investigator who falsified information. The former CPS Investigator pleaded guilty in a district court.

Internal Affairs

Internal Affairs conducts investigations of fraud, waste, abuse, employee misconduct, and contract fraud within the HHS system. This Directorate consists of two units:

- Program Investigations
- Investigative Support

Program Investigations

Program Investigations pursues allegations against employees, vendors, and contractors associated with the HHS System.

This quarter, the PI team completed 167 investigations, substantiating 65. The cases involved, among other things, vital statistics fraud, contract fraud, employee misconduct, privacy breaches, computer misuse, Child Protective Services child deaths, and Adult Protective Services adult death cases.

Audit

Section

4

Audit

Overview

The IG Audit Division conducts risk-based audits of contractors, providers, and HHS programs to reduce fraud, waste, abuse, and mismanagement throughout the HHS system. Among other things, these audits examine the performance of medical service providers and HHS agency contractors, and provide independent assessments of HHS programs and operations. Additionally, the Audit Division conducts nursing facility and hospital utilization reviews to determine whether Medicaid reimbursements were accurate and appropriate, and assesses Medicaid recipient risk for misuse of prescriptions and services.

The Audit Division comprises three Directorates:

- Audit
- Audit Operations
- Quality Review

MCO special investigative units informational report issued

The Division is conducting a series of audits to determine how effective MCO special investigative units (SIUs) are at preventing fraud, waste, and abuse.

On February 5, the Audit Division issued an informational report containing a compilation and analysis of information submitted by MCOs during the planning phase of the audit. The information indicated that:

- MCOs produced limited results in SIU detection, investigation, recovery, and referral efforts.
- In 2015, MCO SIUs reported a total of \$2.5 million in recoveries, representing .02 percent of \$12.5 billion in medical claims submitted for services provided during

Year	Total claims	Total recoveries	Recoveries as % of claims
2014	\$11.7 billion	\$3.9 million	0.03%
2015	\$12.5 billion	\$2.5 million	0.02%

Top Audit accomplishments this quarter

- Ten audits from the fiscal year 2016 plan made progress, including an audit of MCO special investigative units' performance in detecting and investigating fraud, waste, and abuse.
- Changed hospital utilization review process to implement new statutory requirements.
- Created utilization review quality assurance function to ensure consistent results across the state.
- The HHSC Executive Commissioner permanently transferred the federal audit coordination function to IG, after the successful completion of a six-month pilot.

Outcomes of completed audits

- 9** Pharmacy audit reports identified \$1,451,764 for recovery. One of the audits identified errors related to billing, medication quantities, and prescription expiration, resulting in overpayments of \$213,022.
- 2** Audit reports issued for Medicaid outpatient hospital cost reports, resulting in adjustments of \$746,918, which are expected to have an estimated impact to the Medicaid program of \$6,200.
- 4** Performance audit reports identified \$196,634 for recovery. One of the audits identified incorrectly charged respite services, claims containing incomplete information, and other unallowable costs.

Reducing Audit Division backlog

- 56** Audits carried forward from FY 2014 and FY 2015
- 24** Audits issued in first quarter FY 2016
- 15** Audits issued in second quarter FY 2016
- 5** Audits to be issued in third quarter FY 2016
- 7** Audits on hold, pending investigation
- 5** Audits cancelled (no significant issues)

Audit

the same year. This was down from three hundredths of one percent in the previous year.

- There is a wide variation in MCO personnel resources committed to the SIU function. For example, MCOs reported a range from less than one full-time employee to more than eleven full-time employees allocated to SIU activities.

Collaboration with HHS agencies leads to new audit approach

The Audit Division stepped up its efforts to collaborate with HHS agency program areas. As a result, it changed its approach to performing contractor and provider audits.

Beginning with the fiscal year 2016 audit plan, the IG considers the HHS agency program area that has oversight of the audited entity to be its audit client. The Audit Division communicates frequently with the HHS agency program area throughout the course of the audit, beginning with developing a common understanding of audit criteria and resulting in recommendations issued directly to the program area.

This approach, which is building a foundation of communication and collaboration with HHS programs, will lead to more consistent and accurate audit results.

Utilization review quality assurance work under way

In response to concerns voiced by providers that IG utilization review results were inconsistent, the Audit Operations and Quality Review Directorates worked collaboratively to create a Utilization Review Quality Assurance unit. The unit began initial evaluations of nursing facility and hospital utilization review activities in February 2016, and is working to identify opportunities for improvement in utilization review practices.

New audit projects under way

Recovery of overpayment amounts identified in federal audits

Objective: Determine the effectiveness of HHSC policy and related processes for:

- Recovering the federal and state share of overpayment amounts identified in federal audits.
- Negotiating and agreeing to recovery amounts less than the identified overpayment amount.
- Ensuring timely recovery of overpayment amounts from providers and contractors.

Background: When federal audits identify overpayments to contractors and providers, HHSC is required to recover both the federal and state shares of the overpayment amount and repay the federal share to the applicable federal entity. HHSC program areas associated with the audit are responsible for the timely and complete recovery and repayment of all funds related to the final overpayment amount. Twelve federal audits issued from fiscal years 2011 through 2015 identified overpayments that included state shares of about \$10.9 million.

Review of eligibility, payment, and service provider information technology interfaces

Objective: Evaluate the adequacy of information technology interface controls designed to ensure data transmitted between computer systems is complete, accurate, and reliable, and protect data transmittals from unauthorized access and disruption.

Background: The audit focuses on application controls over interfaces to protect the validity, reliability, and security of data processed through the Department of Aging and Disability Services' (DADS) Claims Management System. The Claims Management System is a collection of computer applications and systems used to process Medicaid claims for DADS programs, including long-term care and home and community-based services. Approximately \$4.2 billion in payments to Medicaid providers is processed annually through the Claims Management System.

Audit

Audit projects in progress

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

- Managed care organization SIUs' performance.
- Delivery supplemental payments.

- Acute care utilization management in managed care organizations.
- Performance of contractors selected through non-competitive procurements of more than \$10 million.
- Pharmacy audits.

Inspections

Section

5

Inspections

Overview

The Inspections Division was created in June 2015 to fulfill a long-neglected IG statutory requirement. The division performs inspections and reviews of health and human services programs and systems and provides practical recommendations on improving program efficiency and effectiveness, with a focus on preventing fraud, waste, and abuse. Quinton Arnold is the new Deputy Inspector General for Inspections and Evaluations.

Provider self-report inspections progressing

Inspections collaborates with the Chief Counsel Division to review, where appropriate, provider self-report settlements and determine if the reports include all potential Medicaid overpayments. Each review team will include Inspections healthcare professionals and involves visits onsite.

WIC Vendor Monitoring Unit

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

In this reporting period, the unit conducted a total of 133 compliance-buys and 42 in-store evaluations, meeting 100 percent of the compliance activities and 88 percent of the in-store evaluations mandated by the USDA. A total of 101 cases were closed during the quarter. Cost avoidance of \$6,115,009 was identified. This included \$4,874,263 from a disqualification for trafficking and \$1,240,746 from disqualifications revealed through invoice audits. In addition, invoice audits

Top accomplishments this quarter

- Identified \$6,115,009 in cost avoidance
- Identified \$7,555 in unsubstantiated claims for recovery
- Exceeded 100 percent of compliance activities mandated by USDA

were completed on seven vendor outlets yielding \$7,554 in unsubstantiated claims identified for recovery.

Compliance buys and on-site evaluations

Compliance buys were conducted this quarter at 133 vendor outlets in the Rio Grande Valley, Houston, Dallas, El Paso, Laredo, and in several rural areas. From these, 57 outlets were found to have no program violations. At the remaining 76 outlets, a total of 236 violations were cited.

On-site evaluations were conducted this quarter at 42 vendor outlets in Houston, Dallas, Abilene, Wichita Falls, Mineral Wells and central Texas. Sixteen had no program violations. A total of 226 violations were cited at the remaining 26 outlets.

Disqualification for unsubstantiated WIC sales upheld

Effective December 1, 2015, a Department of State Health Services Fair Hearing decision upheld the disqualification of a Houston vendor for unsubstantiated WIC sales resulting from an invoice audit. The vendor was disqualified from the program for three years, generating cost avoidance of \$492,455. The review identified \$25,367 in unsubstantiated WIC sales.



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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

