OCT 17 2014

OFFICE OF INSPECTOR GENERAL

TEXAS HEALTH & HUMAN SERVICES COMMISSION

DOUGLAS C. WILSON, CPA, CIG
INSPECTOR GENERAL

October 17, 2014

Mr. Ken Levine, Director
Sunset Advisory Commission
Robert E. Johnson Building
1501 North Congress Avenue
Austin, Texas 78701

Dear Mr. Levine:

We would like to take this opportunity to thank you and your staff for the job they have done during this review process. We appreciate their efforts to conduct a comprehensive assessment of the Office of Inspector General (OIG).

Attached you will find our response to the Sunset Staff Report for OIG. The report captures the challenges we face in our efforts to prevent, detect and pursue fraud, waste, and abuse in the Health and Human Services System on behalf of the taxpayers of Texas, to ensure that Medicaid funds are spent wisely and only for services for those truly in need. We understand that we must be flexible and adaptable to ways we can do our job better, and we stand ready to work with the Sunset Commission and Legislature to enact any improvements they determine are needed.

We look forward to discussing these recommendations with the Sunset Commission during the hearing process, and with the Legislature during the next session.

Sincerely,

Douglas Wilson
Inspector General

HHSC - Office of Inspector General (OIG)

Response to Issue 4

HHSC Has Not Fully Adapted Its Processes to Managed Care, Limiting the Agency's Ability to Evaluate the Medicaid Program and Provide Sufficient Oversight.

Change in Statute

4.4 Require OIG and HHSC to define, in rule, the respective roles and purpose of managed care audits and to coordinate all audit activities.

While OIG is not required to coordinate its audits, OIG seeks to obtain program input into relevant areas in conducting MCO audits. OIG also reviews prior external audits of the entity in conducting its planning and risk assessment.

While OIG may review the same MCO, the audit scope and the issues reviewed are not the same unless prior auditors had significant findings that would require successor auditors to also take a look in accordance with standards.

OIG fully supports the recommendation for audit coordination and the sharing of audit plans.

Fragmented Provider Enrollment and Credentialing Processes Are Administratively Burdensome and Could Discourage Participation on Medicaid

Change in Statute

5.2 Provide that OIG no longer conduct criminal history checks for providers already reviewed by licensing boards.

OIG is concerned with this recommendation given the requirements of the affordable care act. HHSC is responsible for Medicaid program integrity and cannot delegate that responsibility. OIG has recommended denial of many applications based on criminal history and board orders, and the failure to disclose the information on the application. For example, there have been physicians who are no longer under board order but have significant practice issues, e.g., death of a patient, inappropriate sexual conduct finding or professional boundary violation, or inappropriate prescription practices. Under the federal regulations, 42 CFR § 455.410, the review of Medicaid providers is to be done by the State Medicaid Agency based on the requirements outlined in 42 CFR Part 455, Subpart E. It does not designate that this determination can be delegated to a state licensing board.

Managed Care Organizations have their own credentialing processes and are allowed to independently consider whether or not a provider can participate in their network. It seems reasonable that if State contractors are given flexibility to protect patients under their care the same flexibility would be afforded the State agency that has responsibility for Medicaid program integrity.

5.3 Require OIG to develop criminal history guidelines for provider types for which it conducts background checks.

OIG agrees that standard criminal history guidelines should be made transparent that outline the factors on which a recommendation is made. Many of the guidelines exist in federal law and in the current rules. For clarification, OIG makes recommendations and not the final decisions regarding the eligibility of a Medicaid provider.

5.4 Require OIG to complete provider background checks within 10 business days.

OIG supports this recommendation if the application is "clean" (meaning no issues and complete information) and all that remains is the background checks. A ten-day requirement for those applications with issues could potentially result in more denied applicants than the achievement of an efficient process.

Poor Management Threatens the Office of Inspector General's Effective Execution of Its Fraud, Waste, and Abuse Mission.

Change in Statute

10.1 Remove the gubernatorial appointment of the inspector general and require the executive commissioner to appoint and directly supervise the inspector general.

OIG agrees with the Sunset goal of accountability, integrity and effective operation of the office. In 2003 the Legislature, via HB 2292, established the reporting structure of the OIG and the reporting structure is the same as the executive commissioner. The oversight for the IG is provided by the Governor's office and the Legislature. The IG is also accountable to the HHSC council and citizens of the State of Texas. Whichever structure the Legislature implements the OIG believes independence has to be its core.

OIG will work with the Legislature as it determines the best reporting structure for the office to ensure the Green Book principles of:

- integrity
- objectivity
- independence
- confidentiality
- professionalism
- competence
- courage
- fairness
- forthrightness and
- public accountability are maintained

10.2 Require OIG to undergo special review by Sunset in six years.

OIG supports the recommendation.

10.3 Require OIG, by rule, to establish prioritization and other criteria to guide its investigation processes.

OIG supports the recommendation. OIG is currently reviewing the existing policies and procedures that govern how investigations are prioritized, and will determine the appropriate places to reference the policy in rule to afford the office the flexibility and nimbleness necessary to keep pace with technology and other developments in the field. OIG placed criteria in rule for Medicaid provider investigations in accordance with SB

1803. The OIG agrees that current rules can be strengthened. Because the OIG has implemented investigative initiatives in Medicaid provider investigations for the past three years, the priorities for provider investigations were determined prior to each fiscal year. OIG will do a better job of documenting the investigative priorities to include the research, data mining and data analytics conducted to determine the priorities.

10.4 Require OIG to complete Medicaid provider preliminary investigations within 45 days and full investigations within 180 days.

OIG supports this recommendation. As evidenced from the three-year average completion time for FY 2013, OIG still has a case backlog to work through that will impact the 180-day goal. The cases completed in FY 2013 included cases that were opened in FY 2004, 2005, 2006, etc. Once the backlog of cases has been worked the timeframes should be viable. Any standard should have some flexibility to account for difficult and more complex cases. For example, cases requiring medical review will be impacted by the availability of consultants.

10.5 Require OIG, by rule, to establish criteria for scaling its enforcement actions for Medicaid provider investigations to the nature of the violation, including penalties.

The OIG is unaware of any state or federal agency with similar program integrity functions that has criteria for scaling provider overpayments. It is possible to scale other enforcement actions, for example the time period of a discretionary exclusion. The concept of scaling violations in a licensing environment may be common as that appears to be the parallel drawn by Sunset.

Historically, penalties are assessed in program integrity if the actions of the provider are so egregious as to suggest something in addition to recovery of the overpayment is warranted, or if the violations identified are not recoverable violations but are instead repeat findings from prior investigations or audits that have not been corrected. OIG supports the idea of strengthening criteria for scaling penalties and other enforcement actions that do not involve overpayments.

OIG is already soliciting input from other states and the federal government for any such criteria that may exist in rule or statute and will ensure any criteria adopted does not violate federal law and jeopardize federal funding. If the Sunset staff is aware of criteria that exists in the program integrity space OIG welcomes the opportunity to review it, and we will work with the Legislature to ensure its proper implementation.

10.6 Require OIG to conduct quality assurance reviews and request a peer review of sampling methodology used in its investigative process.

OIG supports the recommendation to conduct quality assurance (QA) reviews and will collaborate with the Association of Inspectors General (AIG), the SAO and other investigative agencies to develop a QA process.

OIG is not aware of any agency that has conducted a peer review of its sampling methodology, since any concerns with the validity of sample results would be adjudicated during a hearing or trial. OIG will, however, work with the AIG to create and implement a peer review of sampling processes and protocols. If Sunset staff has knowledge of an existing peer review protocol for statistical sampling units in other state agencies, OIG will consult and collaborate with those agencies

10.7 Define OIG's role in managed care, including strengthened oversight of special investigative units.

OIG supports this recommendation and will work with the Medicaid/CHIP Division to coordinate the role each will play in managed care, to include OIG's involvement with special investigative units.

10.8 Remove the prohibition on participation in both the Health Insurance Premium Payment program and Medicaid managed care.

OIG supports this recommendation.

10.9 Allow OIG to share confidential drafts of investigative reports concerning child fatalities with DFPS.

OIG will not continue reviewing child fatality cases beyond the current fiscal year unless the Commissioner or the Legislature requests our continued involvement in an ongoing or case-by-case basis. OIG began these investigations at the request of the former Commissioner, and OIG involvement provides an independent review of the handling of the case with recommendations and risk findings for management in an effort to bolster DFPS processes and identify areas of improvement.

Sharing "confidential" drafts of investigative reports impairs independence in fact and appearance and would not serve the objectives identified when OIG was asked to investigate the cases. The integrity of the investigative process is intact when the independent reviewer is allowed to issue findings and recommendations without influence.

If the Legislature determines that OIG should continue reviewing child fatality cases OIG will work with the Legislature to ensure independence is not impaired.

Management Action

10.10 Direct OIG to narrow its employee investigations to focus on high priority allegations, such as those at state institutions and related to program integrity, and develop guidelines for investigations of child fatalities.

OIG supports the recommendations to continue investigations within state institutions. In accordance with statute (SB 643 and SB 152) these investigations involve criminal allegations of abuse, neglect and/or exploitation involving clients, residents and/or patients of the state institutions and not employee misconduct.

OIG also supports the recommendation of continuing to investigate allegations related to program integrity. Current allegations received involve the misuse or defrauding of state benefit programs, complaints involving the misuse/abuse of state equipment, loss of or stolen state assets, misuse of taxpayer dollars and other violations by state employees that may place others at risk of harm, threats or danger.

See issue 10.9 as it relates to child death investigations.

10.11 Direct OIG to actively take steps to improve training for its staff and communication with HHS system programs and providers.

SB 1803 required OIG to provide training to staff and OIG identified relevant, applicable training for each distinct discipline and functional area of OIG over the past three years. OIG staff has attended trainings at the US Department Of Justice Medicaid Integrity Institute; the office worked with the AIG board to bring two Inspector General Institute certification programs to Texas so auditors, investigators and senior staff could be trained and certified by the AIG; and the office has sponsored and paid for several outside trainers to provide training to OIG staff, as well as held internal trainings specific to job responsibilities. In August 2014, OIG staff, across several divisions, attended the National Association of Medicaid Program Integrity Annual Conference in San Antonio. OIG will continue to actively seek applicable training within budget constraints, and will continue to seek cross-training opportunities and communication with HHSC program staff and providers. OIG supports this recommendation and will survey staff to determine if there are additional training needs that staff has not previously identified.

10.12 Direct HHSC and OIG to work together to transfer certain OIG functions to other areas of the HHS system where they would fit more appropriately.

OIG supports the recommendation.

10.13 OIG should track basic performance measures needed to monitor the efficiency and effectiveness of its investigative processes.

OIG has a robust performance data compiler (metrics system) that it maintains in an access database that tracks more than 120 distinct metrics and performance indicators. The system is antiquated and lacks ad hoc querying capabilities. The OIG is in the implementation stage of a new case management system that was approved and funded last session by the Legislature that will improve management information system capabilities greatly, and allow OIG to track timeliness and measure efficiency and effectiveness more readily.

10.14 OIG should establish a formal plan for reducing its backlog and improving inefficiencies in the process.

OIG supports the recommendation and is already working to eliminate the backlog.

Response to Issue 11

Credible Allegation of Fraud Payment Hold Hearings Do Not Achieve the Law's Intent to Act Quickly to Protect the State Against Significant Cases of Fraud.

Change in Statute

11.1 Streamline the CAF hold hearing process to more quickly mitigate state financial risks.

OIG concurs that the CAF hold hearing process may be improved to mitigate state financial risks. The recommendation identified several reforms that OIG will individually address.

Notice of a payment hold. Federal rules and existing Texas statutes currently require the notice of payment hold to be sent by OIG within five days of placing a CAF hold. *See* 42 C.F.R. § 455.23(b)(1)(i) and Tex. Gov't Code § 531.102(g)(2). Currently, the provider has 30 days to request an appeal. 1 Tex. Admin. Code § 371.1709(e)(2).

The recommendation for OIG to request the hearing at SOAH within three days of the provider's request for hearing requires further review to determine whether this time frame is sufficient. Further, the recommended requirement that payment hold hearings are conducted by the State Office of Administrative Hearings (SOAH) within 30 days of OIG's request for docketing concerns SOAH's underlying statute. OIG cannot address SOAH's ability to meet a statutory change to hold a hearing within 30 days of a request for a setting.

OIG Sanctions Trial team is responsible for the preparation and presentation of the majority of the contested case hearings on Medicaid payment holds. Any requirement that final hearings occur within 30 days of docketing will result in frequent scheduling conflicts with other assignments and cases set for that same time period. OIG, providers, and SOAH will require flexibility in setting cases for hearing.

OIG payment hold hearings often involve complex medical issues and usually involve the testimony of medical experts. A 30-day hearing requirement would adversely impact and limit the parties' ability to conduct discovery in advance of the hearing. SOAH's rules provide that most discovery responses are due in 20 days and all discovery must be completed 10 days before the hearing. 1 Tex. Admin. Code §155.521.

The recommendation for reduced time frames related to hearing requests appears to stem from the desire to address expedited hearings. The report pointed to the temporary suspension process in place at the Texas Medical Board and Texas Nursing Board. OIG

agrees that the temporary suspension process may be analogous and, where appropriate, similar processes can be considered for CAF payment holds.

Hearings. Under current rule and practice, the four hour per side limitation will be unduly restrictive and could result in necessary evidence being omitted from consideration by the administrative law judge (ALJ).

Rules for the State Office of Administrative Hearings (SOAH) place the burden of proof in a payment hold hearing on the OIG. *See* 1 Tex. Admin. Code §155.427. The numbers of witnesses needed to meet the burden of proof weighs against a four-hour limit. A typical OIG payment hold hearing will involve: (1) an investigator (proves preliminary facts; proves how evidence was obtained; authenticates evidence); (2) a Medicaid policy witness (gives evidence of the Medicaid requirements at issue in the dispute); and (3) an expert reviewer (testifies in support of specific violations of the applicable Medicaid requirements). OIG estimates that it would need, at a minimum, at least one day to present its case. OIG believes that most payment hold hearings could be held within two or three days.

OIG supports the recommendation that the parties should be limited to two continuances for reasonable circumstances.

Standard of proof. OIG agrees that a legal standard with more common usage than "credible allegation" may be helpful. In general, the probable cause standard requires more than a bare suspicion but less than proof by a preponderance of the evidence.

OIG does not agree that it is appropriate to add an additional required element of proof to justify a payment hold. As written, the recommendation requires proof of the fraud allegation and proof "that continued payment to a Medicaid provider presents an ongoing significant financial risk to the state and threat to the integrity of the Medicaid program…."

This added requirement is at complete variance with federal regulations. *See* 42 C.F.R. §455.23. The addition of an independent showing of ongoing harm to the state and/or Medicaid program is an improper burden and would be a clear departure from the federal requirements.

Decisions and appeals. OIG agrees that the present system of allowing multi-level appeals in payment hold cases is highly inefficient and detracts time and resources away from allowing the underlying issue of whether and how much the provider was overpaid to be finally resolved.

Any change to allow the final decision to be made by SOAH will likely come at some cost. Medicaid is an immense and complicated program. The medical and policy issues

which are inextricably intertwined with the determination of possible provider misconduct cry out for consideration by someone with some precognitive knowledge of those processes.

Texas' current process for payment holds is, to OIG's knowledge, uniquely onerous. The ideal resolution would be for final hearings to be conducted by the HHSC Appeals Division ALJ's with no opportunity for appeal. This would give the opportunity for a judge with specialized knowledge and experience with Medicaid rules and policy to decide these issues. However, that change would be a reversal of recent modifications in the law.[1] If an ideal solution is not tenable, then the next best alternative may be allowing SOAH to make the final decision. However, considering the large amounts of Medicaid funds at stake, OIG hopes this experiment will be closely monitored.

OIG supports the recommendation that any final decision by a SOAH ALJ should be limited to determining whether the CAF hold should continue.

Resolution of the case.

OIG agrees that cases must be resolved in an efficient and timely manner. OIG supports the recommendation to complete the overpayment case underlying a CAF hold within 180 days of beginning the full investigation of the overpayment case, subject to the availability of qualified experts for review.

Informal resolution meetings. This recommendation seeks to modify the informal resolution meeting (IRM) process for CAF payment holds to make the IRMs optional instead of mandatory. OIG agrees with this recommendation so the IRM process should not delay the CAF hold hearing. For overpayment hearings, the recommendation specifies that the process would continue as currently structured. OIG disagrees with the recommendation that the IRM process for overpayment hearings should remain the same. OIG has no opposition to having IRMs or engaging in meaningful discussions for an informal resolution of a matter, but a mandatory requirement for IRMs in all overpayment cases is a tool frequently used by providers to effectively delay the overpayment hearing.

Overpayment hearings are not mandated as "expedited" by statute. In an overpayment hearing, the ALJ must determine an exact dollar amount to be recouped from the provider. While a provider may be highly motivated to resolve the payment hold issue in a timely fashion because the issue concerns the flow of Medicaid payments, the opposite motivation is present in many overpayment hearings where OIG is seeking to recover funds from the provider.

[1] S.B. 1803 (June 14, 2013) – Giving providers option for overpayment cases to be heard by SOAH where previously those cases were heard by HHSC Appeals Division.

OIG suggests that it be permitted to have the discretion to delay docketing of the overpayment hearing during the IRM process as opposed to a mandatory requirement that docketing be delayed.

11.2 Clarify good cause exceptions for OIG's application of a credible allegation of fraud payment hold.

OIG supports the recommendation to clarify the good cause exceptions in 42 C.F.R. § 455.23. Regardless of a change in statute, OIG is subject to and complies with the current federal regulation that sets out the good cause exceptions. *See* 42 C.F.R. § 455.23. Rather than incorporate the federal regulation into state statute, OIG suggests that the federal regulation be referred to or incorporated by reference. In this way, the OIG remains subject to the requirements in the federal regulations for good cause exceptions without the need for any subsequent statutory changes in the event the federal regulations are amended. These exceptions are listed in OIG's current rule, 1 Tex. Admin. Code § 371.1709(f)(5), and these exceptions incorporate 42 C.F.R. § 455.23(e) by reference.

11.3 Clarify OIG's authority to place payment holds only in serious circumstances.

"Payment holds" have been permitted by state law and regulations since before the creation of the OIG. *See* 1 TAC § 357.587(27) (Rule history indicates this process has been in place since at least 1986); *see* also Hum. Res. Code § 32.0291. Rules were adopted to implement the statute and have been amended as needed to comply with the statutory amendments that address "payment holds." Since 2005, HHSC rules have authorized HHSC and OIG to impose a temporary payment hold when a Medicaid provider commits a program violation, whether or not fraud is alleged. Money on payment hold is applied according to the final determination – to offset or recoup any overpayment, pay restitution or penalties imposed, with the remainder being paid to the provider if more is being held than is owed.

The Affordable Care Act of 2010 (ACA) strengthened federal requirements for states to suspend payments to a Medicaid provider when there is a pending investigation of a credible allegation of fraud. The rule implementing this provision was published by the Centers for Medicare and Medicaid Services (CMS) on February 2, 2011. Federal regulations address the minimum that states must do to receive Federal Financial Participation funds. *See* 42 C.F.R. § 455.23

Sunset staff recommends that payment holds be limited to compel production of records, when requested by the state's Medicaid Fraud Control Unit, or on the determination that a credible allegation of fraud exists. Although there is no discussion of the parameters of a payment hold to compel production of records or the parameters of a request by the

state's Medicaid Fraud Control Unit, these three enumerated reasons are described as limiting payment holds to serious circumstances.

Note that existing statutes underlie the current broader authority to place payment holds. *See* Tex. Hum. Res. Code §§ 32.0291 and 32.034 (payment holds during the pendency of a contract cancellation hearing); *see also* Tex. Gov't Code §§531.102(g)(2) and 531.102(g)(7) (permissive and automatic holds).

Medicaid is a complex statutory scheme which provides health care to poor Texans in a partnership with the federal government. HHSC is charged with overseeing that complex regulatory scheme. The amounts of money that flow through the Medicaid program add to the challenges of preventing or correcting waste, fraud, and abuse. The payment hold is but one tool in the arsenal of protecting the public money and providing services to the recipients. Limiting the use of the payment hold to three statutorily enumerated instances is an overcorrection to address the issues specifically enumerated.

An alternative method to addressing shortcomings in the use of payment holds is to leave the statute, including Tex. Gov't Code §531.102(g)(2), as is, but add language to the statute that requires the Executive Commissioner to adopt rules that specify the criteria for placing a payment hold, the circumstances under which a payment hold will be imposed, and an analysis of the need for the hold or the factors to be considered in maintaining or lifting the hold.

11.4 Require OIG to pay all costs of CAF hold hearings at SOAH.

The requirement that providers pay half of the costs for CAF hold hearings at SOAH was implemented as part of S.B. 1803 enacted in the last legislative session. The recommendation indicates that requiring OIG to pay the full cost for CAF hold hearings at SOAH would be consistent with the standard state practice of the agency pay for SOAH hearings. OIG notes that, in some circumstances, agencies have the authority to assess the costs of an administrative hearing against the practitioner where a violation is substantiated in the hearing. *See, e.g.,* 22 Tex. Admin. Code § 187.39.

Fiscal Implication

Hearings at SOAH have a fiscal implication to the state. Because the OIG is not included in SOAH's appropriations like many state agencies, OIG pays SOAH an hourly fee for each hour a judge spends reviewing, hearing, or making determinations during the pre-trial, trial and post-trial phases of a case. When a case exceeds two days, two judges are assigned to oversee the hearing process. These costs are in addition to any costs for the court reporter and transcript. Though OIG has no opinion on this matter, it is an expensive process and will have fiscal implications.