

Report of the Health and Human Services Strike Force

March 2015

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Executive Summary

Every day, Texas' five health and human services agencies, known collectively inside HHSC as "the enterprise," deliver services to millions of Texans, providing public assistance, child and adult protective services, facilities for the state's most vulnerable citizens, response to public health emergencies and more. Because of the enormous scope and cost of their work, and the steadily increasing demand for it, we cannot afford for these agencies to perform at anything less than their highest level.

And yet, the agencies — and particularly the system's oversight agency, the Health and Human Services Commission (HHSC) — have spent recent months mired in ongoing controversy over the handling of several contracts designed to further their missions, as well as other issues. The Legislature, through its Sunset process and now in its regular biennial session, is evaluating the system's current structure and performance and charting its future in view of recent developments.

It's difficult to understate how important the Governor's and Legislature's decisions will be to the Texans who depend on health and human services (HHS) — and to state government itself. Texas commits more than a third of its budget to health and human services, and the cost is rising annually. For the 2014-15 biennium, HHS functions received All Funds appropriations of \$73.9 billion, 36.9 percent of all state appropriations. The five HHS agencies employ more than 54,000 workers, or about 17.5 percent of the entire state workforce, and serve millions of Texans each year.

Given its size and importance, the HHS system is always a focus of legislative concern, but the current session marks the first time the Legislature has embarked on a detailed examination of the system since 2003. The 2003 Legislature's H.B. 2992 fundamentally restructured Texas' health and human services, consolidating 12 agencies into five under the expanded oversight of HHSC and its executive commissioner. A report released a year after the consolidation called it "one of the most significant governmental reorganization efforts in recent U.S. history," a fair assessment. A dozen years after this restructuring, it is fair to ask how well the changes have worked.

This was a recent goal of the Sunset Advisory Commission, which reviewed HHSC and related system issues in 2014. The Sunset staff report was released in October 2014, and the full commission subsequently adopted most of its recommendations. The report included a list of recommended improvements, and noted that "the vision of H.B. 2292 is far from complete." The Sunset staff recommended — and the commission agreed — not only that the H.B. 2292 consolidation should be completed, but also that the five current HHS agencies should be merged into a single agency by the end of fiscal 2016.

Less than two months after the Sunset staff report was released, HHSC became the subject of intense scrutiny related to the procurement of fraud detection services by HHSC's Office of Inspector General (OIG) from an Austin-based company called 21CT. This controversial procurement stretched the limits of state procurement law and exposed weaknesses not only in HHSC's procurement and contracting policies but also in the cooperative contracts program managed by the Department of Information Resources.

Several reviews of HHSC were spurred by this controversy, including investigations by the Travis County District Attorney's Public Integrity Unit, the State Auditor's Office and this strike force, which Governor Greg Abbott created before formally taking office on January 20.

As the strike force began its work, Governor Abbott made it clear that he would set no limits on the scope of its work. Given the importance of the issue and to ensure its recommendations would be available to the Governor during the legislative session, the strike force moved quickly. This report focuses on six broad issue areas the strike force believes are most critical to dealing with recent events and improving the future direction of the agency. These include the 21CT controversy; the Office of Inspector General; HHSC contracting in general; HHSC organization and management; consolidation of the HHS agencies; and vision and leadership.

In the two months following the strike force's creation, we conducted more than 50 interviews with staff members of HHSC and the other HHS agencies. We talked to service providers; vendors that do business or have done business with the system; former employees, including three former commissioners; and other individuals who have worked on HHS issues since the H.B. 2292 consolidation and before.

Our conclusion is that the OIG's procurement of fraud detection services from 21CT at the very least skirted the limits of permissibility under state law, and represented a case in which OIG executive personnel exercised judgment so poor that it put HHSC's credibility at risk. It also produced skepticism concerning state contracting and procurement policies in general that could affect the state for years to come.

Whether the 21CT procurement represented a useful technology has become less important than the process of its selection. The causes of this breach of managerial responsibility have not been fully explained to date, and may await the completion of investigations by the Public Integrity Unit and State Auditor's Office. For now, it is enough to understand how the controversy unfolded — and how another can be prevented.

It is important that the Legislature recognize that the 21CT controversy had as much to do with the actions of individuals as it did with the contracting process. DIR's cooperative contracting process has been valuable to Texas state and local governments, but its current structure, particularly as it relates to purchase of services, is weak, providing little or no external or internal oversight. It can be improved, and we make recommendations to fix the program's problems without ending it.

HHSC also needs to make improvements in its procurement and contracting processes, and indeed significant changes are already under way. These changes, however, should not simply focus on preventing another 21CT contract. It is essential that they extend to other HHS contracts, particularly those involving the information technology infrastructure that ties agency programs together — or fails to do so — and the large contracts the agency uses to hire the vendors that provide outsourced services for the agencies.

Although the 21CT controversy and contracting generally received the lion's share of attention in recent months, we believe it is best viewed as a symptom of other problems within HHSC's management structure. OIG functions independently of HHSC's managers, as is appropriate for the inspector general role. We believe changes can be made in its current structure to put limits on that independence without eliminating it altogether. OIG's role in detecting fraud, waste and abuse is important; its recent execution of those responsibilities, however, has been damaging to the HHS system.

We believe, too, that good can come from bad. In this case, the 21CT controversy uncovered significant management issues within HHSC. Since the controversy first became public in November 2014, six individuals have left the agency or have been put on administrative leave. Many of these individuals were senior managers, a sure indicator of management problems.

When we arrived at the agency, we found it in a state of quiet turmoil. Our interviews indicated that communications between HHSC's upper management and the other HHS agencies had largely broken down. Staff members were frustrated and upset by the 21CT controversy and related internal issues.

The contracting issues at the center of this controversy can be resolved. The agency's organizational issues, however, are not so easily resolved, and certainly can't be resolved without a significant departure from the status quo.

While mistakes can be made at any time in any organization, the ultimate responsibility rests with agency leadership. Under the current management structure, the executive commissioner's span of control includes dozens of senior staff members, and requires him to juggle dozens of important tasks daily, including budget and hiring decisions; policy and strategy; and meetings with stakeholders, the other HHS commissioners, legislators, legislative committees and representatives of federal agencies. The executive commissioner had developed an informal "work around" for dealing with these issues by relying on an

informal “kitchen cabinet” that created an “us vs. them” environment among senior management and ultimately did not serve the executive commissioner’s needs well.

The structure makes the executive commissioner the linchpin to the effective operation of the HHS enterprise and puts him in a difficult position structurally. For the enterprise to succeed, he must succeed. In our view, this simply isn’t possible without significant changes either in management structure or in executive leadership.

HHSC has a good staff and vital responsibilities. What it lacks is a clear vision for its future and a strategic direction. HHSC’s role is changing. Given the rapid expansion of Medicaid managed care and other changes, a smooth transition from service delivery to strategic oversight is critical. We found little evidence of a path or plan for this transformation. Too often, HHSC’s decisions are reactive. While we were reviewing the agency, it was forced to issue an emergency contract worth hundreds of millions of dollars because it failed to plan adequately for a problem with the Medicaid claims payment process that was first identified in 2008, and that had been investigated by HHSC and the Attorney General as early as 2012. While emergencies happen in the best organizations, this issue raised serious questions about the agency’s internal functions.

Finally, we examined the issue of consolidation. In some ways, many of HHSC’s current problems spring from the HHS agencies’ execution of the 2003 consolidation. The Sunset report showed clearly that the consolidation of administrative services mandated by the legislation was never finished. The divided nature of HHSC’s organization, which includes oversight, Medicaid program operation and statewide eligibility determination, is another result of the agency’s response to the consolidation. It is clear now that the HHS agencies faced enormous challenges in responding to the 2003 legislation. While they succeeded in many instances, other aspects of this effort remain incomplete and problematic.

This raises a final issue addressed by the report, which is Sunset’s recommendation to complete the consolidation of the HHS agencies, combining the five current agencies into a single entity. The commission offered a clear vision for this consolidation and its intended purposes and timeline, but in our view, the agency is not prepared to execute it. It can be mandated, but it can’t be achieved successfully—at least not as quickly as the Sunset staff proposes. It may not be the right strategy for future success. HHSC needs the time to complete its last consolidation, get its managerial house in order and stabilize its procurement and contracting functions. It needs to open lines of communication within the agency and develop a coherent plan for the path forward. It needs time to plan, prepare and evaluate the options that it faces.

We also recommend that the Legislature and Governor consider the implications of consolidation. A strong case can be made that the public health and child and adult protective services functions, at minimum, should remain as separate agencies under HHSC oversight. These agencies perform vital services for the state’s citizens, and by nature differ from the social service programs that make up much of the rest of the enterprise. They will be more likely to attract and retain the sort of leadership they need as separate agencies rather than as two divisions within a “mega-agency.” The risk of neglect in such an agency is just too great.

In the end, careful and thoughtful planning is the best insurance against missteps in the case of an organization this vast. It will be far better to take more time to plan now than to find in another dozen years that, as Sunset concluded about the last consolidation, “the vision is far from complete.”

The strike force would like to acknowledge the timely and extensive cooperation we received in our work, from Governor Abbott and his staff, the Sunset Advisory Commission and the managers and staff of Texas’ health and human service agencies. At our first meeting with Executive Commissioner Janek and his executive team, he asked that everyone provide whatever assistance we asked and be fully candid in their answers to our questions.

To the degree that it is possible to be certain of anything, given the circumstances, we believe that we received full cooperation. Agency employees were uniformly helpful and candid in their comments, and we benefited greatly from their knowledge and suggestions. As is often the case, the people closest to a problem generally have the best ideas for fixing them.

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1 | “The Enterprise”

In 1991, the Texas Legislature created the Health and Human Services Commission (HHSC) effective at the beginning of fiscal 1992 to coordinate the delivery of state health and human services.¹ The commission’s creation was part of a larger consolidation of services previously delivered through 14 primary agencies and 11 others providing some health and human services-related functions. This initial consolidation combined these functions into 12 agencies overseen by HHSC.

The 2003 Legislature’s House Bill 2292 further consolidated Texas’ HHS functions, reducing the 12 agencies into five, again under HHSC’s leadership.² In addition to HHSC, the remaining agencies include the Department of Aging and Disability Services (DADS), Department of Assistive and Rehabilitative Services (DARS), Department of Family and Protective Services (DSPS) and Department of State Health Services (DSHS). The five agencies are known collectively as “the enterprise” within HHSC.

HHSC now has three distinct roles within Texas’ HHS system. The commission maintains strategic oversight over the other health and human service agencies. It also holds program responsibility for the bulk of the state’s Medicaid program, although some tasks are divided between the Department of State Health Services and the Department of Aging and Disability Services. Finally, it is responsible for system-wide eligibility determination. Thus, its focus is broadly divided among oversight, Medicaid policy and regulation, and operation of the eligibility determination system.

The Governor appoints an HHSC executive commissioner to oversee the enterprise. The executive commissioner in turn appoints commissioners for each of the other four agencies, and oversees HHSC’s day-to-day operations, including Medicaid administration and the approval of enterprise policies and rules.

The Governor also appoints a nine-member advisory council for each of the HHS agencies to assist the executive commissioner and each agency commissioner in developing policies; to provide a vehicle for public review and comment on rules; and to make recommendations regarding agency operations and management. These advisory councils, however, unlike other state boards and

¹ Tex. H.B. 7, 72nd First Called Sess. Available at: <http://www.capitol.state.tx.us/BillLookup/history.aspx?LegSess=721&Bill=HB7>. (The legislation took effect on September 1, 1991.)

² Tex. H.B. 2292, 78th Reg. Sess. Available at: <http://www.legis.state.tx.us/billlookup/History.aspx?LegSess=78R&Bill=HB2292>.

commissions, do not have decision-making authority. HHSC's executive commissioner ultimately approves all rules developed by the agencies and their councils.

All council members serve staggered, six-year terms with the Governor designating the chair. According to the Sunset Advisory Commission, in addition to these councils more than 95 other advisory committees and boards assist the system with advice and expertise.³

It is difficult to overstate the central role of health and human services in Texas state government. The five agencies employed an average of about 54,000 workers in fiscal 2014, or about 17.5 percent of the entire state workforce, including agencies and institutions of higher education.⁴ For the two-year 2014-15 biennium, HHSC and its companion agencies have an employment cap of 57,800 full-time equivalent positions (FTEs) and total all-funds appropriations of \$73.9 billion, or 36.9 percent of all state appropriations. This represented an increase of \$5.1 billion or 7.4 percent above the previous biennium.⁵

Funding for these functions has increased significantly since Texas began consolidating them. In fiscal 2014, Texas' health and human services function spent about \$41.7 billion, 41.8 percent of state All Funds spending, with more than half of the total coming from federal funding. In 1991, by contrast, the year preceding the first HHS consolidation, state spending on these functions totaled \$7 billion or 27.3 percent of state All Funds spending.⁶

The Sunset Report

During the recent legislative interim, the Sunset Advisory Commission (SAC) reviewed the state's HHS agencies for the first time since 1998, releasing its report on the Health and Human Services Commission and system issues in October 2014. SAC staff concluded that the goals of the 2003 consolidation have not been achieved:

...the vision of H.B. 2292 is far from complete. The problem is not with the concept of consolidation. Nor is the problem with the energetic, capable commissioners or the hard-working, dedicated employees at the agencies. The problem is with the nature of the system itself, and the incompleteness of its set up. The problem is that for whatever reason, the state did not finish the job.⁷

³ Texas Sunset Advisory Commission, *Health and Human Services Commission and System Issues: Staff Report with Commission Decisions*, December 2014, p. 13. Available at: https://www.sunset.texas.gov/public/uploads/files/reports/HHSC%20and%20System%20Issues%20Commission%20Decisions_Revised%20January%202015.pdf.

⁴ Texas State Auditor's Office, *A Summary Report on Full-time Equivalent State Employees for Fiscal Year 2014*, February 2015, p. 3. Available at: <http://www.sao.state.tx.us/reports/main/15-705.pdf>

⁵ Texas Legislative Budget Board, *Fiscal Size-Up: 2014-15 Biennium*, February 2014, p. 2, Available at: http://www.lbb.state.tx.us/Documents/Publications/Fiscal_SizeUp/Fiscal_SizeUp_2014-15.pdf. www.lbb.state.tx.us/Documents/.../Fiscal_SizeUp/Fiscal_SizeUp_2014-15.pdf.

⁶ Texas Comptroller of Public Accounts, "Texas Expenditures by Function - Fiscal 1978-2013 (All Funds, Excluding Trust)." Available at: http://www.texastransparency.org/State_Finance/Budget_Finance/Reports/Expenditures/by_Function/exp_end_hist.php.

⁷ Texas Sunset Advisory Commission, *Health and Human Services Commission and System Issues: Staff Report with Commission Decisions*, p. 1.

Not everyone agrees that the vision of H.B. 2292 was consolidation into a single “mega-agency,” nevertheless, Sunset staff recommended — and the commission eventually agreed — that HHS consolidation should be completed by the end of fiscal 2016, with the merger of the five remaining agencies into a single entity. The Sunset Commission also made other recommendations for improving HHS functions; significantly, in view of subsequent events, SAC was particularly critical of HHSC’s Office of Inspector General (OIG).

The Legislature created OIG in 2003, as a part of the H.B. 2292 reorganization. As a matter of law, OIG is a division of the Health and Human Services Commission, but as the Sunset report states, “organizationally and practically, OIG operates with a large degree of independence and separation.” This is largely by design; to free OIG from departmental conflicts, the law provides that the Governor appoints OIG’s inspector general to one-year terms, allowing for annual reviews of the official’s performance. At the time of Sunset’s recent review, Doug Wilson served as inspector general, having been appointed by Governor Rick Perry in 2011.

Sunset staff offered numerous recommendations for improving OIG’s operations, noting troubling management performance that raised concerns about possible abuses and a lack of transparency, among other issues. Members of the commission also were critical of OIG during hearings in November 2014. Among other recommendations, SAC staff proposed removing gubernatorial appointment and requiring the HHSC executive commissioner to appoint and directly supervise the inspector general; to require OIG, by rule, to establish priorities and other criteria for its investigation processes; and to place the office under Sunset review every six years.

In its response to the issues raised by Sunset, HHSC reported that it had taken steps “to identify and resolve deficiencies outlined in the report,” and that the agency’s Executive Commissioner Kyle Janek had established a team to conduct a management review of OIG to ensure “its policies and processes are fair, effective, and clearly communicated to providers.”⁸ The executive commissioner stated that he believed this review would fix many of the problems identified by Sunset and improve the office’s efforts to eliminate fraud, waste and abuse.

The special review has been completed and provided to the agency management for further action. Many of its recommendations mirror and elaborate on those already made by Sunset, and will, according to the new inspector general, provide a roadmap for improvements in OIG. However, before this internal review could even get under way, however, OIG management and procurement practices became the subject of intense public scrutiny and legislative and executive-branch concern.

The 21CT Controversy

This scrutiny began on November 29, 2014, when the *Austin American-Statesman* published an article raising questions about the handling of a contract between HHSC and an Austin-based data analytics company, 21CT. Specifically, the *Statesman* had uncovered a past business relationship between Jack Stick, HHSC chief counsel and former deputy inspector general for enforcement, and James Frinzi, a former contract lobbyist for 21CT. According to the *Statesman*:

⁸ The review is the responsibility of the HHSC internal auditor. A contract was issued to Navigant Consulting, Inc. to assist with this review via HHSC Task Order 16 under the general Medicaid consultant contract.

The state health agency's top lawyer, instrumental in steering more than \$110 million in contracts to an Austin tech company, is a former business partner with that company's lobbyist, state records show.⁹

This *Statesman* article followed earlier reporting on the relationship between OIG and 21CT conducted by the paper and Austin's KXAN television in the preceding summer. When 21CT initially refused to produce a copy of its "contract" with HHSC at the *Statesman*'s request, and eventually released a heavily redacted version of the purchase order for its services, reporters began to dig deeper into the issue.

The initial stories spurred a steady stream of additional reporting by the *Statesman*, the *Houston Chronicle*, the *Texas Tribune* and other news organizations. This reporting revealed, among other things, that 21CT's services had been procured using the Department of Information Resources (DIR) Cooperative Contracts program. Under this program, DIR establishes "master contracts," agreements with technology vendors based on legally required terms and conditions. These master contracts effectively allow sole-source purchases of technological goods and services from pre-qualified vendors with no competitive bidding other than the process DIR uses to select vendors for participation. HHSC's OIG thus did not competitively bid its 21CT agreement, raising further questions given the size of the original agreement and the much larger size of a pending extension last fall.

This reporting raised questions about HHSC procurement and contracting processes and cast a shadow over the agency and its work as the 2015 legislative session began. It also revealed that another HHS agency, the Department of Family and Protective Services, had issued a \$452,000 purchase order for 21CT's services on a child protection analytics solution pilot project in September 2014, and that Jack Stick had referred the company to DFPS.

The impact of this media reporting was felt both within and outside the organization, and the months of December and January saw continuing revelations in the news media about the HHSC-21CT relationship; announced investigations by the Travis County Public Integrity Unit and the State Auditor's Office; multiple resignations of HHSC staff; the introduction of legislation to tighten state contracting rules; a letter to state agencies from Governor Greg Abbott directing immediate changes in contracting practices; and the creation of this strike force.

The Strike Force

Even before assuming office on January 20, 2015, Governor-elect Abbott felt the need for an independent review of the issues surrounding the ongoing issues at HHSC to inform decision-making during the legislative session. On January 14, he announced the formation of this strike force to conduct its own performance review of HHSC, stating that:

In the wake of recent revelations at the Health and Human Services Commission, my transition team has taken steps to

⁹ J. David McSwane, "Texas health official who steered deals has ties to firm's lobbyist," *Austin American-Statesman*, November 29, 2014. Available at: <http://www.mystatesman.com/news/news/state-regional-govt-politics/texas-health-official-who-steered-deals-has-ties-t/njH4M/>

ensure there is a full and thorough outside review of management, operations and contracting at the agency.¹⁰

As the strike force came together, the Governor made it clear that he set no limits on the scope of its work. The strike force was free to pursue any relevant issues. With the legislative session in progress and critical decisions about the HHS enterprise already being discussed, strike force members concluded that it could best serve Governor Abbott, the agency and the Legislature by completing its analysis in a timely fashion for use during the regular legislative session.

As such, the strike force confined its review to management of the enterprise, contracting and related issues. This report is not a review of individual programs administered by HHSC except insofar as they factor into issues concerning HHS management and organization. The strike force's interest is in making recommendations that will ensure that controversies such as the current one are not repeated, and that the HHS agencies have the most effective governance structure possible to carry out the directives of the Governor and Legislature, including full consolidation of the health and human services agencies, if enacted.

This report, therefore, focuses on six issue areas the strike force believes are most critical to effective HHSC management. These include:

- the 21CT controversy
- the Office of Inspector General
- contracting in general
- HHSC organization and management
- consolidation of the HHS agencies
- vision and leadership

We envision these issues as a pyramid of concerns with 21CT representing the tip, an indicator atop a larger set of management and organizational issues (Figure 1).

The strike force's general conclusion, as supported by the following analysis, is that the 21CT procurement at the very least skirted the limits of permissibility under state procurement law and represented a case in which OIG executive personnel exercised judgment so poor that it put HHSC's credibility at risk. It also produced skepticism concerning state contracting and procurement policies in general that could affect the state for years to come.

Whether the 21CT procurement was in fact a useful technology has come to be seen as less important than the process of its selection. The causes of this breach of managerial responsibility have not been fully explained to date and may await the completion of investigations by the Public Integrity Unit and the State Auditor. For now, it is enough to understand how the controversy unfolded — and how another can be prevented. This is possible with some relatively easy fixes in state law and agency rules, and indeed, many of these fixes are under way.

Similarly, the strike force views 21CT less as a central problem for HHSC than as a symptom of larger management issues that have troubled the agency in recent years. A separate section of this report will describe these issues and their results, although again, some changes to correct the problems are already being made.

¹⁰ Edgar Walters, "Abbott Calls for Independent HHSC Review," *Texas Tribune*, January 14, 2015. Available at: <http://www.texastribune.org/2015/01/14/lawmakers-scold-health-agency-amid-contracting-fal/>.

FIGURE 1: HHSC Issue Pyramid



The report also discusses HHSC's overall procurement and contracting process. Although the amounts potentially involved in the 21CT controversy were large — up to \$110 million, although only a fraction of that amount was ever paid to the vendor — they raise even larger concerns about other contracting failures the agency has experienced in recent years. These problems go far beyond an isolated case of bad judgment and lax procedures, and fixing them will be a significant challenge. In the end, it is imperative that the weaknesses we have identified be addressed if the agency is to deal effectively with its critical mission, and most certainly if there is to be any prospect of a successful further consolidation of HHS functions along the lines recommended by the Sunset Advisory Commission.

In fact, the strike force's analysis raises serious questions about the further consolidation of health and human services functions, particularly under the accelerated schedule envisioned by Sunset staff. The strike force believes it would have a deleterious effect on the HHS agencies, their programs and the Texans who depend on them.

This is not to imply that some useful reorganization is impossible. It is merely to suggest that there may be better approaches to achieving the Sunset Commission's goals, given what the strike force has learned about HHSC since the 21CT controversy first became public. SAC did not have the benefit of this knowledge, and it is important that recent events inform the decisions to be made concerning the future direction of the HHS enterprise.

Finally, the strike force would like to acknowledge the timely and extensive cooperation we received in our work, from Governor Abbott's staff, the Sunset Advisory Commission and the managers and staff of Texas' health and human service agencies. At our first meeting with Dr. Janek

and his executive team, he asked that everyone provide whatever assistance we asked, and be fully candid in their answers to our questions. To the degree that it is possible to be certain of anything, given the circumstances, we believe that we received full cooperation. Agency employees were uniformly candid in their comments, and we benefitted greatly from their knowledge and suggestions. As is often the case, the people closest to a problem generally have the best ideas for fixing them.

The goal of this report, along with recommendations we feel could help the commission carry out its responsibilities more effectively, is to put the events of recent months into context — and to explain as clearly and fully as possible how the situation arose and what its broader implications are. The challenge has been that circumstances are evolving at a rapid pace, as HHSC and lawmakers respond to the unfolding story. Changes have already been made to strengthen the organization, and the OIG review team, State Auditor’s Office and HHSC management will certainly identify others. On many of the key points, all of the investigators are likely to agree, although the conclusions they draw from the facts may differ.

2 | The 21CT Controversy

One of the strike force's first goals was to determine the facts behind the 21CT procurement. We began by assembling a timeline of events and interviewing HHSC staff and others to gather information on the issue. After several weeks of interviews and reviews of documents related to the matter, we are better able to explain *how* the episode occurred than to explain *why* it happened. Some of the key players are no longer employed at HHSC, and ongoing investigations by the Travis County District Attorney's Public Integrity Unit and the State Auditor have far greater latitude to probe into the relationships that created this situation.

Nevertheless, our conclusion, based on the best available information, is that the 21CT situation had as much to do with HHSC's organizational structure and management relationships as with its procurement processes, although all should be improved.

The Office of Inspector General and Medicaid Fraud

The issue of Medicaid fraud lies at the center of the 21CT controversy. This concern is hardly new in Texas or the U.S. as a whole, and in fact predates the creation of the Health and Human Services Commission. Twenty years ago, one of the Texas Comptroller's biennial performance reviews recommended the creation of a Medicaid fraud task force with representatives of the Department of Human Services, the Comptroller's office, the State Auditor's Office, the Department of Public Safety and the Office of the Attorney General, which "would allow DHS to draw upon the expertise of other state agencies to help improve the efficiency of fraud investigation and collections."¹¹

Eventually, fraud prevention efforts in the 1990s led to the procurement and the first application of the "neural net" technology to Medicaid fraud detection, a successor of which, the Medicaid Fraud and Abuse Detection System (MFADS), went live in 1997 and is still used today.¹²

The state's interest in analyzing and understanding the vast amounts of data flowing through its HHS system has grown over time. One outgrowth of this interest is the idea of creating an enterprise data warehouse (EDW), a database housing a variety of information that would allow the system to draw connections between different data sets, leading, it is anticipated, to savings and improved services. The Legislature first considered the idea in 2005 and funded it in 2007, calling for the warehouse to be operational by February 2009.

Because of federal funding issues and other delays, however, the project fell behind schedule. It wasn't until 2010 that HHSC began looking for companies to carry out the data warehouse project, and the agency didn't hire a dedicated chief data officer until early 2014. It did, however, initially identify two teams of companies with experience in this area. Eventually the EDW procurement, which has not yet occurred, came to play a role in the 21CT controversy.

¹¹ Texas Comptroller of Public Accounts, "Establish a Public Assistance Fraud Oversight Task Force," *Gaining Ground*, Volume 2, November 1994.

¹² Hewlett-Packard, "Capability Fact Sheet: Prevent Medicaid Abuse," October 2013. Available at: <http://www8.hp.com/h20195/v2/GetPDF.aspx%2F4AA2-8246ENW.pdf>.

In the meantime, the organization of the HHS agencies and the investigation of Medicaid fraud continued to evolve. When the agencies were reorganized in 2003, the HHSC Inspector General was created and given overall responsibility for preventing, detecting and investigating fraud, waste and abuse throughout the HHS system.¹³

The OIG occupies a position unique in Texas state government. While in law the OIG is a division of HHSC, in practice the office operates with a large degree of independence, reporting to the Governor rather than the HHSC executive commissioner. The Sunset staff report accurately characterizes the office as an “administrative attachment” to HHSC, acting independently from the agency while functioning within it. Other inspector general offices, such as the Inspector General for the Texas Department of Criminal Justice, answer either to the agency board or executive director.

The idea behind OIG’s independence is sound, and grounded in practices used by the federal government and several other states. It’s intended to allow the office to conduct its investigations without interference, reporting only to the state’s chief executive officer. The problem is that the Governor has an enormous range of responsibility, making effective routine monitoring of OIG difficult.

Because of its day-to-day independence, OIG has a history, which was described in several interviews, of ongoing tension with the agency proper — not on the central issue of fraud and waste detection, but on its adherence to internal policies related to procurement, human resources and the like. The 21CT controversy is, in part, a direct outgrowth of this loose and sometimes dysfunctional relationship.

This uneasy relationship was simply a fact of life at HHSC. From its creation until the 2014 Sunset review, OIG had not been the subject of a detailed external review, although the State Auditor’s Office did recommend some improvements in a 2006 report.¹⁴ The 2014 Sunset report notes that OIG conducted 103,618 investigations, reviews and audits in fiscal 2013. It also concludes that the office was relatively inactive prior to 2011, having “never brought a case before the State Office of Administrative Hearings and both identification and recovery of overpayments to providers were considerably less than they are now.”

The upswing in OIG activity in 2011 may be related to multiple factors, but it closely coincided with the appointments of Doug Wilson as inspector general and Jack Stick as deputy inspector general for enforcement. According to the *Texas Tribune*, in a July 2012 article:

When Douglas Wilson took over as HHSC’s inspector general last year, he approached the job from an accounting background. Traditionally, he said, the division had operated like a law enforcement agency, performing lengthy investigations to get cases ready for criminal prosecution. Instead, he wanted to halt the flow of financing to questionable providers at the first sign something was amiss.¹⁵

¹³ Tex Gov’t Code §531.102(a).

¹⁴ Texas State Auditor’s Office, *An Audit Report on the Office of Inspector General at the Health and Human Services Commission*, November 2006. Available at: <http://www.sao.state.tx.us/reports/main/07-004.pdf>.

¹⁵ Emily Ramshaw, “In Medicaid Fraud Investigations, a Controversial Tool,” *Texas Tribune*, July 20, 2012. Available at: <http://www.texastribune.org/2012/07/20/medicaid-fraud-investigations-controversial-tool/>

OIG's increased enforcement activity, Sunset reports, "also brought increased attention and scrutiny from the public on OIG's processes and results."¹⁶ The increased scrutiny was a result of increased controversy. According to the *Texas Tribune* article:

OIG's dollar-recovery strategy — which includes an increased reliance on a rule that allows investigators to freeze financing for any health provider accused of overbilling — has enraged doctors, dentists and other providers who treat Medicaid patients. They say an anonymous call to a fraud hotline or a computer-generated analysis of a handful of billing codes is enough to halt their financing without so much as a hearing, jeopardizing their practices and employees and leaving thousands of needy patients in a lurch while the state works to prove — or rule out — abuse.¹⁷

The strike force was told that, during this period, many vendors were "pitching" new Medicaid fraud detection solutions as superior to anything the agency currently had, presumably meaning MFADS. Many of these products, however, were too new and unproven to be purchased based on their advertised benefits alone. Instead, HHSC allowed vendors to do a "proof of concept," in which they would apply their solution to selected agency data, and the agency would evaluate the result. It was, in effect, a form of market research by HHSC, freely open to all vendors. The agency did not guarantee that any particular product — or indeed, any product at all — would be procured. The goal was to eventually issue a competitively bid request for proposal (RFP) for fraud detection services and technology.

Not long before becoming involved with 21CT, OIG had been courting two qualified vendors with experience in Medicaid fraud detection, but, shortly after Wilson became inspector general and Stick joined OIG as deputy inspector general for enforcement, 21CT completed the necessary paperwork to become eligible to provide services in this area — and was quickly selected for the job.

Stick first met with 21CT in an official capacity in July 2011, a month after joining HHSC. It was later revealed in news reports that Stick met 21CT's CEO Irene Williams in 2007, during a business meeting between 21CT and AutoGov Inc., Stick's former employer and a company doing business with the state at the time.¹⁸

In an undated audio recording from 2011 (possibly October) — Stick stated that OIG was applying for a federal grant to buy the most "advanced pattern recognition software in the world" and hoped to complete the procurement "no later than after the first of the new year." Stick said the company, which he did not name, "wants to work with us and is making this really affordable for

¹⁶ Texas Sunset Advisory Commission, *Health and Human Services Commission and System Issues: Staff Report with Commission Decisions*, p. 129.

¹⁷ Emily Ramshaw, "In Medicaid Fraud Investigations, a Controversial Tool," *Texas Tribune*, July 12, 2012. Available at: <http://www.texastribune.org/2012/07/20/medicaid-fraud-investigations-controversial-tool/>

¹⁸ Terri Langford, "A Look Back at the Health Commission-21CT Contract," *Texas Tribune*, February 3, 2015. Available at: <https://www.texastribune.org/2015/02/03/21ct-health-commission-recap/>

us.”¹⁹ Whatever the intended nature of the comment, it left a clear impression that in the space of only a few months on the job, Stick had identified and tentatively selected a specific vendor to assist OIG with its fraud detection mission.

A few months later, on March 19, 2012, Stick made a presentation to a webinar sponsored by the National Conference of State Legislatures in which he discussed several OIG initiatives. In the presentation, Stick said that OIG was implementing a revolutionary tool, “graph pattern analysis,” to help Medicaid fraud investigators, calling it “the next line of defense for this office.”²⁰ He also described improvements that had been made in OIG’s internal processes to increase productivity and completion rates.

Graph pattern analysis was a featured selling point of 21CT’s technology, and Stick’s presentation offers a fairly detailed description of how it works. The presentation does not, however, mention 21CT or, more importantly, the fact that OIG had not yet contracted for this technology with anyone, including 21CT. At that point, HHSC was still seeking federal funding for the project, which was not approved until fall 2012.

On August 10, 2012, HHSC submitted an advance planning document (APD) requesting federal financial participation “to implement a comprehensive fraud case management software toolset in support of its Fraud, Waste and Abuse reduction initiative.”²¹ In the APD, the agency laid out the case for the fraud detection toolset and case management system:

Currently, the systems and processes within HHSC OIG are built around a complaint-based investigative process. The addition of active analytic tools to identify fraud as it happens represents a significant paradigm shift towards a more aggressive approach to recovering taxpayer money lost to Medicaid fraud and abuse.²²

The APD also described how it went about selecting its vendors, listed as 21CT with case management software from IBM through 21CT:

After more than a year of evaluating various proposals and technologies, HHSC OIG determined that no single approach can entirely capture the scope and breadth of waste, fraud and abuse in the Medicaid system. Based on identified needs,

¹⁹ Andrea Ball and J. David McSwane, “Questionable Texas Contract Deal was Years in the Making,” *Austin American-Statesman*, December 14, 2014. Available at: <http://www.mystatesman.com/news/news/state-regional-govt-politics/questionable-texas-contract-deal-was-years-in-the-njXw8/#6cdd073c.3930337.735647>.

²⁰ J. David McSwane, “How one Texas official directed millions to Austin tech firm 21CT,” *Austin American Statesman*, December 13, 2014. Available at: <http://www.mystatesman.com/news/news/state-regional-govt-politics/how-one-texas-official-directed-millions-to-austin/njRy8/>

²¹ Letter from Billy Millwee, HHSC associate commissioner for Medicaid/CHIP and state Medicaid director, to Bill D. Brooks, associate regional administrator, Division of Medicaid and Children’s Health Centers for Medicare & Medicaid Services, “APD: HHSC OIG: Fraud, Waste, and Abuse Reduction Initiative - Graph Pattern Analysis and Fraud Case Management Software,” August 10, 2012.

²² State of Texas, Health and Human Service Office of Inspector General, Advance Planning Document, “Fraud, Waste, and Abuse Reduction Initiative: Graph Pattern Analysis and Fraud Case Management Software,” submitted to Centers for Medicare and Medicaid Services, Region VI, August 2012.

HHSC developed a Statement of Work it used to initiate a search via Texas' existing collective purchasing vehicle managed by the State Department of Information Resources (DIR). HHSC OIG reviewed several vendors via a competitive, best value procurement which provided the Statement of Work to vendors with offerings within specific standard industry classifications.²³

However accurately the APD described the competitive nature of the DIR procurement process, HHSC received federal approval on September 26, 2012.

On October 30, 2012, Stick sent a memorandum through Doug Wilson to Executive Commissioner Janek, requesting his approval of a Business Associate Agreement, which sets terms for accessing confidential HHSC data, with 21CT.²⁴ Janek approved and OIG finally reached an agreement to secure 21CT's fraud detection product and case management system, at the time called the LYNXeon Graph Pattern Analysis Fraud Solution, in December 2012.

On December 14, Stick forwarded a brief action memo through Wilson to the executive commissioner, who approved it shortly thereafter. The memo says that the system is "designed to modernize the entire OIG case processing system using analytics as the cornerstone of an investigative process," and that "OIG intends to dramatically expand its case identification methods with graph pattern analysis."²⁵ The price for the system is given as \$19,688,341. The document does not explain how the system would be procured or provide the source of funding, although it identifies 21CT and LYNXeon.

After the executive commissioner's approval, HHSC issued the first purchase order for the system on December 19, 2012, in the amount of \$15,564,024. Doug Wilson later told reporters that OIG "began flowing more than 2.7 terabytes of data into Torch," the Medicaid fraud version of the LYNXeon product, in January 2013.²⁶

A request to continue funding the 21CT project was sent to Executive Commissioner Janek on September 10, 2013, and was approved. A subsequent purchase order for \$4,335,202 was issued on September 26, 2013. The two purchase orders account for the full \$19.7 million originally budgeted for the project. At this writing, almost all of these funds have been expended.

These two purchase orders and a subsequent extension of the procurement lie at the center of the issues that followed. They represented a substantial amount of public money being paid to a small company new to the Medicaid fraud arena. 21CT previously had been a defense contractor, acquiring business as a participant in the U.S. Small Business Administration 8(a) Business Development Program. In addition, 21CT was a federally certified Small Disadvantaged Business

²³ According to internal HHSC documents, the actual case management installation was subcontracted to BP3, an Austin-based provider of business process management software.

²⁴ Memorandum from Jack Stick through Doug Wilson to Executive Commissioner Kyle Janek, "Business Associate Agreement for 21st Century," October 30, 2012.

²⁵ Action Memorandum from Jack Stick through Doug Wilson to Executive Commissioner Kyle Janek, "PRF #2000110854-21CT – LYNXeon Graph Pattern Analysis Fraud System Solution Purchase," December 14, 2012.

²⁶ J. David McSwane, "With New Tech, Texas Looks to Crack Down on Medicaid Fraud," *Austin American-Statesman*, August 10, 2014. Available at: <http://www.mystatesman.com/news/news/crime-law/with-new-tech-texas-looks-to-crack-down-on-medicaid/ngyyH/#12183eea.3930337.735647>.

(SDB). Stick has contended that, after seeing a demo of the 21CT analytical product, it was clear to him that it was what OIG needed.

The company, however, had not gone through the proof-of-concept methodology developed for testing competing Medicaid fraud solutions. Thus OIG ignored the potential value of similar technologies offered by competing vendors that had completed proofs of concept — and, for that matter, the notion of improving MFADS, the technology already in place.

This is not, however, how OIG portrayed the situation to the executive commissioner in an October 27, 2014, briefing memorandum. According to the memo, which recaps a briefing of the executive commissioner and other senior staff:

In 2012, HHSC-OIG determined that a more appropriate response to the ever-changing schemes and artifices to defraud required an adaptable, multi-pronged, overlapping approach that provided internal validation of discoveries while also permitting a rapid response to identify patterns, behaviors or schemes. In support of this approach, HHSC-OIG conducted significant research to determine the best solutions to address undetected ‘suspected’ fraud.... In October 2010, HHSC-OIG and the Medicaid/CHIP Division (MCD) began the process of identifying various solutions which could provide the needed services to assist with fraud detection. More than a dozen potential solutions for detection of waste, fraud and abuse were identified with HHSC-OIG evaluating several proof of concept processes.²⁷

Companies said to have completed these proofs of concept included Reflective Medical (RMIS), HealthCare Insight (HCI), LexisNexis, SAS and 21CT. No interviewee, however, recalled 21CT participating in the proof-of-concept protocol.

OIG’s procurement method, moreover, allowed it to award the contract without soliciting other bidders that might have produced a better price or better product. The October 27 memo, which dealt with an extension of 21CT’s services through fiscal 2015, does state that OIG “utilized the Department of Information Resources (DIR) cooperative contracts (co-op contracts) program to secure the services of 21CT.” It briefly describes the co-op program, indicating that the “contracts are competitively bid and comply with all state purchasing requirements.” That is true but disingenuous, given how the DIR contracts actually work.

Interviews with HHSC staff indicate that Jack Stick rather than Doug Wilson was the key decision maker on 21CT even after becoming chief counsel and certainly as deputy inspector general. One probable motivation of foregoing the normal HHSC procurement process was almost certainly the avoidance of bid solicitation, which would have taken months longer to complete. Stick later said that he did not know much about procurement at the time and sought help from HHSC’s Procurement and Contracting Services Division (PCS). One staff member who worked on

²⁷ Memorandum from Doug Wilson to Kyle Janek, “21CT – Torch Graph Pattern Analysis Fraud Solution Continued Funding Through State Fiscal Year 2015,” Event/Meeting Briefing and Decision Summary, October 27, 2014. Jack Stick was not involved in this memorandum, presumably because he had, by this time, become HHSC Chief Counsel.

the 21CT project told us that “Jack had a tremendous amount of contacts. He used them to circumvent process — to go around the bureaucracy.”

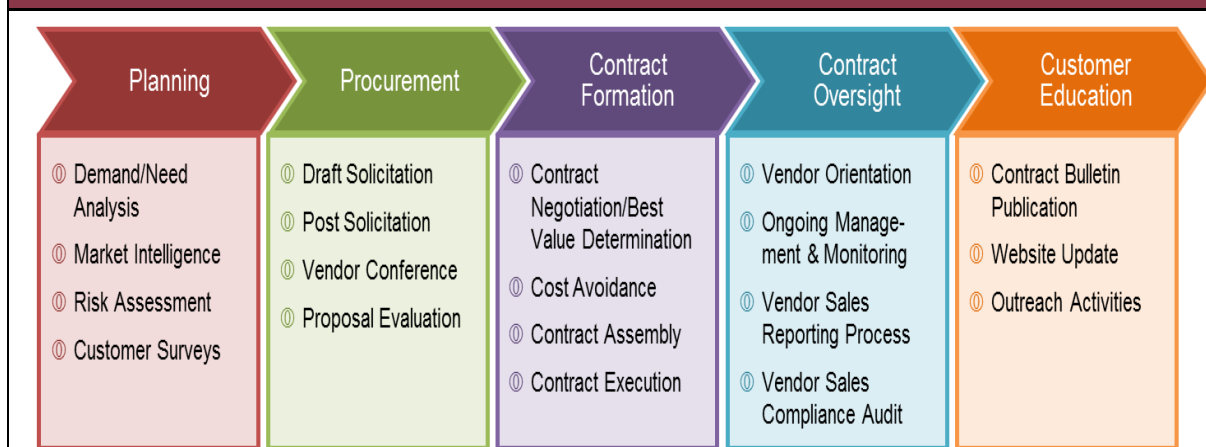
Stick was also assisted by OIG’s unusual position within the HHSC organizational structure. Its curious status, both a part of and separate from HHSC, offered the freedom needed to pursue the purchase through an unorthodox methodology that, given the size and complexity of the contract, might have raised more questions if proposed by another part of HHSC or if reviewed in advance by HHSC’s Information Technology Division.

Cooperative Contracts

The vehicle selected for the 21CT procurement was the DIR cooperative contracts program (Figure 2). DIR manages this program on the state’s behalf under legislation enacted in 2005.²⁸ It provides more than 750 cooperative purchasing contracts for technology products and services including hardware, software, staff augmentation services, maintenance and other related services with high customer demand, such as managed services and technology training. In addition to state agencies, it is available to local governments, school districts, universities and other publicly funded entities, including other state governments. On each transaction, DIR collects a small administrative fee which is used as part of the agency’s method of finance.

The cooperative contracts program is used for more than \$2 billion in purchases each year. Many of these purchases are relatively small — well under \$1 million — although DIR staff members say that procurements as large as the \$19.7 million initial 21CT purchase are not unknown. These contracts generally are considered to be for “commodities,” although the commodities being bought can include software, hardware, labor and other services.

FIGURE 2: DIR Cooperative Contracting Process



Source: Texas Department of Information Resources.

²⁸ Tex. Gov’t Code §§2157.068, 2157.006 and 2157.003; and Tex. Admin. Code Title 1, Chapter 212.

Under this program, DIR awards “master” contracts “through an open and competitive procurement process, beginning with a formal and public Request for Offers (RFO).”²⁹ Once DIR awards a master contract, agencies can make purchases under the master contract without further competitive action, although DIR says that agencies can “request quotes or Statements of Work from multiple MCs [master contracts with individual vendors] if they feel it is necessary or appropriate for a specific transaction.”

The program determines the structure and scope of individual contracts and establishes terms of use for vendors. Eligible entities can contact vendors qualified under the program for product and pricing information and send purchase orders and payments directly to the vendor. DIR contract managers monitor the volume of use of vendor contracts and sales reports, requiring vendors to submit sales reports by the 15th of each month reflecting their sales activity during the prior month. DIR does not have statutory authority or the staffing levels to manage agencies’ use of its contracts, although purchasing agencies must follow the same procurement and ethics laws and rules as DIR.

In using the cooperative contract program to buy 21CT’s services, OIG was not technically making a sole source or no-bid purchase, since DIR competitively selects vendors for its cooperative contracts. The action did, however, come about as close to being a sole-source procurement as possible while still claiming to employ a competitive process.

DIR’s master contract used for the 21CT procurement was for “information technology security services.”³⁰ DIR staff told the strike force that fraud prevention could fit broadly under the contract as structured, although, again, DIR does not oversee the use of its contracts by customers. They also said that the LYNXeon technology does have some use in the information security arena and had been reviewed by DIR for possible use in its own processes, although it was not purchased.

The 21CT statement of work in the purchase orders, critical to an effective contractual relationship between the state and a vendor, was a six-page document which outlined three work phases and the deliverables in those phases, including hardware, site licenses, software, fraud detection support, training and a case management solution.³¹

Due to its flexibility, the cooperative contract program is popular and useful for state agencies and local governments. In particular, it allows smaller agencies to take advantage of competitive pricing, and is a faster way to purchase routine IT goods and services than a request for proposals process.

Here, though, an important distinction should be made — that between tangible commodities and services. “Commoditizing” services introduces an element of risk not generally present in the purchase of tangible goods. Where goods are concerned, the situation is fairly clear-cut: the product either works as advertised or doesn’t. With service purchases, there is always a possibility that the service will be workable but ineffective, or present other significant problems. This element of increased risk requires an element of increased contract detail and oversight not present under the cooperative contracts program.

²⁹ Texas Department of Information Resources, “21CT, HHSC, and DIR Cooperative Contracts.” Available at: <http://dir.texas.gov/View-About-DIR/FAQs/Pages/Content.aspx?id=27#1>.

³⁰ Texas Department of Information Resources, Contract No. DIR-SDD-1863.

³¹ 21CT, “LYNXeon Graph Pattern Analysis—Statement of Work,” undated, signed by Irene Williams.

Despite the idea that the process is competitive, it is surprisingly easy for vendors to qualify for the program. The *Houston Chronicle* reported in January 2015 that nearly three-quarters of all companies that applied for inclusion in the program were accepted; a rate the DIR interim executive director told the Senate Finance Committee is too high during testimony on January 30. As the *Chronicle* reported:

While the program is supposed to be competitive, records show it has allowed most applicants into the catalog, raising questions about whether it is really forcing firms to offer low prices. Some critics say it also calls into question whether the program provides a blank check to officials to give business to anyone they want.³²

Moreover, citing its lack of legal authority and resources, DIR has chosen not to review the appropriateness of agencies' use of its contracts. Its oversight is limited to a review of monthly sales to verify that prices being offered are consistent with the terms it has negotiated and that the individual vendor contracts are being used. Essentially, agencies' use of master contracts is monitored only by the agencies themselves — and, informally, by vendors who sometimes report procurements they feel are unfair or non-competitive.

The cooperative contracting program allowed OIG to contract directly with 21CT without the time and effort involved in a true competitive bid process. While it is possible to argue that 21CT's services are unique, interviews with other vendors — and information given to the executive commissioner on at least one occasion — show that many offer fraud detection software and services and that, in some cases, this technology has already been used successfully in other states' Medicaid fraud detection efforts.

The most obvious example is the Hewlett-Packard MFADS system already used by HHSC. In a vendor fact sheet, HP claims that its MFADS product provides detection, investigation, case management and analysis tools; identifies unknown schemes through sophisticated data mining, rules-based logic and state-of-the-art neural network predictive modeling; integrates data from multiple sources for a customized data warehouse built to client specifications; and enables immediate desktop access to data through data queries and viewing results from targeted detection queries and predictive models.³³ In short, MFADS is very similar conceptually to 21CT's offering, other than the case management feature 21CT planned to obtain from IBM.

We found that the use of DIR master contracts is not unusual at HHSC. Its deputy executive commissioner for Procurement and Contract Services told us that the agency has made such procurements in the past, although they were usually for specific IT commodities. What separated the 21CT procurement from those is its complexity.

Also problematic is the fact that OIG's approach made it possible to avoid review by the HHSC Information Technology Division. The deputy executive commissioner who oversees the division told the strike force:

³² Brian Rosenthal, "Popular State Purchasing Program Lacks Oversight, Competition," *Houston Chronicle*, January 30, 2015. Available at: <http://www.houstonchronicle.com/news/politics/texas/article/State-purchasing-program-not-as-competitive-as-6052742.php#0>

³³ Hewlett-Packard, "Capability Fact Sheet: Prevent Medicaid Abuse," HP Medicaid Fraud and Abuse Detection System. Available at: <http://www8.hp.com/h20195/v2/GetPDF.aspx%2F4AA2-8246EEW.pdf>

The first time I heard of 21CT was when the award was made. We raised issues about the need for an Advanced Planning Document [required on federally funded projects] and started to talk in detail about the location and services and so on — and then they just went dark.

Many HHSC executives and staff interviewed by the strike force were similarly in the dark, and said that what they knew of the 21CT controversy came mainly from the news media. In an agency of HHSC's size, this isn't entirely unexpected, although it is somewhat remarkable given the publicity that OIG and the system had received between 2012 and the summer of 2014. Executive Commissioner Janek knew of the project and told the strike force that, based on the information provided to him, he believed it offered an innovative solution. He also said he had no clear understanding of exactly how 21CT's services were obtained until much later.

Also unusual was the nature of what OIG was buying. The purchase orders issued to 21CT were thin on details, making the procurement sound like a software and hardware installation and put a gloss on what would prove to be a major project, although the statement of work was more detailed. The purchase order says that:

21CT is capable of rapid installation and deployment of the pattern recognition software and supporting hardware, and can identify, integrate and implement a case management system that will service to enhance OIG's overall effectiveness.

This description does not precisely capture what OIG was in fact purchasing.

What OIG was buying was a service — graph pattern analysis — supporting 21CT hardware, fraud detection expertise, training and a case management system. (A case management system is software that allows users to manage information on cases, including contacts, calendars, documents and other specifics, through automated recordkeeping.) It also appears likely that OIG was effectively paying for application development, since it is not at all clear that 21CT's product was fully developed for use in Medicaid fraud detection prior to the initial purchase order — hence the change in the product's name, from LYNXeon to Torch, as it developed over the course of the contract agreement. In addition, 21CT did not have an existing case management solution and acquired it separately.

OIG was, in effect, outsourcing a significant portion of its fraud detection responsibility and wrapping a significant number of services, software and hardware purchases into a single licensing arrangement under which the agency was charged a single “blended” rate. OIG was not, however, acquiring the actual software for fraud detection, a fact that later would come to have significant implications. HHSC staff reports that the federal Centers for Medicare & Medicaid Services commented at the time that it had never seen a similar procurement, although it was not necessarily a prohibited use of federal funds — at least given the terms described in the October 2012 advanced planning document.

Another issue with the 21CT agreement is what it covered. While the services, hardware and labor fit the DIR contract used for the procurement, the case management software did not. It was outside the scope of the contract, according to interviews with DIR staff. As such, it should have

been procured separately. Again, however, contract oversight effectively falls to the entity making the purchase.

DIR did not question the validity of the purchase because its oversight focuses exclusively on making sure that vendors report their sales as the law requires. It is clear in retrospect that this loophole could, under the right conditions, allow an agency to buy a number of services not covered by contractual agreement or competitive bid. Vendors and DIR alike told us that the appropriateness of purchases made under master contracts is monitored mainly by the vendors themselves, who will often object to a contract awarded to a competitor if they believe it is questionable.

The contract also escaped oversight by the state's Quality Assurance Team (QAT). The QAT, charged with overseeing major information resource development projects, includes representatives of the Legislative Budget Board, the State Auditor's Office and the Department of Information Resources.

A "major information resource development project" under the QAT process is defined as one identified in a state agency's *Biennial Operating Plan* whose development costs exceed \$1.0 million and that requires one year or longer to reach operational status; involves more than one agency; or substantially alters the work methods of state agency personnel or delivery of services to clients.³⁴ In addition, the Legislature may designate a project for QAT monitoring in the General Appropriations Act.

In this case, the QAT decided the project did not constitute a major information resource development project because they believed it was, in essence, a purchase of services and hardware, and therefore not the sort of development project QAT normally monitors.

Finally, we believe the use of federal funding for the project, which provided \$17.3 million of the original cost of \$19.7 million covered by the first two purchase orders, represents significant issues. CMS has promulgated several regulations governing a state's use of Medicaid funds to acquire "automated data processing" equipment and services, including software. CMS approves of non-competitive purchases in only four situations:

- (1) The item is available only from a single source;
- (2) public exigency or emergency will not permit the delays involved in competitive solicitation;
- (3) CMS authorizes noncompetitive negotiation; or
- (4) after solicitation of a number of sources, offerings are found to be inadequate.³⁵

The 21CT procurement was not an emergency, or at least not one established as such, and based on the existence of MFADS and the proof-of-concept protocol established to test Medicaid fraud detection solutions, it is clear that 21CT was not the sole source for this capability. It is a type of product with several nationally known vendors.

³⁴ Tex. Gov't Code Chapter 2054; and Texas 2014-15 General Appropriations Act, Article IX §9.02, Quality Assurance Review of Major Information Resources Projects.

³⁵ 45 C.F.R. §92.36.

Questions Are Raised

Once HHSC purchased 21CT's solution, little was heard about it until last year. Stick continued to be involved in the project, although he was promoted to HHSC interim chief counsel in March 2014 and eventually to chief counsel on a permanent basis. Interviews with HHSC staff indicate that he did not separate himself from the 21CT project. He continued to play a major role in its supervision and was involved with OIG's decision to extend and expand the agreement for fiscal 2015 and beyond.

In August 2014, the OIG found itself back in the news media regarding its fraud detection efforts, although initial reporting was favorable. An August 3, 2014, report on Austin's KXAN television reported briefly on OIG's fraud efforts and 21CT's fraud detection product, now called Torch. "Torch will collate state data around the clock," the report said. "The system will monitor frequency of claims, the size of claims and any funny patterns or anomalies." It noted that 21CT, which had begun receiving state data for use in Torch in January 2013, had grown to 100 employees, "most of them devoted to the crackdown" on Medicaid fraud.³⁶

An August 10, 2014, article in the *Austin American-Statesman* again focused on 21CT and Torch, and its use in cracking down on Medicaid fraud. According to the article, "Texas is leading the way... with new software that officials say has already helped identify more than \$42 million in Medicaid fraud that would have previously gone unnoticed." The piece described the Torch system generally, and quoted 21CT CEO Irene Williams as saying, "People look up to and admire what the state of Texas is doing. It's becoming the model."³⁷

It is possible that both of these stories were encouraged by 21CT itself, but if so, the results were not what the company may have intended. At some point following this article, a *Statesman* reporter asked 21CT for a copy of its state "contract." 21CT refused to produce it and eventually sued HHSC to prevent its release under the Public Information Act. The company eventually released a heavily redacted version of the purchase order, which led to further investigation by the *Statesman* and eventually by other news organizations.

Other significant events in 2014 would have an effect on subsequent developments. On February 25, 2014, OIG submitted an "Advance Planning Document—Update" (APDU) to CMS, requesting funding to complete both the 21CT graph pattern analysis system and the case management system during an additional 36-month time period. A later document OIG submitted to the HHSC executive commissioner requested matching funds and indicated that approval of the APDU was:

...specific to the 21CT proprietary solutions and technology for both Torch and the Case Management System. In the event HHSC opts to deviate from the CMS-approved APDU,

³⁶ David Scott, "Austin Company Leads Medicaid Fraud Crackdown," KXAN-Austin, August 3, 2014. Available at: <http://kxan.com/2014/08/03/austin-company-leads-medicaid-fraud-crackdown/>.

³⁷ J. David McSwane, "With New Tech, Texas Looks to Crack Down on Medicaid Fraud," *Austin American-Statesman*, August 10, 2014. Available at: <http://www.mystatesman.com/news/news/crime-law/with-new-tech-texas-looks-to-crack-down-on-medicaid/ngyyH/#d1a4ebc3.3930337.735651>.

HHSC will be required to submit a new APDU to CMS for review and approval.³⁸

On September 26, 2014, CMS approved the APDU and its funding through fiscal 2017.

In the meantime, on June 13, 2014, HHSC announced a tentative contract award for its long-delayed enterprise data warehouse project to Truven Health Analytics Inc. On September 5, 2014, however, HHSC gave formal notification that the procurement was cancelled. HHSC said it would be re-evaluating the need for the project and expected to re-solicit for the service at a later date.³⁹ This cancellation followed an internal HHSC meeting on August 18 that, ostensibly, was intended to decide on how to move forward on the data warehouse project. During this meeting, Stick is reported to have remarked that 21CT might be able to provide these services, although the company had not bid on the project.

Following this meeting, Truven contacted an HHSC staff member to ask about the meeting. Some weeks later, agency officials pulled down the contract, raising concerns about its cost and suggesting that a staff member had divulged information about the meeting to Truven. “Nobody in that room should have taken that conversation out of there and called the vendor,” the executive commissioner was later quoted as saying. “Somebody in the agency was way too cozy with a vendor, and I cannot sit still for that.”⁴⁰

Subsequently, an employee was fired as a result of the incident. Ultimately, Executive Commissioner Janek said, the company demanded a higher rate than lawmakers authorized. HHSC spokeswoman Stephanie Goodman said the contract was canceled because of concerns that it was made outside of a competitive bidding process. Whatever is the case, a segment of the vendor community told us in interviews that the belief is widely held — whether true or not — that the procurement was cancelled because Jack Stick wanted to channel the work to 21CT. The strike force was unable to confirm this with any internal staff or with Dr. Janek.

On September 22, 2014, the Department of Family and Protective Services issued a purchase order for what was called a 21CT/Child Protection Analytic Solution Pilot in the amount of \$452,000. The DFPS Commissioner told the strike force that Jack Stick referred 21CT to the agency, a point also made by 21CT’s Irene Williams in a news report.⁴¹ Once again, the cooperative contracts process was used for the procurement. No proofs of concept were developed, and the services were not competitively bid other than through DIR’s cooperative contracting process.

³⁸ Memorandum from Doug Wilson to Kyle Janek, “21CT – Torch Graph Pattern Analysis Fraud Solution Continued Funding Through State Fiscal Year 2015,” Event/Meeting Briefing and Decision Summary, October 27, 2014.

³⁹ Texas Health and Human Services Commission, Enterprise Data Warehouse, RFP# 529-13-0018, Notice of Cancellation, September 5, 2014. Available at: <http://www.hhsc.state.tx.us/contract/529130018/announcements.shtml>.

⁴⁰ Brian M. Rosenthal, “State Halts Project over Cost, ‘Cozy’ Relationship with Vendor,” *Houston Chronicle*, September 22, 2014. Available at: <http://www.houstonchronicle.com/news/politics/texas/article/State-abruptly-ends-massive-data-warehouse-project-5773232.php>.

⁴¹ Terri Langford and Bobby Blanchard, “Second HHSC Contract Scrapped Amid Bidding Questions,” *Texas Tribune*, December 17, 2014. Available at: <http://www.texastribune.org/2014/12/17/hhsc-cancels-2nd-contract-21ct/>

In October 2014, the Sunset Commission released its staff report on HHSC. One of the concerns the report raised was the poor performance of OIG management, which was embroiled in a controversy over its aggressive pursuit of medical and dental billings by Medicaid providers.

“Historically, the OIG’s enforcement division has been fairly inactive,” Sunset project director Sarah Kirkle told the commission in testimony in November. “OIG’s recent efforts to take a more active role in pursuing fraud, waste and abuse have garnered much attention and scrutiny and raised significant questions about its process and results or lack thereof.” The Sunset staff report noted that OIG had estimated more than \$1 billion in Medicaid overbillings in recent years, but that only about \$5.5 million had been recovered.⁴²

Sunset’s comments on the 21CT technology reflected concerns that poor OIG management could lead to the misuse of Torch. According to its report,

Additionally, the agency’s recent fraud initiatives for Medicaid provider investigations, together with a sophisticated new fraud identification system, Torch, compound the risk associated with a lack of priorities. Torch promises significant results for OIG, identifying \$41 million in suspicious Medicaid payments for investigation in fiscal year 2014. However, the addition of such a substantial workload, without a demonstrated system for efficiently and effectively sorting and prosecuting cases in a way that maximizes monetary returns, jeopardizes the state’s return on investment for these significant, and expensive, fraud identification efforts.⁴³

The commission recommended improvements in this and other areas.

Sunset’s main focus, however, was on earlier OIG efforts to crack down on alleged fraud by providers of orthodontics and other services. At hearings on the staff’s HHSC recommendations, commission members expressed concern that OIG had failed to reclaim substantial sums despite having alleged hundreds of millions of dollars in possible fraud each year. The office also was criticized for a three-year backlog of cases and aggressive pursuit of providers that sometimes hampered their businesses over what turned out to be clerical error rather than fraud.

After receiving CMS approval for additional federal funding of up to \$76.6 million for the 21CT project over three years (2015-17), OIG sought approval for funding authority for 2015 from the executive commissioner at a meeting on October 24, 2014. In all, OIG received approval of funding in the amount of \$16,645,000 as a result of that meeting, according to an Event/Meeting Briefing and Decision Summary dated October 27, 2014, that was prepared in accordance with agency policy.

⁴² Texas Sunset Advisory Commission, *Health and Human Services Commission and System Issues: Staff Report with Commission Decisions*, p. 132.

⁴³ Texas Sunset Advisory Commission, *Health and Human Services Commission and System Issues: Staff Report with Commission Decisions*, p. 130. It was later shown \$41 million was not identified by the 21CT technology but by an individual investigator.

Significantly, neither Doug Wilson, who was out of state, nor Jack Stick, who continued to be involved in the project, was present at this meeting. Those present included Kyle Janek, Wayne Wilson (PCS), Casey Haney (deputy chief of staff), Erica Stick (chief of staff), Kay Ghahremani (state Medicaid director), Carey Smith (general counsel) and Stephanie Goodman (communications). Jennifer Stansbury, director of OIG's Medicaid Data Analytics & Fraud Detection Division, made the presentation.

Not long after this meeting, a series of news articles began revealing details of the 21CT contract and reporting a string of official reactions, both within and outside HHSC. It began with a November 13, 2014 *Austin American-Statesman* article summarizing the Sunset Advisory Commission report and prominently featuring the commission's general criticisms of OIG. On November 15, a second *Statesman* article looked specifically at OIG and took a far harsher tone than a generally positive August story on OIG.⁴⁴ The November 15 article mentioned the imminent extension of the original \$20 million agreement to a total of \$90 million over three years, implying a total project cost of \$110 million.

Notably, the article didn't raise specific questions about 21CT and its Torch product, other than to note the company's inexperience in the Medicaid fraud area. Most of it focused again on the Sunset staff report's criticism of OIG and the question of whether the office could be trusted to enter into large contracts given recent controversies over its fraud detection efforts. Executive Commissioner Janek was quoted as saying Torch had been well received for its potential to analyze patterns and catch fraud early or even predict it. "I'm happy with the results I've seen," he said. "The concept is sound." Irene Williams, 21CT's CEO, told the *Statesman* reporter that the inspector general's problems were unrelated to her company's product.

A November 29, 2014, *Statesman* article was far more damning of the 21CT-HHSC relationship. It alleged a connection — and potential conflict of interest — between Jack Stick and a 21CT lobbyist, James Frinzi, a former business partner of Stick's. According to this article:

Records show that beginning in 2002 Jack Stick, chief counsel for the state Health and Human Services Commission, managed two companies with James Frinzi, the registered lobbyist for 21CT, a data analytics company courted by Stick to overhaul the state's Medicaid fraud investigations.⁴⁵

Both Frinzi and Stick denied any conflict of interest and said they were no longer in business together. Irene Williams, 21CT's CEO, also denied any conflict of interest. The damage was done, however.

The November 29 article was followed by a steady stream of additional reporting by the *Statesman*, the *Houston Chronicle*, the *Texas Tribune* and other news organizations. This revealed further bits and pieces related to the HHSC-21CT relationship, including the use of the cooperative contracts process, often subsequently characterized as a "no-bid" process.

⁴⁴ J. David McSwane, "'Broken' State Agency Near \$90 Million Deal on Medicaid Fraud Detection," *Austin American-Statesman*, November 15, 2014. Available at: <http://www.mystatesman.com/news/news/state-regional-govt-politics/broken-state-agency-signs-90-million-medicaid-fraud/nh776/>

⁴⁵ J. David McSwane, "Texas Health Official Who Steered Deals Has Ties to Firm's Lobbyist," *Austin American-Statesman*, November 29, 2014. Available at: <http://www.mystatesman.com/news/news/state-regional-govt-politics/texas-health-official-who-steered-deals-has-ties-t/njH4M/#19761531.3930337.735651>

As the weeks passed, additional problems at HHSC were revealed, including large tuition payments for select staff members and the purchase of expensive office chairs for Stick and Wilson. This reporting raised questions about HHSC's purchasing and contracting processes, and making the agency a focus of legislative scrutiny at the beginning of the 2015 legislative session. A summary of events following the November 29 *Statesman* article demonstrates the precipitous cascade of events in late 2014 and early 2015:

- On December 12, Jack Stick resigned from his position as chief counsel.
- On December 12, HHSC also announced it was canceling the second 21CT agreement.
- On December 18, the Travis County District Attorney's Public Integrity Unit announced it was opening a criminal inquiry into the 21CT agreement following two separate complaints, including one from Senator John Whitmire.
- On December 19, the State Auditor's Office announced it would look into the issues surrounding the 21CT agreements. (Both this inquiry and the Public Integrity Unit's investigation are still in progress at this writing.)
- On December 19, Inspector General Doug Wilson resigned.
- Also on December 19, three additional HHSC employees—Executive Commissioner Janek's chief of staff Erica Stick, wife of Jack Stick; Cody Cazares, Jack Stick's former chief of staff; and Frianita Wilson, the Inspector General's wife who worked in purchasing at the Department of Family and Protective Services — were put on administrative leave.
- On January 9, House Speaker Joe Straus issued a press release announcing his intention to file a budget proposal significantly enhancing oversight of state agency contracts.
- On January 14, Governor-elect Greg Abbott announced he was creating a "strike force" to review HHSC performance.
- On January 15, HHSC Chief of Staff Erica Stick announced her resignation effective February 6.
- On January 16, Deputy Chief of Staff Casey Haney announced his resignation effective February 6.
- On January 21, shortly after taking office, Governor Abbott named Stuart Bowen, a former top aide to George W. Bush as governor and president, and former special inspector general for Iraq reconstruction, as new HHSC inspector general.
- On January 26, Senator Jane Nelson introduced Senate Bill 353, which would tighten standards on state agency purchasing. (This bill was later resubmitted by Senator Nelson as S.B. 20 in February 2015.)
- On January 28, shortly after taking office, Governor Abbott sent a letter to all state agency heads calling for higher standards in the state's contracting and procurement process, including specific reforms aimed at restoring public trust in the contracting process.⁴⁶

Conclusion

The 21CT story is long and convoluted. Without further evidence, it is difficult to say with certainty what motivated the principal players. It appears that Doug Wilson — and Jack Stick in particular — viewed the 21CT product as a revolutionary technology that offered OIG the

⁴⁶ Tex. S.B. 353, 84th Reg. Sess. Available at: <http://www.capitol.state.tx.us/BillLookup/history.aspx?LegSess=84R&Bill=SB353>; and Texas Office of the Governor, "Governor Abbott Calls on State Agencies to Reform Contracting Process," January 28, 2015. Available at: <http://gov.texas.gov/news/press-release/20453>.

opportunity to break out of a cycle of poor performance that had plagued it for years and establish a national reputation in Medicaid fraud detection.

The strike force was told in interviews that Stick had talked of making the 21CT solution available to other states, and spoke at one conference at which he encouraged other state Medicaid officials to adopt 21CT's graph pattern analysis system, making comments that infuriated vendors of other fraud detection solutions called out by name in Stick's presentation. In one interview, we were told that vendors were so offended that conference sponsors asked Stick to skip a second presentation later in the day.

Ironically, after all of this time and the expenditure of nearly \$20 million, it is difficult to say whether the Torch technology is "revolutionary," ordinary or a failure. With the end of its original purchase orders, the agency is left with nothing to show for its multi-million-dollar investment. The HHSC Director of Information Technology told the strike force that HHSC does not have access to the source code for the technology, since it was bundled as a service, and therefore cannot make further use of the 21CT solution. While such situations are becoming more and more common when government contracts for software as a service, it nonetheless puts HHSC in the position of having spent nearly \$20 million on a product that, at present, has no practical value.

Whether the technology was sound or not is almost beside the point. By using a dubious procurement method for such a large, complex purchase, and by failing to competitively bid the service apart from DIR's master-contract process, OIG undermined its credibility and touched off a cascade of events that has rippled throughout state government. Jobs have been lost, careers disrupted and HHSC's work tarnished in the public eye. It has received a rocky reception in the current legislative session, whose members are understandably frustrated and upset with OIG and HHSC.

During our review, we found that steps are being taken to correct some of the defects that created this situation, and further investigation by the Public Integrity Unit and State Auditor may reveal whether the 21CT controversy was something worse than an ill-considered decision that went badly awry. There are, however, further steps that should be taken to prevent similar situations in the future. Some of these are specific to HHSC, while others extend across state government. Some of these reforms have already been outlined in Governor Abbott's letter to state agencies and in S.B. 353 — now S.B.20 — which is moving through the legislative process.

The following are steps the strike force believes would be effective in putting the controversy in the past. Our findings and recommendations are as follows:

Findings

1. The strike force is not in a position to judge the efficacy of the 21CT technology. Neither is HHSC, since the agency cannot continue to use the technology without entering into another agreement with 21CT.
2. Nevertheless, our review made it clear that HHSC's contracting process must be improved. This conclusion is not limited to the 21CT procurement alone. HHSC has suffered through a series of contracting missteps in recent years. 21CT, while it has received the lion's share of public scrutiny, is certainly not the only example. Contract planning must be improved, as must the process itself. To this end, HHSC has a team working on improvements at this time.

Our recommendations on contracting generally are contained in a separate section on that topic.

3. HHSC's contract for the Medicaid fraud technology that it does have, MFADS, runs out on August 31, 2015. HHSC has issued an emergency extension of the contract for 21 months to allow time for a competitive bid for Medicaid fraud technology, providing yet another example of a broken planning and contracting process for agency critics.
4. That said, the 21CT agreement appears to owe as much to the actions of specific employees and the organizational relationship between OIG and HHSC as it does broader contracting policy. The Office of Inspector General also is currently under direct review by a consultant hired by the commission. Our recommendations related to the office are contained in a separate section of this report.
5. OIG was able to secure 21CT's services and avoid a normal contracting process by taking advantage of DIR's cooperative contracts program. This program is a valuable tool for state and local agencies wishing to save time and money on routine technology purchases. It never should have been used for a large, complex procurement such as the 21CT agreement. The fact that it could be used in this way without oversight is a weakness, and state law or administrative policy should be amended to prevent further mishaps.
6. In addition, the cooperative contract's structure, in which DIR benefits financially, from each transaction, which is tied to its funding, creates a perverse incentive in favor of sales over oversight. This is not an agency policy, but it is a practical result of the program's structure.

We recommend the following changes to the program to tighten it without eliminating its usefulness to state and local agencies.

Recommendations

- 1. Given the questions concerning the 21CT agreement and lack of a measurable deliverable, the Health and Human Service Commission should seek, through legal channels, to recover all funds paid to 21CT.**
- 2. The Department of Information Resources should change the cooperative contracts program as it affects commodity services.**

It should, at minimum:

- a. treat co-op contracts and procurements by agencies as a three-way contractual arrangement.
- b. require agencies contemplating procurements above \$1 million to notify and solicit responses from all vendors on the contract.
- c. require agencies purchasing commodities other than tangible goods such as computers to prepare a memorandum of understanding between the agency and DIR that includes the size of the procurement, a signoff by the agency chief information officer, evidence of a competitive solicitation and certification from the agency that the procurement is within the scope of the DIR contract.

- d. require that MOUs be signed by authorized representatives of the agency and DIR.
- 3. DIR should rebid each contract category over the next three years, in phases, to bring all contracts into line with the new requirements.**

DIR needs to do a better job of screening vendors so that agencies know the awarded vendors are fully competent to provide the product or service. DIR should consider having agency experts in the contract area as participants in the evaluation process.

- 4. DIR should limit awards under the cooperative contracts program to technology providers alone.**
- 5. DIR should develop a risk management analysis for technology purchases and review the success or failure of selected large deliverables-based IT services (DBITS) and cooperative contract purchases, reporting its findings to the Governor and Legislature annually.**
- 6. DIR should review all purchases made through its technology programs each biennium, to identify trends in procurement, common themes or other elements that could be used to improve the state's technology decisions.**

It should report this information to the Governor and Legislature and make it available to agencies, vendors and the general public to provide an overview of technology procurement trends in the state.

- 7. The Legislature should commit resources to DIR to handle the additional work implementing these recommendations will entail.**

3 | Office of Inspector General

Government agencies face enormous challenges in preventing and detecting improper payments resulting from fraud, waste and abuse.⁴⁷ Whatever the cause of such payments — data entry errors, authentication and verification errors or criminal intent — taxpayers end up footing the bill. Fraud also takes a toll on government programs themselves, eroding their budgets and undermining public and legislative confidence.

This problem is especially challenging in the health and human services arena. The sheer size and complexity of the joint state-federal Medicaid program alone — 60 million Americans covered at a cost of more than \$450 billion annually — put it at continual risk of exploitation. Exactly how much is lost nationally under Medicaid is unknown, but estimates by the Centers for Medicare and Medicaid Services suggest it could total tens of billions of dollars annually.

But the risk of fraud and abuse does not stop with Medicaid. Today, health and human services fraud cuts across programs and grows more sophisticated every year. Unfortunately, these programs, creations of an earlier era, often are run by completely different groups, each with its own program requirements, automated systems and distinct procedures. These groups often do not work well together in identifying fraud and abuse — or share information among themselves and with other groups.

Federal funding, technical assistance and, in some cases, collaboration with federal agencies can assist state efforts to combat fraud. Even so, day-to-day responsibility for fighting fraud rests with the states, and depending on the state, can involve efforts by health and human service agencies, fraud control units, attorneys general, state auditors and inspectors general.

The Role of Inspectors General

Inspector general offices are independent units within a government or government agency whose duties are to combat waste, fraud, and abuse. Each OIG is responsible for audits and investigations relating to the programs and operations of its agency or government. In addition, inspectors general provide leadership, training and coordination and recommend policies designed to promote efficiency and effectiveness and prevent and detect fraud and abuse. OIGs typically receive and investigate complaints and most can independently initiate investigations. When they find wrongdoing or inefficiency, they file reports, recommend remedial measures and in the case of criminal misconduct refer cases to legal authorities.

In the U.S., the inspector general concept dates back to the nation's founding when, borrowing from European practices, George Washington and the Continental Congress established

⁴⁷ The National Association of Medicaid Directors defines *fraud* as “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person and includes any act that constitutes fraud under applicable federal or state law.” *Waste* is a more elusive concept but is generally understood to include the overuse, inappropriate use or misuse of resources, and typically is not a criminal or intentional act. *Abuse* includes practices inconsistent with sound fiscal, business or medical practices that result in unnecessary program costs, or in government payments for services that are not medically necessary or that fail to meet professionally recognized standards. It also includes non-fraudulent recipient practices that result in unnecessary program costs.

an inspector general to improve the effectiveness and discipline of the Continental Army. It was not until the 1960s, though, that the U.S. Department of Agriculture established what is generally viewed as the first modern inspector general's office, after a participant in its grain storage program — Texan Billie Sol Estes — defrauded the agency of an enormous amount of funds. This office, which reported to the Secretary of Agriculture, performed well but was eliminated in 1974.⁴⁸

The idea was quickly resurrected, however. In 1978, in the wake of the Watergate scandal, Congress established a system of inspectors general in 12 federal agencies under the Inspector General Act of 1978. These IGs joined two offices that had already been created at the Department of Health, Education and Welfare and the Department of Energy. Some of these inspectors general are appointed by the president, others by the heads of the agencies they oversee. Today, the federal government includes 72 OIGs.⁴⁹

State and local OIGs are a more recent development — the first statewide OIG was created in Massachusetts in 1980 — but have grown steadily in number. At least 12 states now have inspector general offices with statewide jurisdiction, and at least 28 states including Texas have created inspectors general with jurisdiction limited to specific state agencies and authorities, according to Philip Zisman, executive director of the Association of Inspectors General.⁵⁰ The growth in state and even local inspector general offices is a result of the high visibility of public corruption cases and efforts to end fraud, waste and abuse in public programs.

In general, a strong and independent inspector general's office should feature the following characteristics:

- an independent reporting structure — to maintain independence, the inspector general should not report directly to any agency or public office that may be the subject of an investigation.
- fixed terms of office — terms of office vary according to the scope of responsibility and the nature of the office. In many states, the term is four years. Massachusetts recently revised its statutes and provided for five-year terms with a two-term limit.
- subpoena power — the OIG's ability to issue and enforce subpoenas is essential.
- budget protection — the inspector general's budget should not be subject to possible reprisals for controversial investigations.
- protection of the inspector general position — the inspector general should be removable only for cause, not for official displeasure at the course or results of an investigation.

⁴⁸ Diane M. Hartmus, "Inspection and Oversight in the Federal Courts: Creating an Office of Inspector General," *California Western Law Review*, Vol. 35, No. 2, Spring 1999. Available at: <http://scholarlycommons.law.cwsl.edu/cwlr/vol35/iss2/3/>.

⁴⁹ Council of the Inspectors General on Integrity and Efficiency, "The Inspectors General," July 14, 2014. Available at: https://www.ignet.gov/sites/default/files/files/IG_Authorities_Paper_-_Final_6-11-14.pdf.

⁵⁰ Philip Zisman, "The People's Watchdog: Inspectors General Foster Accountability, Transparency," *Capitol Ideas*, January/February 2015. Available at: http://www.csg.org/pubs/capitolideas/2013_mar_apr/inspectorsgeneral.aspx.

- cooperation among agencies — agencies and officials should be required to comply with requests, submit documents when asked and refrain from interfering with investigations.⁵¹

Inspectors general are uniquely positioned to uncover and prevent public corruption. In addition, they often contribute to investigations conducted by other agencies, such as state attorneys general, and investigate misconduct falling outside the jurisdictions of other agencies.

OIGs have special access to the agencies or units of which they are a part. Typically, they are granted broad access to facilities and documents, and can request information from all employees of their governmental unit. In turn, employees often have a statutory duty to cooperate with the OIG. Second, the OIG's exclusive focus is its own agency or unit. Law enforcement agencies with broader jurisdictions necessarily must be selective about the matters they pursue. Third, because of their unique access and narrow focus, OIGs develop a specialized understanding of their "beat," knowing where corruption is most likely to occur and how best to detect, address and prevent it. Finally, OIGs provide a central clearinghouse for complaints about corruption.

To function effectively, an OIG needs the support of political leaders who take corruption seriously and communicate their seriousness to their employees. But it *also* requires sound internal leadership, since its powers can be abused.

Texas Inspectors General

Texas has created inspectors general in the Texas Health and Human Services Commission, the Texas Juvenile Justice Department, the Texas Department of Criminal Justice and the Texas Department of Public Safety.⁵² These offices were created under separate statutes and share some key similarities as well as differences. Past legislative proposals to create a statewide inspector general, and inspectors general at agencies such as the Texas Department of Transportation and the Texas Department of Insurance, have not been approved.

In the health and human services arena, the Legislature charged HHSC with the investigation and enforcement of fraud, waste and abuse in health and human services beginning in 1997, through an Office of Investigations and Enforcement. House Bill 2292, enacted in 2003, created the OIG and the office's current framework. OIG's responsibilities include monitoring services provided through any state-administered HHS program that receives federal funds, and enforcing state law related to the provision of those services.⁵³

HHSC's OIG is charged with ensuring the integrity of all HHS programs, with particular emphasis on the Medicaid, Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP) programs. The inspector general is appointed by the Governor to a one-year term that may be extended at the Governor's pleasure. The office thus maintains independence from the larger HHS enterprise but functions administratively within it.

⁵¹ Katherine Barrett and Richard Greene, "States and Localities Realize the Importance of Inspectors General," *Governing*, July 2013. Available at: <http://www.governing.com/columns/smart-mgmt/col-states-localities-realize-importance-of-inspectors-general.html>

⁵² Some city and county governments, including the city of Houston and Hidalgo County, have appointed inspector generals as well.

⁵³ Tex. Gov't Code §531.102.

Operationally, the OIG's responsibilities are divided among five divisions, including operations, compliance, internal affairs, enforcement and chief counsel. The office has grown significantly since its inception, reflecting the imposing share of the state budget consumed by HHS programs. In 2014, OIG had 774.5 full-time equivalent positions and a budget of \$48.9 million.

OIG's relationship with HHSC sets it apart from other Texas state inspectors general, since the position is appointed by and reports to the Governor. Other Texas inspectors general report to an agency board or commission, although some, such as the OIG of the Juvenile Justice Department, also file extensive reports with the Governor, Lieutenant Governor, Speaker and relevant House and Senate oversight committees.

H.B. 2292 and subsequent legislation not only give the HHSC OIG broad latitude to investigate fraud, waste and abuse across a wide range of programs but also instruct HHSC to "obtain any information or technology necessary to enable the office to meet its responsibilities." The legislation further provides that the commission, in consultation with the inspector general, "shall set clear objectives, priorities, and performance standards for the office" that emphasize coordinating investigative efforts, allocating resources to cases with the strongest evidence and greatest potential for recovery and maximizing opportunities for case referrals to the Attorney General for prosecution. HHSC is required to provide training for OIG staff to pursue Medicaid and other HHS fraud recovery and to work with the inspector general to create the criteria needed to trigger an investigation.

OIG Management

The Sunset Commission staff report on HHSC was released in October 2014. It is important to recognize that the report was completed *prior* to the 21CT controversy, but it was still particularly harsh in its criticism of OIG's general lack of effectiveness in carrying out its responsibilities. According to the report,

OIG must have the proper mechanisms and approaches to effectively guide its efforts, to judge its own performance, and to accurately inform state leaders of the results of its work throughout the system. Much of what follows portrays aspects of bureaucracy that have become buzzwords in this business — a lack of priorities, criteria, processes, transparency, or accountability. However, behind these words is a real harm that can result when their basic tenets are missing.⁵⁴

The Sunset report noted that prior to 2011, OIG had never brought a case before the State Office of Administrative Hearings, and both the identification and recovery of provider overpayments were considerably less common than they are now. This increase in enforcement activity, however, also brought "increased attention and scrutiny from the public on OIG's processes and results."

The report said that OIG's investigative processes, especially Medicaid provider investigations, lacked the structure, data and performance measures needed for effective

⁵⁴ Texas Sunset Advisory Commission, *Health and Human Services Commission and System Issues: Staff Report with Commission Decisions*, p. 129.

management and evaluation. OIG, according to the report, “does not differentiate between the gravity of violations of the Medicaid provider agreement,” and thus contributes to large overpayment estimates and inconsistent results. In cases in which it was called upon to conduct internal investigations of enterprise employees, it had improperly focused on matters that would, in other agencies, be handled by management. The office also could not break its data into categories to show the types of investigations on which it spends its time. The report also cited deficiencies in training, poor communication within and outside the HHS enterprise and a lack of transparency.

In addition to these general problems, the Sunset report dedicated one entire section, Issue 11, to problems associated with OIG’s use of “payment hold,” an administrative and enforcement tool OIG can use to stop the flow of Medicaid payments to an individual provider. This process is based on the federal concept of “credible allegation of fraud,” defined as an “allegation, which has been verified by the State, from any source.” These allocations can come from fraud hotline complaints, claims data mining, patterns identified through provider audits, civil false claims cases or law enforcement investigations. In addition, state law allows a payment hold “on receipt of reliable evidence that the circumstances giving rise to the hold on payment involve fraud or willful misrepresentation under the state Medicaid program in accordance with 42 C.F.R. 455.23, as applicable.”⁵⁵

According to HHSC, “[a]llegations are considered credible when they have indicia of reliability and the State Medicaid Agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.”⁵⁶ Federal law allows a payment hold to continue until the agency or prosecutors find insufficient evidence of fraud, or until legal proceedings related to the alleged fraud are completed.

OIG began using the payment hold mechanism more extensively in late 2011, following the appointment of Doug Wilson as inspector general and Jack Stick as deputy inspector general for enforcement. In a 2012 interview, Wilson said that the division traditionally had operated like a law enforcement agency, performing lengthy investigations to get cases ready for criminal prosecution. Instead, he wanted to halt the flow of financing to questionable providers at the first sign of something amiss.⁵⁷ HHSC data show payment holds based on a credible allegation of fraud hit a five-year high of 76 in fiscal 2012, after reaching a five-year low of six holds in the previous year.

Heightened use of payment holds enraged doctors and other providers who treat Medicaid patients. Among other complaints, they alleged that an anonymous call to a fraud hotline or a computer-generated analysis of a sample of billing codes could be enough to halt their financing without a hearing, jeopardizing their practices and employees and leaving thousands of needy patients without services while the state worked to investigate the suspect activity. Sunset concluded that OIG’s actions in imposing payment holds went beyond the intent of both federal and state law and were administratively burdensome for providers. “Despite the intended serious nature of payment holds, OIG uses payment holds as a negotiation tactic or bargaining tool, even for cases that do not pose significant financial risks to the state,” the report said.⁵⁸

⁵⁵ Tex. Gov’t Code §531.102(g)(2).

⁵⁶ Texas Health and Human Services Commission, “What is a Payment Hold?” Available at: <http://oig.hhsc.state.tx.us/OIGPortal/tabid/86/ShowArticle/mid/25/Default.aspx?TabID=85>.

⁵⁷ Emily Ramshaw, “In Medicaid Fraud Investigations, a Controversial Tool,” *Texas Tribune*, July 20, 2012. Available at: <http://www.texastribune.org/2012/07/20/medicaid-fraud-investigations-controversial-tool/>

⁵⁸ Texas Sunset Advisory Commission, *Health and Human Services Commission and System Issues: Staff Report with Commission Decisions*, p. 153,

Some providers took the state to court over the issue, and on November 25, 2014, the Third Court of Appeals invalidated three rules authorizing OIG to impose pre- or post-payment holds on Medicaid funds during a fraud investigation, siding with plaintiffs Harlingen Family Dentistry PC and Trueblood Dental Associates PA in a reversal of the trial court's ruling.⁵⁹ The court held that the rules holding violated due process rights. The Court of Appeals also invalidated a rule that allowed the HHSC to retain seized funds even after a pre-notice payment hold had terminated. The court held that such rules run counter to legislative intent, finding that as written they could apply to even minor violations. The court summarized its position thusly:

As written, the rules permit the OIG to impose a payment hold, without notice and in the absence of fraud, and yet avoid the due process notice procedures and expedited administrative review the legislature required in connection with the payment holds it expressly authorized.⁶⁰

Even before this outcome, the Sunset report recommended extensive improvements in OIG operations, including reforms to and streamlining of the payment hold process.

With minor changes, all of the Sunset staff's recommendations were adopted by the full commission, including what is probably the most administratively significant proposal — Recommendation 10.1, which proposes legislation to remove the gubernatorial appointment of the inspector general and require the executive commissioner to appoint and directly supervise the position instead.

Under this recommendation, the executive commissioner would assume oversight responsibility for the OIG's functions, thus removing, according to Sunset, "any questions about the executive commissioner's authority and mak[ing] the executive commissioner clearly accountable for OIG's performance, as is common in other state offices of inspector general."⁶¹ Where a perceived conflict of interest arises, such as criminal allegations involving the executive commissioner, OIG would refer the allegations to the Texas Rangers for investigation.

The 21CT Controversy and Beyond

It was in this period of increased activity and growing controversy that OIG sought to expand its use of technology in its fraud detection efforts by contracting with the Austin-based data analytics company, 21CT, as discussed in the preceding section. Again, it is difficult to fully explain the web of circumstances that produced the 21CT controversy without further and more extensive investigation by the Public Integrity Unit and the State Auditor. But we believe that one major

⁵⁹ Jess Davis, "Texas Court Strikes Down Medicaid Payment Hold Rules," *Law360*, November 25, 2014. Available at: <http://www.law360.com/articles/599390/texas-court-strikes-down-medicaid-payment-hold-rules>.

⁶⁰ Third Court of Appeals, Austin, Harlingen Family Dentistry, P.C.; and Trueblood Dental Associates, P.A., Appellants v. Texas Health and Human Services Commission and Office of the Inspector General, Appellees, NO. 03-14-00069-CV, Decided: November 25, 2014. Available at: <http://caselaw.findlaw.com/tx-court-of-appeals/1685714.html>

⁶¹ Texas Sunset Advisory Commission, *Health and Human Services Commission and System Issues: Staff Report with Commission Decisions*, p. 142.

motivation behind the rush to contract with 21CT was OIG's desire to dramatically improve its fraud detection results.

In other words, 21CT must be understood, at least in part, as a facet of the same effort that led to the expansion of the payment hold program: a reaction to longstanding criticism of the office and an effort on the part of new managers to create a nationally recognized Medicaid fraud program. OIG badly — or more accurately, disastrously — mishandled this push, however well intended, resulting in weeks of public and legislative scrutiny, a wave of resignations, the appointment of a new inspector general and a management review of the office by the HHSC internal auditor in conjunction with Navigant Consulting.

The strike force elected not to duplicate the internal review already in progress. In developing background on the 21CT controversy and related issues, however, we heard comments from executive staff and others that supported the Sunset findings. In interviews, we were told that the relationship between OIG and HHSC had been strained for some time, dating to executive commissioners before Dr. Janek. The staff was aware that there were problems in identifying program violations and imposing payment holds. Many of the violations claimed by OIG, we were told, “were simple billing errors.” A commissioner of one of the enterprise agencies, while saying that OIG had improved recently, nevertheless told us: “I question the expertise of OIG. They’re all criminal investigators. If you’re a hammer, everything looks like a nail.”

With regard to the 21CT controversy, we were told that OIG could and often did initiate IT projects without the involvement of the agency’s information technology department, reaching out only when problems developed. Staff also pointed out that most OIG attorneys work in compliance, with only two to three assigned to general law work and *none* dedicated to contracts.

Because of the ongoing review of the office and its procedures, this report will confine itself to recommendations related only to the organizational structure of OIG and Sunset Recommendation 10.1, which proposed that the office be placed directly under the oversight of the executive commissioner rather than the Governor.

In that regard, we disagree with the Sunset recommendation. Among the most important requirements for inspectors general is their need for independence from the entities they examine. We recommend, instead, that the Legislature avoid making significant changes based on mismanagement or misconduct by previous OIG managers. We believe it is possible to maintain a level of independence for the office without effectively making it an operating unit of HHSC, which would violate the independence that is the goal of creating an inspector general function in the first place.

While other Texas inspectors general do not report to the Governor, it is equally true that none report to the agency director. Most report to a governing board or commission, something not possible in this case since HHSC does not have an oversight body similar to the Texas Board of Criminal Justice or the Texas Public Safety Commission. We believe it is possible to impose a greater level of administrative oversight on the office without going as far as Recommendation 10.1 envisions.

OIG accountability is best served by strong qualifications for office holders and frequent reporting to the Governor, Legislature and executive commissioner. Periodic peer reviews also should be a part of this cycle of accountability. Finally, public reporting is an essential component. Public reports that are analytical and not limited to statistics are desirable — including analyses of

why, in OIG's opinion, corrupt conduct took place, and recommendations regarding any structural reforms that might preclude its repetition. At present, OIG is notably lacking in public reporting on its activities. To take but one example, its most recent "annual" report available on the Internet is for 2011.

While the 21CT controversy was the product of a near-perfect storm of circumstances — a lax procurement process, aggressive pursuit of a single vendor, internal control weaknesses at HHSC and poor contracting — the real problem was *leadership*. OIG leadership failed to exercise the integrity and respect for transparency that it looks for in the HHS agencies and providers of state services.

Laws can be tightened and oversight can be increased and better enforced at DIR and elsewhere. The most important improvement that can be made, however, is strong leadership at OIG. There is simply no substitute.

Findings

1. Based on the best available evidence and interviews with HHS enterprise staff, the strike force concurs with most of the findings of the Sunset Advisory Commission relating to the OIG.
2. We do not agree wholly with Sunset Recommendation 10.1, which would move appointment authority for the HHSC inspector general from the Governor to the HHSC executive commissioner. We believe this recommendation, though logical in some respects, goes too far in removing the independence of the OIG based on the actions of a handful of bad actors.

Independence is critical. While OIGs are part of the governmental bodies they are charged with investigating, their effectiveness is severely compromised without protections put in place to ensure against interference by the "host" agency. Lack of independence can also undermine confidence in the office among would-be complainants and the public. We believe a closer link between the office and HHSC can be established without entirely sacrificing OIG's current independence — or the role of the Governor in this critical aspect of one of the state's largest executive agencies.

3. In light of the 21CT controversy, OIG, in cooperation with the HHS agencies and the Attorney General's Office, should re-evaluate its approach to the use of computer-based fraud detection technologies.
4. We further believe that the Legislature should appoint an interim committee to review the current structure and function of all inspector general offices in state government, with the goal of answering the following questions:
 - a. Are the inspectors general functioning as intended in the legislation that originally created them?
 - b. What improvements could be made to establish best practices in OIGs across government?

- c. Should inspectors general be created for other agencies of the government?
- d. Should the policies and procedures of current and future OIGs be made more uniform to the degree permitted by their individual functions, such as uniform requirements for the position of inspector general, training requirements for office staff members and avenues for cooperation with other agencies including the State Auditor's Office and the Attorney General's Office?
- e. Should the state establish job qualifications for its inspectors general and key staff members, such as those involved in enforcement, to ensure they have the proper background to execute their responsibilities effectively?

Recommendations

- 1. Despite its problems, the OIG should retain some degree of independence. We do not believe the Sunset recommendation allowing the executive commissioner to appoint the inspector general is the best approach. Independence can be maintained and improved oversight can be attained in one of two ways:**
 - a. Appointment of the inspector general can continue as a responsibility of the Governor, but the Governor's office should assume greater responsibility for more closely monitoring the OIG's activities than it has in the past; or**
 - b. State law can be amended to authorize the appointment of the inspector general by the HHSC executive commissioner with the express approval of the Governor.**
 - c. In either case, the inspector general should only be removed from office by the Governor, either acting individually or on recommendation of the executive commissioner.⁶²**
- 2. OIG should remain independent of HHSC where investigative issues are concerned, but fully integrated into the agency's administrative processes.**

The administrative integration should include working through agency procurement, contracting, information technology and legal services divisions. OIG should be included in the HHSC internal audit's risk assessment prioritization and subject to regular audits on compliance with internal procedures.

- 3. The Legislature should establish strong job qualifications for the HHSC inspector general.**

Common requirements for such positions include experience as a law enforcement officer or judge, or as a manager of a government agency. Basic requirements, such as a college degree and a clean criminal record, typically are included. Experience managing complex investigations involving allegations of fraud, conspiracy and other misconduct is sometimes

⁶² Tex. Const., art. 13, § 30 limits terms of office for many public officials to no more than two years. The OIG should have a term of more than the one year under current law.

specified. Individuals who have recently worked in a Texas HHS agency in an area other than OIG should not serve as inspector general, even though such a restriction may exclude good candidates. The intent is to avoid the creation of an inadvertent conflict of interest.

4. The inspector general and key staff members should be required to fulfill certain professional training designed to improve their knowledge and skills.

The inspector general should create a staff development plan for key employees. For example, the Inspectors General Institute conducts certification programs for inspectors general and their senior staff that includes certification as an inspector general, an inspector general auditor or an inspector general investigator.

5. OIG should perform only those activities that directly contribute to its oversight responsibility or significant internal issues related to fraud or mismanagement of state or federal funds.

Responsibility for other OIG activities not associated with assessment of management systems and controls or investigations of alleged fraudulent activities should be transferred to agency management.

6. OIG should improve its transparency by producing more comprehensive reports of its activities and making them available to the public on its website and through other channels.

7. OIG should work with HHSC's operations and information technology divisions, as well as the other HHS agencies, to conduct a thorough review of computer-based fraud detection technology and services, including predictive and post-payment analytics.

This review should evaluate as many vendor solutions as possible, including the current MFADS solution, and should solicit analysis from the state's public universities as well. Particular attention should be given to the integration of fraud detection technology with the proposed enterprise data warehouse.

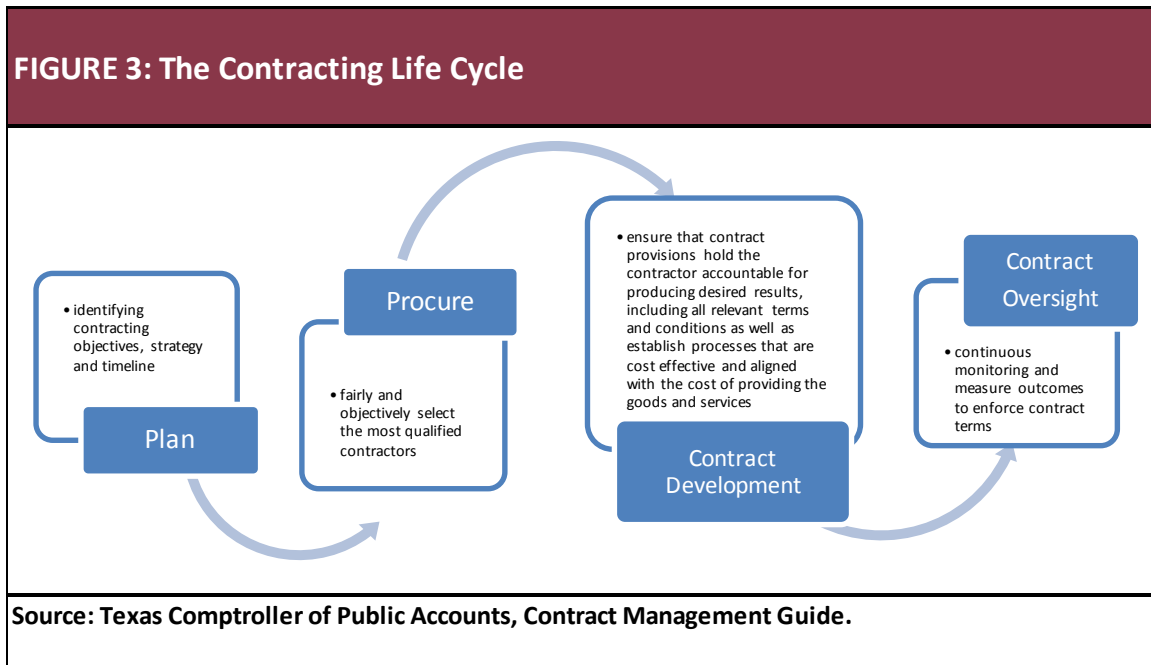
8. The Legislature should consider evaluating the role of all state inspectors general during the next legislative interim, with the goal of reviewing current performance, proposing improvements in current law and making the application of inspector general statutes more consistent throughout government.

9. The Governor, in consultation with the Legislature, should create a task force organized by the Department of Information Resources to evaluate the state's current use of fraud detection technology.

The review would seek to find ways to avoid duplicated effort and take advantage of common best practices.

4 | Contracting

The state's contract management cycle begins with *planning* for project scope and funding, followed by *procurement* — bid solicitation and evaluation — and *contract development and award* (Figure 3). Once the contract is executed, the emphasis moves to *oversight* to ensure that the contract's outcomes are met. This oversight continues until contract closure and is generally the longest of the four phases associated with the contract management life cycle.⁶³



As part of this review, we examined anecdotal information concerning how the enterprise functions in each of these four core contracting phases.

Texas' HHS enterprise administers more than 200 programs ranging from Medicaid and Child Protective Services to regulatory and licensing functions. Its programs and its 57,800 approved FTEs are supported by biennial appropriations of \$73.9 billion.⁶⁴ The majority of this funding supports services obtained primarily through contracts that include complex state, federal and individual program requirements.

In 2005, the HHSC executive commissioner ordered the creation of a Contract Council, including representatives from the entire system, charged with improving system-wide contracting.⁶⁵ The council was given responsibility for developing guidelines, policies and reports and implementing a contract management system for the entire enterprise. Its goals included

⁶³ Texas Comptroller of Public Accounts, *Contract Management Guide*, Version 1.12, March 2014. Available at: <http://www.window.state.tx.us/procurement/pub/contractguide/contract-mgmt-guide-v1.12.pdf>.

⁶⁴ Texas Legislative Budget Board, *Fiscal Size-Up, 2014-15 Biennium*, February 2014. Available at: http://www.lbb.state.tx.us/Documents/Publications/Fiscal_SizeUp/Fiscal_SizeUp_2014-15.pdf.

⁶⁵ Health and Human Services, Circular C-003, "The HHS Enterprise Contract Council," 2005.

improving contracts and related skills and training and implementing recommendations stemming from internal and external audit findings.⁶⁶

The council assisted in modifying a web-based contract tracking system, ultimately called the HHS Contract Administration and Tracking System (HCATS), for use by all the HHS agencies. HCATS provides electronic document storage and retrieval and the option of electronic tracking for contract deliverables.⁶⁷ After the 2013 creation of HHSC's Procurement and Contracting Services Division (PCS), the Contract Council stopped meeting, although technically, it was never abolished.

HCATS is used inconsistently across the HHS enterprise making it a less than reliable repository for contract data. The agencies' criteria for HCATS reporting depend on varying definitions and dollar thresholds.

The 2014 Sunset staff review noted that it took HHSC three months to collect system-wide data on the number and value of contracts, and that the agency could not ensure the data's completeness, consistency or reliability.⁶⁸ Based on the data it provided to Sunset, HHSC estimated the enterprise's contract expenditures at about \$24.1 billion in fiscal 2013 (Figure 4).

FIGURE 4: Health and Human Services Agencies, Contract Expenditures Reported to the Sunset Advisory Commission, FY 2013		
Agency	Number of Contracts	Expenditures
Department of Aging and Disability Services	12,706	\$5,316,952,628
Department of Assistive & Rehabilitative Svcs.	2,174	\$203,259,793
Department of Family & Protective Services	2,917	\$572,009,362
Department of State Health Services	7,690	\$1,812,877,564
Health and Human Services Commission	8,395	\$16,240,258,002
Total	33,882	\$24,145,357,349
Source: Texas Health and Human Services Commission.		

At the February 17, 2015, meeting of the House Committee on Government Transparency & Operation, HHSC Executive Commissioner Kyle Janek testified on HHSC contracting, telling the committee:

When a lawmaker or Sunset or anybody says how many contracts and we can't really give a ready answer because we

⁶⁶ Texas Health and Human Services Commission, Procurement and Contracting Services, HHSC Contract Council, "FY 2010 Contract Council Report of Accomplishments." Available at: <http://hhscx.hhsc.state.tx.us/ContractingSupport/index.html>.

⁶⁷ Texas Department of Family and Protective Services, *Contract Administration Handbook*, HCATS, p. 1.8.

⁶⁸ Texas Sunset Advisory Commission, *Health and Human Services Commission and System Issues: Staff Report with Commission Decisions*, p 47.

are in different systems across five agencies, that's a problem.... If you ask me right now, based on what you know, how many contracts do you have, I would have to hedge it, and say 'what kind of contracts?...' [W]e provide services, and providing the payments for these services to the service providers means that in this world we cannot take a pause, we do not get to stop and remodel the kitchen and allow the restaurant to reopen in a couple of months.... We have to get these contracts right and cannot have breaks in the operations of these things.⁶⁹

In an attempt to “get it right” and report the actual number of existing contracts system-wide, HHSC staff is collecting data itemizing currently active contracts from each of the five agencies. Included in this census are all contracts, including open-enrollment contracts, grants, interagency and inter-local contracts and statutorily required contracts that do not require competitive bidding. HHSC continues to analyze the data to categorize contracts by type and develop an accurate count. The final total seems certain to be much higher than the totals reported in Figure 4.

In 2013, all enterprise purchasing operations, including Historically Underutilized Business (HUB) programs, were consolidated at HHSC under the newly created Procurement and Contracting Services Division. The consolidated procurement operation and HUB programs report directly to the executive commissioner, through the PCS deputy executive commissioner. Contract management responsibilities remain with the individual agencies.

In assessing the need for this consolidation, HHSC concluded that multiple purchasing operations within the enterprise produced duplicated effort and reduced the enterprise's buying power. The executive commissioner approved the consolidation in March 2013.

The benefits expected included:

- consistent rules, policies and procedures.
- a more coordinated and balanced approach to achieving procurement and HUB goals.
- The ability to tailor enterprise and agency-specific goals based on unique contract portfolios while still achieving HUB goals as a five-agency enterprise.
- lower risk exposure.
- cross-training and development of highly desirable skill sets among staff.
- more rapid and consistent adoption of best practices across the agencies.
- more streamlined and simplified reporting processes.
- compliance with H.B. 2292-mandated consolidation of administrative functions and establishment of a unified procurement operation.⁷⁰

PCS has worked as intended — up to a point. The division, however, has yet to develop clear

⁶⁹ Kyle Janek, Texas Health and Human Services Executive Commissioner, Testimony before the Texas House of Representatives, Committee on Government Transparency and Operation, February 17, 2015, transcription.

⁷⁰ Action memorandum from Wayne Wilson, Deputy Executive Commissioner for Procurement and Contracting Services, to the Executive Commissioner, March 12, 2013.

oversight authority for certain types of procurements and lacks some important tools for managing the enterprises' contracts.

Specific issues identified in the strike force's interviews and analysis include:

- unclear roles and responsibilities.
- inconsistent program guidance, technical assistance and oversight.
- the use of "action memos" to circumvent the procurement approval process. The September 10, 2013, action memo approving the 21CT agreement is an example (see Section 2).
- inconsistent assignments of responsibility. Some programs have contract management; others do not.
- delays: "With PCS, a purchaser is assigned to handle each procurement. If the assigned purchaser takes a vacation so does the procurement." One division's request for procurement training wasn't fulfilled for a year.
- confusing organization: HHSC has no easily accessible guide identifying assigned purchasers by program area.
- inadequate attention to HHSC-specific procurements: PCS generally focuses on system-wide procurements and those of the other HHS agencies; purchases within HHSC do not receive the same level of support.

Contract planning is disjointed and inconsistent across the enterprise. Major procurements require an exceptionally long time, delays that often lead to "emergency" purchases with less than ideal terms.

HHSC announced in late 2014, for example, that it would enter into an unusual three-year emergency contract with Accenture, involving hundreds of millions of dollars, to take over the Medicaid payment processing contract formerly managed by the Texas Medicaid Healthcare Partnership (TMHP). The emergency agreement was spurred by the abrupt termination of HHSC's contract with TMHP; the agency concluded that a competitive procurement would require three years to complete. Contracts with managed care organizations (MCOs), which now provide the majority of Medicaid services, commonly require 18 to 24 months to complete (Figure 5).

It is clear from the foregoing that while the Contract Council has not met since early 2013, its work is not done.

Since 1999, state law has required HHSC to establish these tools:

- a contract management handbook establishing consistent contracting policies and practices for the enterprise;
- a single contracting risk-analysis procedure for all enterprise agencies that coordinates contract monitoring efforts and identifies contracts requiring enhanced monitoring; and
- a central database identifying all HHS enterprise contracts.

HHSC has not completed these tasks. The 2014 Sunset staff review noted that managing a complex universe of contracts without these tools increases the risks of contracting problems, with

potentially significant risk to individuals and the state. Since contractors deliver most of Texas' HHS programs, these tools and processes are imperative.

FIGURE 5: Timeline for Procuring Managed Care Services	
Procurement Activity	General Timeframe
Draft RFP Development	3 - 4 months
Required Approvals and Public Input	1 - 2 months
Final RFP Development and Posting	1 - 2 months
RFP Response Time	1½ - 2 months
Evaluation, Scoring, Leadership Approvals	2 - 4 months
Negotiation, Contracting, Federal Approvals	3 - 5 months
Transition and Readiness Reviews	6 - 9 months
Source: Texas Health and Human Services Commission, "Presentation on Medicaid and CHIP Division Contract Management" by Kay Ghahremani, Associate Commissioner for Medicaid and CHIP, February 10, 2015.	

According to the Sunset report, the problem is not with the concept of consolidation, but with "the nature of the system itself, and the incompleteness of its set up."⁷¹ The report added that the incomplete centralization of support services makes the benefits of consolidation impossible to achieve. A key Sunset recommendation advised HHSC:

...to better define and strengthen its role in both procurement and contract monitoring by completing and maintaining certain statutorily required elements; strengthening monitoring of contracts at HHSC; improving assistance to system agencies; and focusing high-level attention to system contracting.⁷²

Audits of the HHSC Contracting Process

Between mid-2013 and December 2014, the State Auditor's Office (SAO) and HHSC's Internal Audit Division performed a series of audits of HHSC contracting. The objectives and conclusions of each are summarized below.

⁷¹ Texas Sunset Advisory Commission, *Health and Human Services Commission and System Issues: Staff Report with Commission Decisions*, p. 1.

⁷² Texas Sunset Advisory Commission, *Health and Human Services Commission and System Issues: Staff Report with Commission Decisions*, p. 48.

SAO Audit of Information and Communications Technology Cooperative Contracts at HHSC — December 2013

The objectives of this audit were to determine whether the Health and Human Services Commission:

1. made purchases through DIR's Cooperative Contracts Program when required to do so; properly procured the contracts, negotiated appropriate prices and deliverables;
2. obtained IT goods and services as statutorily defined through the program; managed and monitored contractors to ensure that they performed in accordance with the contract terms; and
3. reported major IT resources purchased through this program to the Quality Assurance Team as required.

SAO offered these assessments:

1. HHSC does not maintain consistent documentation to support noncompetitive purchases and did not ensure that the prices paid included the DIR-negotiated discount or a greater one.
2. HHSC does not have consistent documentation to show that procurement staff disclosed potential conflicts of interest or confirmed that none existed.
3. HHSC monitoring of contracted staffing was limited to time-sheet approval as a basis for vendor payments.
4. HHSC does have a process in place to identify and report new major IT programs to the state's Quality Assurance Team.

The report recommended that HHSC ensure that it processes a purchase order for *every* program purchase, and record the purchase order or contract in its accounting system when processing payments. In addition to \$147.3 million in program purchases identified by HHSC from September 2011 through February 2013, SAO identified an additional \$19.2 million in payments for IT without corresponding purchase orders in the accounting system. After reviewing a sample of these payments, SAO found that 6 percent of those not associated with a purchase order resulted in overpayments totaling \$33,641.⁷³

SAO Audit of Selected Contracts at HHSC — June 2014

The objectives of this audit were to determine whether HHSC:

1. planned, procured and established two electronic benefits transfer (EBT) contracts for services in accordance with applicable statutes, rules, Comptroller requirements and HHSC

⁷³ Texas State Auditor's Office, *An Audit Report on Information and Communications Technology Cooperative Contracts at the Health and Human Services Commission*, December 2013, p. ii. Available at: <https://www.sao.state.tx.us/reports/report.aspx?reportnumber=14-013>.

policies and procedures, to ensure that the state's interests were protected; and

2. managed and monitored these contracts to ensure that contractors performed according to the contract terms and that contractor billings were valid in accordance with applicable statutes, rules, Comptroller requirements and HHSC policies and procedures.

This audit covered activities related to two contracts:

- the *Texas EBT retailer management services contract*, which HHSC awarded to Affiliated Computer Services State and Local Solution, Inc. (ACS, later Xerox State and Local Solutions, Inc.), in March 2008 for \$19,776,178, with an initial term of five years. The original contract amount did not include certain pass-through fees HHSC was required to pay to the contractor. HHSC later extended the contract term. Payments totaling \$43,419,389 had been made on this contract through December 31, 2013.
- the *Texas EBT Call Center Services contract*, which HHSC awarded to ACS in March 2008 for \$21,685,000, with an initial term of five years. The original contract amount did not account for fluctuations in call volumes associated with caseload growth. HHSC later extended the contract term. Payments totaling \$35,306,704 had been made on this contract through December 31, 2013.

SAO concluded that the two contracts generally complied with state requirements. HHSC, however, was unable to provide documentation showing that its solicitation documents included the weights it would use for evaluation criteria, or that it required employees involved in the contracting process to sign nondisclosure and conflict-of-interest forms.

The report recommended that HHSC strengthen its process for estimating and reviewing contract costs to make sure that it includes all costs.⁷⁴

SAO Audit of HHSC's Telecommunications Managed Services (TMS) Contract

The objectives of this audit were to determine whether HHSC:

- planned, procured and established the TMS contracts in accordance with applicable statutes, rules, Comptroller requirements and HHSC policies and procedures; and
- managed and monitored the TMS contract to ensure that contractors performed according to contract terms and that contractor billings were valid and supported in accordance with applicable statutes, rules, Comptroller requirements and HHSC policies and procedures.

The scope of the audit covered the TMS contract from its inception in fiscal 2008 through February 2014. It examined all phases (planning, procurement, contract formation and contract oversight) of the contracting process.

HHSC awarded the TMS contract to AT&T Global Services to provide telecommunications services to all five HHS agencies. The initial term was from August 29, 2008, through August 29, 2013, with an option for renewal for up to four more years. The initial total contract cost was

⁷⁴ Texas State Auditor's Office, *An Audit Report of Selected Contracts at the Health and Human Services Commission*, June 14, 2014. Available at: <http://www.sao.state.tx.us/reports/main/14-013.pdf>.

\$47,948,920. On September 1, 2011, the commission amended the contract's cost to \$80,633,059. Beginning in September 2013, the commission extended the contract's term through August 31, 2015, and increased its cost to \$105 million.

The report concluded that HHSC did not comply with state requirements to ensure that the contractor performed according to the contract terms and that billings were valid and supported. In addition, HHSC did not adequately estimate contract costs during planning, or ensure that employees completed conflict-of-interest forms. Furthermore, HHSC did not consistently record payments against this contract and could not accurately determine the total amount spent on it. Even so, the report concluded that HHSC generally complied with most contract planning and procurement requirements and that the contract contained all required terms.⁷⁵

HHSC Internal Audit of Non-routine Procurements

The objectives of this audit were to determine whether:

- HHSC's sole source/proprietary and emergency procurements are appropriate, justified and approved in accordance with guidance and requirements established by the state, PCS and the enterprise agencies; and
- whether after-the-fact purchases of more than \$5,000 are appropriate and meet competitive procurement requirements.

A proprietary product or service should have a distinctive characteristic not shared by competing products or services.⁷⁶ An emergency procurement is one for supplies needed immediately, without time for normal bidding procedures; hurricane supplies are a common example. "After-the-fact" procurement occurs when agencies make purchases prior to issuing purchase orders, which then are issued after the fact and aren't an emergency. The audit's scope covered the enterprise's non-routine procurements (sole source/proprietary purchases, emergency procurements and after-the-fact purchases for more than \$5,000) from September 1, 2012 to January 31, 2014.

Internal Audit found that PCS lacked adequate processes to ensure that requests for proprietary and emergency procurements contain sufficient documentation; include a justification clearly stating why the request meets legal requirements; and are approved by the proper authorities. In addition, Internal Audit found that the enterprise's procurement policies and procedures do not provide accurate guidance to ensure uniform practices throughout the enterprise, and that goods and services were purchased outside of the state's competitive bidding requirements.⁷⁷

Given the results of the various audits, the executive commissioner, in a supplemental response to SAO on February 4, 2015, admitted that they had found "a pattern of concern,

⁷⁵ Texas State Auditor's Office, *An Audit Report on The Telecommunications Managed Services Contract at the Health and Human Services Commission*, December 2014. Available at: <http://www.sao.state.tx.us/reports/main/15-017.pdf>.

⁷⁶ Texas Comptroller of Public Accounts, *Procurement Manual*, Section 2.15, February 2015. Available at: <http://www.window.state.tx.us/procurement/pub/manual/2-15.pdf>.

⁷⁷ Texas Health and Human Services Commission, Internal Audit Division, "Report of Non-routine Procurements and Purchases," March 2015.

indicating that contract management issues in this agency extend beyond any single contract.”⁷⁸ He outlined corrective steps to deal with these concerns:

1. Creation of a contract oversight team to review contract management across all five HHS agencies. This team’s first priority has been to strengthen contract oversight by reviewing and improving the management of high-risk contracts. Its key activities are:
 - performing a system-wide inventory of contracts;
 - updating and verifying the completeness and accuracy of contract information in HCATS;
 - performing contract risk assessments;
 - examining the management of highest-risk contracts; and
 - correcting specific contract management issues.
2. The contract oversight team has also been directed to examine cross-cutting issues in contract management resulting from “systemic policy or process weaknesses or the absence of adequate oversight.” The key steps in this effort include:
 - identifying systemic contract management weaknesses.
 - implementing policy and process improvements.
 - enhancing HCATS to include fields for risk-related data.
 -
 - introducing a more structured approach to managing contract-related risks
 - developing ongoing oversight of contract management across the HHS agencies.
3. The contract oversight team has worked with enterprise staff to:
 - draft proposed changes to existing HHSC purchasing and contracting rules to reflect the PCS consolidation and to streamline and update procurement and contracting rules to support a consolidated enterprise-wide framework. The target date for these rule changes is June 1, 2015.
 - evaluate the adequacy and effectiveness of ethics disclosure and update and clarify ethics rules for agency personnel and vendors. The target implementation date for these changes is June 20, 2015. HHSC has hired a new chief ethics officer to implement an enterprise-wide ethics program and oversee staff members who investigate allegations of ethical violations and conflicts of interest.

⁷⁸ Texas Health and Human Services Commission, Supplement Management Response from Executive Commissioner Kyle Janek to the State Auditor, regarding the draft report “An Audit Report on the Telecommunications Managed Services Contract at the Health and Human Services Commission,” February 4, 2014.

- dedicate a PCS liaison to each HHS agency to ensure close communication and early resolution of contracting issues.
- improve the procurement process by dedicating lawyers in the chief counsel's office solely to contract management.
- work with stakeholders to identify improvements to HCATS and ensure that HHS agencies enter consistent, accurate data for all contracts.
- evaluate the status of all RFPs currently in progress to ensure that procurements stay on track and are completed in a timely manner.

A draft of a *PCS Contract Management and Risk Assessment Manual* is currently under review.

In addition, HHSC's Risk and Compliance Management Division, created about a year ago, is developing risk based-assessment tools to allow the HHS agencies to identify and closely monitor high-risk procurements and contracts. These tools will be incorporated into the *Contract Management and Risk Assessment Manual* when complete.

Finally, HHSC has implemented a series of steps to streamline and improve the integrity of the contracting process. The agency has:

- approved the consolidation of system-wide contract oversight, currently housed at each of the enterprise agencies, into PCS.
- posted the enterprise's proprietary contracts on the agency website.⁷⁹
- required the signature of the executive commissioner or his deputy on large or complex contracts.
- established new policies to ensure a higher level of scrutiny for DIR contracts exceeding \$25,000:
 - a. such projects must be approved by IT and legal staff before seeking quotes.
 - b. quotes must be sought from all vendors under DIR contract.
 - c. HHSC will follow the same evaluation process used for competitive procurements, including negotiations.

Findings

1. The work associated with consolidating enterprise purchasing operations into the Procurement and Contracting Services Division is incomplete. PCS lacks the tools and authority needed to manage the enterprise's procurement and contract management effectively.

⁷⁹ See Texas Health and Human Services Commission, "HHSC Business Opportunities." Available at: http://www.hhsc.state.tx.us/about_hhsc/BusOpp/BO_home.shtml.

2. The 21CT controversy shed light on a particular contracting weakness in HHSC, but a series of audits over the past two years has highlighted significantly broader problems with procurement and contract management.
3. HHSC has had a series of significant contract mishaps in the past several years, most recently including problems with the TMHP Medicaid payments contract, which left the agency with little choice but to issue a three-year emergency contract when the TMHP contract was terminated. This abrupt shift and the emergency contract that followed ran counter to all best practices and have opened the agency to significant criticism.
4. During its work at HHSC, the strike force was never able to identify a fixed number of active contracts across the HHS enterprise. The HHS agencies do not have a consistent definition of what a contract is, and so different inquiries produce different results. In the strike force's view, the definition of "contract" should include all legal relationships of a contractual nature, including those resulting from procurements, open-enrollment contracts, grants, inter-local agreements and interagency contracts.

Given the lack of common definitions and inconsistent use of HCATS among the HHS agencies, the enterprise does not have a single, reliable data source for contract information.

5. HHSC has committed to fixing the problems in its contracting process and created a contract oversight team to focus on the issue. During our work, this team appeared to be making tangible improvements. HHSC must maintain its commitment to making this improvement a reality.

Recommendations

Contracting is a complex process, with many steps — and within each are opportunities to strengthen HHSC's ability to plan, execute, report on and monitor contracts. These recommendations would support and enhance HHSC's efforts to improve.

- 1. The HHSC executive commissioner should create or (reconstitute) a working group similar to the Contract Council to assist the HHS Contract Review team.**

This council should have clearly defined objectives, a project plan, timelines and clear lines of authority.

- 2. HHSC should clearly define what constitutes a contract, including legal definitions, and use these definitions to collect system-wide contract data for reporting purposes.**

This definition should include all legal relationships of a contractual nature, including open-enrollment contracts, grants, inter-local agreements, and interagency contracts.

- 3. As it finalizes the contract management manual, HHSC should clearly identify responsibility for all processes in the contract management life cycle.**

This assignment of responsibility could be as follows:

Contract Management Core Processes	Owner
Planning: identify contracting objectives, strategies and timelines.	Initiator/Program Area, Risk Management, Legal, PCS
Procurement: make a fair and objective selection of the most qualified contractors.	Certified Purchasers, although on large projects, program co-ownership is critical
Contract development: establish cost-effective processes and ensure that contracts contain provisions holding the contractor accountable for desired results, defining all relevant terms and conditions.	Initiator/Program Area, Legal, Risk Management
Contract oversight: continuously monitor outcomes to enforce contract terms.	Program staff/Contract Manager

4. **HHSC should address all of the recommendations in the reviews referenced in this report, and clearly assign responsibilities for making the changes needed to comply with their findings.**
5. **PCS should provide the enterprise with recurring training on the Contract Management Guide and statewide procurement laws and rules.**

Until PCS is in a position to perform this training, the agency should use training already offered by the Comptroller or the LBJ School.

6. **As HHSC pursues consolidation, it should define a structure that clearly aligns contract oversight and purchasing resources with enterprise business requirements.**

This will require HHSC to ensure that procurement and contract staff skills are aligned with their specific job responsibilities.

7. **HHSC should assign contract managers to ensure that employees responsible for contract management have a clear understanding of each contract's expected results and relevance to broader program goals and objectives.**

In normal practice where large projects are concerned (in HHSC or any state agency), vendors have trained staff assigned whose primary focus is to ensure that the contract meets agreed upon criteria and does not have "scope creep" that will cost them more money. Project management staff generally is more focused on the overall viability of the finished project. Large, complex projects are never without incremental changes, both from evolving state and federal regulations and because the agency is no able to provide

complete precision when describing the required results. There needs to be a clear process for getting both the vendor and the agency together to the greatest extent possible when working through these changes.

8. Procurement projects should feature formal milestones that measure progress.

The timeline for a solicitation should be established up front and agreed upon by all those involved. Deadlines for each step in the process should be planned and clearly communicated. A clear timeline can make the solicitation process more agile and help to establish user and vendor expectations.

9. HHSC should apply risk analysis to the procurement and contract life cycle to assess fraud and abuse and identify high-risk contracts requiring enhanced monitoring.

10. PCS, with the support of executive administration, should impose a consistent structure on the contracting process, including standardized forms, templates, centralized reporting to a common system and oversight to ensure that these standards are followed.

11. The HHS enterprise should consider options for acquiring or developing a true procurement and contract management system with greater utility and functionality than HCATS.

This enterprise should include clear requirements for processing of procurement requests, approval routing, solicitation creation, contract award and oversight.

12. For all sole-source or proprietary procurements, the HHS agencies should post on the Electronic State Business Daily or send to registered Electronic State Business Daily vendors notices of intent to issue a sole-source or propriety purchase order.

These notices should incorporate the following suggested language:

The issuing office believes that the requested goods or services required by this statement of work may be proprietary to one vendor under Texas Government Code 2155.067; however, the issuing office strongly encourages offers from all qualified respondents that may be able to provide the requested items.

13. HHSC should develop a strategy for training contract lawyers.

The ability of agency attorneys to thoroughly understand and vet large contracts is critical to the process but often is overlooked. Vendors employ attorneys that are expert in this area, and the agency should build expertise in any way it can to insure a level playing field.

14. The executive commissioner should require all executive managers to complete an abbreviated contract management course, as state law already requires for members of state agency governing boards.

- 15. The HHS agencies should implement the requirement contained in Governor Abbott's January 28, 2015, letter to state agencies, which requires the director of each agency's central contracting and procurement office — the deputy executive commissioner for PCS, in this case — to sign off on procurements exceeding \$5 million, and to report in writing to the agency head — the executive commissioner, in this case — any potential problems that could arise in the contract solicitation.**

5 | Organization and Management

When the strike force began its review of HHSC on January 15, we found the agency in a state of quiet turmoil. Part of this was obviously a direct result of unfavorable press coverage, but after a few days of interviews with senior HHSC staff and others, it became apparent that the 21CT controversy and other issues in recent media reports were symptomatic of more significant managerial and organizational problems.

Between December 12 and January 16, six HHS employees either left the agency or were placed on administrative leave. The fact that they included several individuals highly placed in the HHSC administration—including the inspector general, the executive commissioner’s chief of staff and deputy chief of staff, the chief counsel and the chief counsel’s chief of staff—was more than enough evidence of upheaval within the agency.

After more than 50 interviews with agency personnel as well as vendors and stakeholders, the strike force believes that many of the problems the enterprise faces are a result both of recent managerial problems and the agencies’ response to the 2003 consolidation. It provides an example of today’s organizational problems springing from yesterday’s solutions.

According to the October 2014 Sunset report:

In addition to saving money through program cuts and projected administrative efficiencies, the Legislature expected the 2003 consolidation of human services agencies under the direction of HHSC to strengthen accountability by streamlining programs, breaking down cultural and structural barriers, and eliminating fragmentation of services by combining like functions. While partially achieved, this vision is not yet complete.⁸⁰

Sunset staff accurately described the current situation. More than a decade after H.B. 2292, administrative services that were supposed to be fully centralized are “still incomplete, resulting in lost opportunities for efficiencies and cost savings.” The staff recommended, and the commission agreed, that complete consolidation (merging the five HHS agencies into a single one) should be completed by the end of fiscal 2016. During the course of our work, the agency was working on a transition plan and on consolidating some administrative services, notably the legal staff.

It is clear that the challenges posed by consolidation under H.B. 2292 and the resulting organizational changes created a series of unexpected consequences; it’s always easier to rearrange boxes on an organization chart than to actually reorganize and manage large numbers of individuals with varying skills, working under enormous pressure to maintain services to an ever-growing client population.

Over time, academics and experts have developed many different templates for evaluating organizational effectiveness. These often-simple structures are designed to point managers and

⁸⁰ Texas Sunset Advisory Commission, *Health and Human Services Commission and System Issues: Staff Report with Commission Decisions*, p. 6.

evaluators in the right direction as they look for ways to improve performance. Organizational difficulties usually have more than one cause, although blame is often fixed on managers, technology, planning or some other easily identified factor. In reality, these factors are always intertwined, and must be understood to find effective solutions.

HHSC's problems didn't begin with the 21CT controversy, and aren't confined to procurement. Those issues must be addressed, but the enterprise's larger problems cannot be fixed by focusing on them alone. Our review eventually identified four broad elements that need attention from agency management — and likely from the Governor and Legislature.

To borrow McKinsey & Co.'s well-known 7S framework for evaluating organizational design, HHSC's problems involve *strategy*, *structure*, *systems*, and *staffing*. These problems didn't begin with 21CT or with the current administration. As one person we interviewed said: "This has been coming for a decade."

Strategy

The 2003 organizational changes prompted by H.B. 2292 were an important step toward rationalizing the delivery of health and human service programs in the state. Prior to the 2003 legislation, health and human service delivery involved 12 agencies operating 200 programs from more than a thousand facilities and offices. As the Legislative Transition Oversight Committee, created to oversee progress on implementation of the legislation, said in a December 2004 report:

Occurring over many decades and without an overall plan, the health and human services agencies grew into a confusing, disjointed and redundant system.⁸¹

The 2003 legislation actually was the second step in the consolidation of Texas' health and human services. In 1991, H.B. 7 restructured the system by establishing HHSC as an "umbrella agency" to oversee all HHS functions. This legislation started the consolidation process, reducing the number of primary HHS agencies from 14 to 12, and also consolidated some human service programs previously found in 11 other agencies.⁸²

H.B. 2292 sought to resolve issues unaddressed in the 1991 legislation, consolidating the existing agencies into five to be coordinated by stronger leadership at HHSC. As the Transition Oversight Committee put it, creating the new structure meant "undertaking one of the most significant governmental reorganization efforts in recent U.S. history." This is an important point to keep in mind. H.B. 2292 wasn't conceived as a simple reorganization plan. It was a top-to-bottom overhaul of the system.

The legislation also directed HHSC to integrate eligibility determination for the Children's Health Insurance Program (CHIP), Medicaid, Food Stamps, Temporary Assistance for Needy Families (TANF), and long-term care for people who are elderly or have disabilities. In addition,

⁸¹ Texas Legislature, Transition Legislative Oversight Committee, *Biennial Report*, December 2004, p. 3.

Available at:

http://www.house.state.tx.us/_media/pdf/committees/reports/78interim/oversight_transitionLegislative.pdf.

⁸² Tex. H.B. 7, 72nd Leg., First Called Sess. Available at;

<http://www.capitol.state.tx.us/BillLookup/history.aspx?LegSess=721&Bill=HB7>.

HHSC was directed to study and implement appropriate and efficient ways to use new and existing technology to improve HHS operations and service delivery.

At the end of 2004, the Transition Oversight Committee found significant progress in the transition:

Improvements over the past 18 months have resulted in increased efficiencies in the delivery of services, more productive working relationships with providers, and fewer barriers and greater access for clients. Notably, the changes and improvements of the past 18 months have occurred while causing minimal disruptions in service.⁸³

All of which was true; an immense amount of work had been completed with minimal disruption in services. But within the enterprise, the changes were proving to be disruptive. Programs were moved and rearranged, new reporting and operating relationships were created and the agencies began perhaps the most challenging part of the consolidation — actually integrating service delivery and its complex web of systems in the way that H.B. 2292 envisioned. In effect, the HHS agencies had to “rewire” the way they did business in fundamental ways, and the changes were not without pain or complication.

At some point, however, this ambitious strategy began to grind to a halt. A former executive commissioner told us he had believed the consolidation had progressed far enough, and represented an ideal mix of consolidation and decentralization. He said a fully centralized model could create an unresponsive bureaucracy. In other words, the enterprise’s management at the time felt it was important to find a balance between the “confusing, disjointed, and redundant” HHS enterprise that existed before consolidation and an unwieldy but centralized bureaucracy.

In the years following the enactment of H.B. 2292, the HHS agencies faced many challenges, such as large-scale system integration and the advent of Medicaid managed care. Once paused, the consolidation drive was either too difficult to restart or was pushed aside by the press of other projects. The strategic direction of the consolidation thus shifted and arguably never returned to the path set by the Legislature. The Transition Legislative Oversight Committee was abolished by S.B. 1188 during the 2005 legislative session, meaning that legislative oversight largely moved on to other, more pressing concerns.⁸⁴

After almost a dozen years, it is reasonable to evaluate what was achieved by the 2003 consolidation — and what else might be achieved. In that regard, the Sunset staff report’s Issue 2 focused on one aspect of the H.B. 2292 consolidation left partially complete — the consolidation of administrative services. The goal of consolidating services such as procurement, IT, financial management and human resources is to improve efficiency, gain economies of scale and provide the executive commissioner and enterprise senior management with a common view of the enterprise.

The Sunset staff report does an excellent job of showing just how much of this consolidation, a key part of the legislation, has been achieved (Figure 6). It is far from complete.

⁸³ Significantly, H.B. 2292 did not set a date set for the *completion* of the HHS reorganization. The deadline was negotiated out of the final legislation to allow flexibility in planning and implementation.

⁸⁴ Tex. S.B. 1188, 79th Reg. Sess. Available at:

<http://www.capitol.state.tx.us/BillLookup/history.aspx?LegSess=79R&Bill=SB1188>.

FIGURE 6: Status of Administrative Consolidation Efforts, Sunset Staff Report

Function	Degree of Consolidation and Control at HHSC			Comment
	Low	Mid	High	
Human resources				First high profile service consolidated at HHSC
Facilities management				Most regional management activities and personnel are centralized in HHSC
Rate setting				HHSC sets fees for all Medicaid programs and many for other parts of the system
Financial management – actuarial analysis, forecasting				Forecasting and actuarial analysis are mostly consolidated
Financial management – budget and fiscal policy				Agencies maintain their own chief financial officers
Contracting services – competitive procurements				HHSC takes the lead in competitive procurements
Contracting services – noncompetitive procurements				System agencies drive most of these processes
Strategic planning and evaluation				Some functions are also carried out by staff in other agencies, but coordinated through HHSC
Information resources				Function also carried out by staff in other agencies, but coordinated through HHSC
Accounting				Function also carried out by staff in other agencies, but coordinated through HHSC
Legal				Discussions of consolidation of legal services at HHSC ongoing at the time of this review
Audit				All agencies have their own internal audit staff, with little coordination through HHSC. HHSC coordinates or performs enterprise audits.

Source: Texas Sunset Advisory Commission, *Health and Human Services Commission and System Issues: Staff Report with Commission Decisions*, December 2014.

In recent months, HHSC has renewed the push for consolidation in response to the Sunset recommendations. At present, this process is focused on finishing the consolidation of administrative services. But this effort is intended largely to check boxes on a to-do list written almost a dozen years ago. Before full consolidation begins, we believe another step is essential to success; the enterprise must develop a clear vision for the future of health and human services delivery in Texas — and a comprehensive strategy for getting there. At this time, HHSC does not appear to have such a vision or strategy. It has management but lacks leadership. Even then, too often, its decisions are reactive, guided by legislative direction or the crisis of the moment.

HHSC's role is changing. Given the rapid expansion of Medicaid managed care and other changes, a smooth transition from service delivery to strategic oversight is critical. We found little evidence of a path or plan for this transformation, which will involve a major culture shift not unlike the one the HHS agencies faced after H.B. 2292. As one outside critic told us, "They don't know who they want to be and for sure have no idea how to get there."

Systems

The success of the consolidation recommended by the Sunset Advisory Commission will hinge on how well the enterprise's complex computer systems and outsourced service delivery model knit together. This has been a problematic area for HHSC, and although the problems began before the 2003 consolidation, they were definitely complicated by it. Although the back story of this issue is convoluted at best, it's key to understanding the internal challenges any large shift in the HHS business model is likely to present.

In this context, the two most obvious examples of these difficulties are the story of TIERS, the enterprise integrated eligibility system, and the recent controversy over HHSC's Medicaid payment processing contract. Both illustrate the challenges presented when large agencies attempt to overhaul their technology backbone and managing contracted service delivery.

Texas Integrated Eligibility Redesign System (TIERS)

In the early 1990s, the HHSC and the Department of Human Services began discussions about replacing its aging SAVERR system, a legacy computer system containing a database that stored individual and case information. When SAVERR was implemented in 1978, Texas became one of the first states to provide automated support to field staff in determining client eligibility. Written in programming language from the 1950s, SAVERR was well past its prime by the 1990s.⁸⁵

HHSC detailed the problem in a 2007 report to the Legislature:

The state's current system is badly out of date. It uses a computer system built on a language (COBOL) that colleges no longer teach. Its one-size-fits-all approach makes it especially difficult for working families — Texans who have to take off work to apply for benefits at a local office.⁸⁶

According to a 2007 *Austin American Statesman* article, HHSC officials estimated the costs of maintaining the SAVERR mainframe at \$1 million a month.⁸⁷

During the 1993 legislative session, the Department of Human Services and HHSC requested appropriations for a new eligibility system, but the request was denied. Instead, the Legislature and the health and human services agencies began a multi-year process to decide how best to replace SAVERR. This culminated in 1999, when lawmakers decided to build a single, integrated system. A rider in the Department of Human Services' budget directed it to plan and develop what was known at the time as the Texas Integrated Eligibility System (TIES) but which came to be known by the more familiar designation, Texas Integrated Eligibility Redesign System (TIERS).

⁸⁵ SAVERR: System for Application, Verification, Eligibility, Referral, and Reporting.

⁸⁶ Texas Health and Human Services Commission, *House Bill 3575: Health and Human Services Eligibility System Transition Plan*, October 2007, p. 1, http://www.hhsc.state.tx.us/reports/HB_3575_TransitionPlan.pdf.

⁸⁷ Corrie MacLaggan, "After Spending \$500 Million, Texas Is Back Where It Started," *Austin American Statesman*, April 25, 2007. Available at: <http://www.statesman.com/news/content/region/legislature/stories/04/25/25benefits.html>.

The rider established TIERS as a replacement system for SAVERR, with enhanced interfaces with the Texas Workforce Commission, Texas Department of Health and the Attorney General's Office. It was not until 2001, though, that HHSC fulfilled the Legislature's planning requirements and received appropriations to develop TIERS. The contract for TIERS development was awarded to Deloitte LLP in that year, after a competitive bidding process.

In 2003, the initial TIERS pilot began in four eligibility offices in Travis and Hays counties. However, the system's development collided that same year with the HHS changes made under H.B. 2292. The 2003 legislative session was notable due to budgetary problems caused by the tech bust and recession. Nevertheless, H.B. 2292 envisioned a bold new direction for HHS delivery, premised on streamlined processes, outsourced services and reduced costs. It consolidated the enterprise from 12 to five agencies, reducing the HHSC budget by \$42.5 million and eliminating 901 full-time positions. Later in 2003, TIERS expansion was suspended to ensure the system could be transformed to accommodate the new delivery of eligibility services available through multiple access channels that was envisioned under HB 2292.

The bill also directed HHSC to examine ways to streamline eligibility determination for programs such as CHIP, Medicaid, Long-Term Care, Financial and Nutritional Assistance and Community-based Support; to evaluate whether call centers would be a cost-effective addition to the eligibility and enrollment process; and, if so, to contract with a private vendor to operate the call center. The commission determined call centers were cost effective in 2004.

To achieve the goals of H.B. 2292, HHSC needed a more powerful data management system to manage client services across programs and, just as importantly, to support the new call-center model. Its officials had to choose between SAVERR, TIERS or a vendor's proprietary software. At the time, TIERS was still being developed by Deloitte and was thus a work in progress. Neither SAVERR nor TIERS were designed to work with call centers; both were built with in-person interviews in mind. Nonetheless, the agency decided to go with TIERS. Thus, the already complex computer system was suddenly saddled with a new model of service delivery — the call center approach — that would be carried out in whole or part by contractors rather than state employees. It was a more profound change in direction than most people appreciated at the time.

In June 2005, after a competitive procurement process, HHSC announced a tentative award for the Integrated Eligibility and Enrollment Services (IEES) contract to the Texas Access Alliance (TAA) led by Accenture LLP. TAA assumed responsibility for TIERS contracts previously held by various contractors for call center operations, CHIP processing and eligibility determination, TIERS maintenance and enrollment broker services. The contract elements included moving some work currently performed by state eligibility workers to the contractor. At this time, the agency terminated its contract with Deloitte, although TAA eventually contracted with Deloitte for some of the work involved in fixing and modifying TIERS.⁸⁸

In January 2006, TAA, in conjunction with HHSC, implements an IEES pilot in Travis and Hays counties. Almost immediately, problems arose such as high call-center wait times, technical issues with software, inadequately trained contractor staff, delays in application processing, and

⁸⁸ Texas Health and Human Services Commission, *House Bill 3575: Health and Human Services Eligibility System Transition Plan*.

improper benefit denials. As a result of these problems, the pilot was suspended in April 2006, and HHSC took back some functions from TAA.⁸⁹

Based on the lessons learned, HHSC and TAA announced a plan to restructure the contract in December 2006, with the state retaining some functions originally intended for outsourcing. In addition, the terms of the TAA contract were reduced. Finally, in March 2007, the state and contractor mutually agreed to end the contract. HHSC signed short-term contracts with key subcontractors to continue services.

In April 2007, the HHSC inspector general issued a report critical of TIERS development.⁹⁰ “The project was so large and tech-driven that some of the business needs were not properly designed into the system,” then-inspector general Brian Flood said in an interview.⁹¹ The OIG report was followed by a series of legislative hearings and an October 2007 State Auditor report, which concluded:

Poor architectural design and chronic problems have made TIERS cumbersome to use and hinder the ability of TIERS to process and maintain the integrity of data.⁹²

The system had been handling only 5 percent of agency cases, with the pilot programs in Travis, Hays and Williamson counties accounting for most of that.

After the TAA contract cancellation, HHSC took back some functions, but remained committed to the general idea of outsourcing its eligibility system. Maximus, a former member of TAA, took over some of the contracted functions, including providing staff for the call centers who worked with agency employees. HHSC also rehired Deloitte to manage TIERS.⁹³

Despite these changes, problems continued. Processing slowdowns led to backlogged eligibility cases. In 2008, the *Austin American-Statesman* reported that fewer than half of all Texas food stamp applications processed in December 2007 using TIERS were completed within the 30 days required by the federal government.⁹⁴

The basic rollout of TIERS to all state regions was not completed until September 2011. As of that date, programs such as Medicaid, food stamps and the Texas Works employment education and training program were all running through TIERS. Further deployments to handle Medicaid for

⁸⁹ Texas Health and Human Services Commission, *House Bill 3575: Health and Human Services Eligibility System Transition Plan*, p. 10.

⁹⁰ Texas Health and Human Services Commission, Office of Inspector General, *TIERS/IEES Review*, April 18, 2007. Available at: <http://www.inthepublicinterest.org/sites/default/files/Texas%20OIG%20TIERS%20Report%20April%202007%5B1%5D.pdf>.

⁹¹ Patrick Michaels, “Tale of TIERS,” *Government Technology*, July 17, 2007. Available at: http://www.govtech.com/templates/gov_print_article?id=99380279

⁹² Texas State Auditor’s Office, *An Audit Report on The Health and Human Services Commission’s Texas Integrated Eligibility Redesign System (TIERS)*, October 2007, p. i. Available at: <http://www.sao.state.tx.us/reports/main/08-009.pdf>.

⁹³ Patrick Michaels, “Tale of TIERS,” *Government Technology*, July 17, 2007.

⁹⁴ Corie MacLaggan, “Pay Raises, Faster Promotions Aim to Combat Rapid Turnover,” *Austin American-Statesman*, March 24, 2008. Available at: <http://hhscemployee.blogspot.com/2008/03/austin-american-statesman-article.html>.

the elderly, disability and long-term care and a three-year SNAP certification for people receiving Supplemental Security Income were completed in mid-December of the same year.

With the work complete, HHSC's problems with TIERS were largely over, almost 20 years after replacing SAVERR was first discussed. Its problems with contractors were not over, however. In 2014, the agency faced another major issue, one involving Xerox and Medicaid claims processing.

The TMHP Controversy

In May 2014, the Texas Attorney General's Office filed a lawsuit against Xerox in an effort to reclaim hundreds of millions of dollars it alleged had been paid for medically unnecessary Medicaid claims. According to the Attorney general's complaint, filed in Travis County district court,

Xerox's unlawful acts resulted in a substantial breach of safeguards intended to protect taxpayer dollars, maintain the integrity of Medicaid policies, and ensure the appropriate delivery of services to Medicaid clients. Xerox permitted an unprecedented loss of Medicaid funds to predatory and unscrupulous dental providers. As a result of the conduct of both Xerox and these providers, the Medicaid program was deeply compromised.⁹⁵

At about the same time, HHSC notified Xerox that it planned to terminate its contract for Medicaid claims payment services. As a practical matter, the state did not terminate its contract with Xerox, but with the Texas Medicaid and Healthcare Partnership (TMHP), a Xerox subsidiary. The lawsuit alleges that the state spent \$1.1 billion on Medicaid orthodontic services from January 2004 to March 2012, but does not specify how much of this represented provider overpayments. Instead, it alleged that, as a result of the contractor's actions, "hundreds of millions of dollars in payments were made for services not performed and orthodontic benefits not authorized by Medicaid policy," and that the company received "tens of millions of dollars" for services it did not perform.

HHSC originally contracted with TMHP in 2004, when the consortium was managed by ACS State Healthcare LLC, which Xerox acquired in 2010. The problems leading to the 2014 lawsuit emerged over several years. In 2010, Texas spent as much on orthodontic services as the nine other most populous states combined, according to an April 2012 report by the U.S. House Committee on Oversight and Government Reform, which stated:

The state has admitted that widespread fraud was occurring and that the organization the state hired to assess prior authorization forms was essentially rubber-stamping forms for approval.⁹⁶

⁹⁵ Becca Aaronson, "Texas Cancels Medicaid Contract, Sues Xerox Over Allegedly Misspent Money," *The Texas Tribune*, May 9, 2014. Available at: <http://www.texastribune.org/2014/05/09/texas-sues-xerox-recover-millions-misspent-money/>

⁹⁶ U.S. House of Representatives, Committee on Oversight and Government Reform, *Uncovering Waste, Fraud, and Abuse in the Medicaid Program*, Staff Report, April 25, 2012, p. 17. Available at: <http://oversight.house.gov/wp-content/uploads/2012/04/Uncovering-Waste-Fraud-and-Abuse-in-the-Medicaid-Program-Final-3.pdf>.

The problem first came to light in December 2011 as part of an investigation by WFAA-TV in Dallas which looked at state spending on Medicaid orthodontic services. According to a May 2014 *Texas Tribune* article, “From 2011 to 2013, the state paid the contractor \$527 million to process Medicaid claims, despite concerns expressed in a 2008 report that it was not properly reviewing dental claims.”⁹⁷ The 2008 report, by the HHSC OIG, found that the contractor had one dentist who reviewed roughly 10 percent of orthodontic claims.⁹⁸ Employees without dental licenses reviewed the remaining claims, a significant source of concern.

In 2011, Doug Wilson became inspector general and Jack Stick became his deputy for enforcement. Under their leadership, OIG began aggressively cracking down on Medicaid providers. In October 2012, Wilson said the agency had 27 open investigations and had put payment holds on 26 providers while investigators pursued allegations of fraud.⁹⁹ He also stated that the agency had identified more than \$370 million in potential overpayments for Medicaid dental and orthodontic services, and that HHSC was also expanding its Medicaid fraud team in an effort to reduce the duration of fraud investigations from four years to eight weeks. In 2012, too, HHSC, OIG and the Attorney General’s office also formed a joint task force to crack down on Medicaid dental and orthodontic fraud.

It is no coincidence that this was also the period in which OIG began acquiring fraud detection services from 21CT. An October 2012 *Texas Tribune* article obliquely mentions the 21CT contract in connection with a report on increased OIG fraud investigation activities:

The agency is also planning to update the state’s data mining technology within the next few months. While the current system can only be used to look up information on providers the agency already suspects of fraud, the new system will use pattern analysis and other advanced tracking methods to identify fraudulent providers in real time.¹⁰⁰

To further complicate matters, HHSC was in the process of developing a request for proposal for a new Medicaid Management Information System (MMIS) and related systems and two requests for information had already been released. However, the agency was unready to do a competitive bid for the services in the time remaining on the term of TMHP contract. Instead, it announced in May 2014 that it would sign a three-year agreement with Accenture, then a Xerox subcontractor, to take over TMHP’s role in processing Medicaid claims, effective the following August 1.¹⁰¹ HHSC then planned to conduct a competitive bidding process to select a new contractor after Accenture’s three-year term. Accenture had operated the state’s Medicaid claims payment system since 2004, continuing despite its problems with the TIERS project and the subsequent end of that agreement.

⁹⁷ Becca Aaronson, “When is a State Contract Too Big to Fail?” *The Texas Tribune*, May 2, 2014. Available at: <http://www.texastribune.org/2014/05/02/when-texas-state-contract-too-big-fail/>.

⁹⁸ Texas Health and Human Services Commission, Office of Inspector General, *Performance Audit Report: Texas Medicaid Healthcare Partnership Prior Authorization Audit*, August 29, 2008, p. 3. Available at: <http://www.tdmr.org/wp-content/uploads/1TMHP-Prior-Authorization-Final-Report.pdf>.

⁹⁹ Becca Aaronson, “Lawmakers Want Answers on Dental, Orthodontic Fraud,” *The Texas Tribune*, October 15, 2012. Available at: <http://www.texastribune.org/2012/10/15/joint-task-force-tackles-medicaid-dental-fraud/>.

¹⁰⁰ Becca Aaronson, “Lawmakers Want Answers on Dental, Orthodontic Fraud.”

¹⁰¹ Becca Aaronson, “Texas Cancels Medicaid Contract, Sues Xerox Over Allegedly Misspent Money.”

This solution ran into further complication in February, when the *Houston Chronicle* reported that, in signing the contract with Accenture, HHSC did not follow state law by notifying the Comptroller's office that no competition had been involved in selecting the company on a contract estimated to be worth \$192 million a year.¹⁰² This failure to follow state procedures allowed HHSC:

...to avoid having to formally justify the process.... The decision not to classify the deal in the comptroller's accounting system as an 'emergency' agreement reached without competition also may have reduced scrutiny of what has been by far the largest such state contract in recent memory, according to the office.¹⁰³

In retrospect, it was a procurement oversight, but the decision to terminate the contract, while abrupt, was not necessarily the wrong decision. However, the timing was difficult for the agency given where it was in the re-procurement process.

At meetings of a state House Appropriations subcommittee and the state House Government Transparency & Operation Committee in February 2015, the executive commissioner told committee members that a no-bid emergency contract was inevitable when he started his job in September 2012, because the contract with Xerox was due to end in summer 2014, and that a competitive procurement process for such a complex contract would require three years — begging the question of why the agency had not been preparing for this contingency since 2012.

HHSC also said that in a competitive rebid, it would break the large contract into as many as five separate parts to make it easier to take action against a vendor without disrupting medical care for Medicaid clients. These procurements presumably would still require three years to complete.

Furthermore, the strike force subsequently learned that the state, through Accenture, was retaining Xerox, by then facing a state lawsuit, to continue running its pharmacy benefits management program with a lucrative new contract. The explanation given was that a different subsidiary of Xerox was handling this function and was performing well.

During interviews, the strike force heard various explanations for this chain of events, including the arguments that very few contractors can process Medicaid payments; that Accenture was a logical choice because services needed to be continued without interruption; and that there was no time to rebid the TMHP contract because of the long lead time required. The agency has publicly said that it continued its contract with TMHP, despite the alleged problems in claims processing, because HHSC feared Medicaid patients would lose access to care if the contract were canceled.

HHSC management accepts this reasoning, although the abruptness of the decisions point to the need for more effective planning and contract monitoring. The agency had hints of a problem in

¹⁰² Brian M. Rosenthal, "Officials Skirted Rules by Not Classifying Mega-deal as Emergency," *Houston Chronicle*, February 27, 2015. Available at: <http://www.houstonchronicle.com/news/politics/texas/article/Officials-skirted-rules-by-not-classifying-6106592.php?t=632a9f229f29895b84&cmpid=twitter-premium>.

¹⁰³ Brian M. Rosenthal, "Officials Skirted Rules by Not Classifying Mega-deal as Emergency."

the dental program as early as 2008. It launched a crackdown on providers beginning in 2012 and participated in a task force on the issue with the Attorney General's Office in 2012 and 2013.

HHSC knew that TMHP had played a role in the situation, whatever it proved to be, and just as certainly knew the TMHP contract term was ending and that sound practice would require a rebid even if the agency was unsatisfied with TMHP's performance. It also knew in 2013 that the Attorney General's Office was laying groundwork for a lawsuit against the company. Chief Counsel Jack Stick even brought a settlement offer from the company to the attorney general, who rejected it as inadequate given the scope of the problem. Vendors told the strike force that they believed HHSC was negotiating with Accenture to take over the contract while simultaneously negotiating a settlement agreement with Xerox.

Not unreasonably, it took the Attorney General's Office until 2014 to build a case for what was bound to be a complex lawsuit, but HHSC inexplicably took no remedial steps against TMHP early on that might have corrected the problem before it came to a lawsuit. By the time the lawsuit was filed, it was, according to the executive commissioner, years too late to competitively rebid the contract without a stopgap solution that handed the TMHP contract to a vendor with which the state had parted company after another large system failure only seven years before.

For a large contract, worth hundreds of millions of dollars, HHSC should have used a risk-based assessment to anticipate and plan for these potential problems. The available evidence suggests that nothing of the kind happened. HHSC coasted into a major procurement problem that put the state at risk for millions in additional costs.

Structure

By structure, we mean how an agency is organized — its organizational chart and reporting relationships. It's one of the most visible and easy-to-change elements of any organization — at least on paper.

The HHS enterprise has an organizational structure largely unique in Texas government. Most state agencies can be broadly divided between those headed by statewide elected officials — the Attorney General's Office, Comptroller's Office, Department of Agriculture, Railroad Commission and General Land Office — and those headed by executive directors but governed by appointed boards or commissions. Under H.B. 2292, the Legislature created an executive commissioner appointed by the Governor and confirmed by the Senate. All existing boards and commissions of the HHS agencies were made advisory. This is as close as Texas has come to true cabinet-style government, in which all agency heads report to the Governor.

This organizational structure was not in place at HHSC's creation. H.B. 7 from 1991 created the HHSC and its commissioner (executive commissioner was a title created by H.B. 2292), but in practical effect, the other HHS agencies remained separate and were governed by separate boards. As one former HHS commissioner from this period told the strike force:

It was a loose confederation. There were separate boards and separate responsibilities. Every one of them was a full-time job, and my role was shepherding everything along and trying to get coordination, not controlling what the agencies did.

Role of the Executive Commissioner

To fix the perceived problems of this loose structure, the 2003 legislation significantly strengthened the role of executive commissioner, granting the position much broader authority to manage the HHS enterprise. The executive commissioner was authorized to appoint the other HHS commissioners, with the Governor's approval, and to

- adopt rules and policies for HHS agencies;
- manage and direct HHS agency operations and each agency director;
- allocate resources within HHSC, including federal funds;
- set reimbursement rates for services;
- oversee the enterprise's human resources, contracting, purchasing, IT and facility functions; and
- coordinate enterprise activities with other state agencies.

Moreover, the HHS budget is consolidated under HHSC and presented to the Legislature in a consolidated form.

In short, the executive commissioner has extraordinary authority to govern the HHS enterprise, subject to oversight from the Governor and the Legislature. The problems we observed at HHSC are not ones of organizational control; they concern the sheer scope of the executive commissioner's daily responsibilities, which range from financial management to questions of arcane federal policy, and which may involve decisions on human resource issues, procurements and the interaction of the enterprise agencies. And this daunting list doesn't include the time and effort involved in meeting with staff, stakeholders, legislative committees, individual lawmakers and other state officials.

As with a major company, an organization the size of the HHS enterprise must be structured to allow the CEO to use his or her time wisely. Otherwise, time is wasted, strategic direction becomes muddled, and management can become sluggish and ineffective.

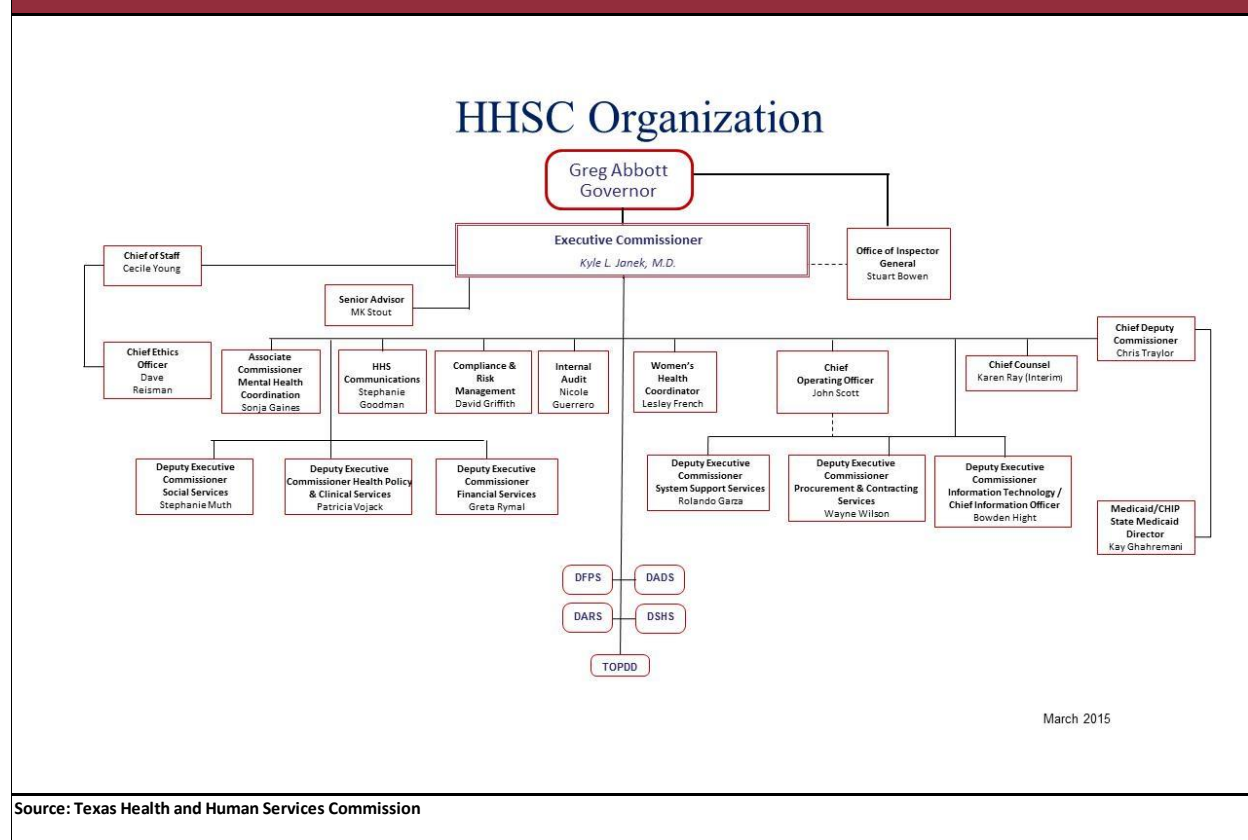
HHSC is indeed locked in an ineffective management structure. Figure 7 shows the HHSC organization in March 2015. The executive commissioner had 23 listed direct reports, including the four other commissioners and the executive director of the Texas Office for the Prevention of Developmental Disabilities. This list, moreover, does not include other staff members, such as the Sunset coordinator, who regularly report to the executive commissioner. In all, the number of senior management positions in HHSC includes 28 staff members.¹⁰⁴ Given the scope of the executive commissioner's roles, both internal and external, this is an extraordinarily broad span of control for one person, but it is a span of control that has been a characteristic of HHSC since just after the 2003 consolidation.

¹⁰⁴ Texas Health and Human Services Commission, breakdown of upper-level HHSC employees and position detail as of March 15, 2015, prepared by the Human Resources Division.

According to agency conventional wisdom, HHSC’s original executive commissioner following consolidation, Albert Hawkins, preferred a flat upper management structure since he wanted to be able to interact with all of the agency commissioners and deputy executive commissioners, unfettered by intervening levels of management. This may have worked well for Hawkins, given his long experience in the state and federal governments. It does not, in the strike force’s view, fit well in the current commission environment, which involves much more expansive and complex demands.

The executive commissioner has the accountability and the latitude to create a functioning organizational structure that fits the evolving needs of the agency. The skills and vision necessary to do those things should be a critical competency for an executive commissioner. The Legislature should not be forced to require an investigation and report every two years to see how the agency is operating and if their organizational structure works for what they want done—that is what the leader of the organization is paid to do.

FIGURE 7: Health and Human Service Agency Organization, March 2015



Management at this level of detail requires active, constant interaction, rather like the old circus act in which a performer must keep multiple plates spinning on poles simultaneously. If the executive commissioner’s span of control is too great, the organizational structure can deteriorate into a network of informal business arrangements, with poor communication flows up and down the organization. We believe that this has happened in HHSC. More than one commissioner of the other HHS agencies told us that biweekly meetings with the executive commissioner had become a formal routine of reports on Sunset activities and “roundtable,” in which the commissioners report

on their current activities. Given the size and challenges facing the HHS enterprise at the time of these interviews, this approach is inadequate.

In our view, HHSC needs a layer of executive managers below the commissioner, not to reduce his authority but to help with the day-to-day burden of administration and to deal more frequently and directly with program areas than the executive commissioner's normal schedule allows. In other words, the executive commissioner needs this help in dealing with the intricacies of the HHS programs and administrative operations to give him more time to focus on developing a vision and strategies for health and human services, and for interactions with key stakeholders, including the Legislature and executive administration, that are critical to the enterprise's successful operation.

Former Governor Perry appears to have understood this problem when he appointed Dr. Janek as executive commissioner in August 2012. At the same time, he appointed Chris Traylor, then commissioner of the Department on Aging and Disability Services, as chief deputy commissioner. This implies a role above other deputy commissioners; unfortunately, for most of his tenure this has not been his role, as Figure 8 illustrates. Traylor has primary responsibility for Medicaid, an admittedly imposing set of responsibilities, but is often left out of other direct lines of responsibility except when directed by the executive commissioner. This is not the best use for one of the agency's most talented staff members, a point made several times by those inside and outside the organization. The executive commissioner needs direct line support to be successful, as in most large agencies.

Divided Responsibilities

The presence of Medicaid in HHSC, whose primary mission is to provide oversight for the entire HHS enterprise, is another issue that complicates the executive commissioner's job. As originally conceived under H.B. 7, HHSC provides overall guidance and oversight of the HHS agencies. Under federal law, however, the agency is also the State Medicaid Office.

Under the pre-2003 structure, the actual task of running the Medicaid program rested with the Department of Health. The 2003 reorganization moved the state's largest and most complex HHS program into HHSC, which made sense given its federal designation as the State Medicaid Office, but blurred its role as oversight agency. As it is, the agency is both an oversight organization and a program operator. This inevitably divides HHSC's attention between operations and oversight.

The "Kitchen Cabinet"

Dr. Janek seems to have recognized his need for administrative support with his broad responsibilities, but the path he took to answering this need has proven problematic. In numerous interviews, we were told that the executive commissioner had created an "executive team" apart from executive management, including the chief of staff, deputy chief of staff and several other staff members, many of whom were new or relatively new to the health and human services arena but who had Dr. Janek's confidence. We were told that this group, which we heard called "the bubble," "the inner circle," the "kitchen cabinet" and other names, met regularly for lunch to make decisions without input from deputy executive commissioner-level managers. Several of these individuals were tied together by longstanding relationships, some personal and some professional. Some had ties to the executive commissioner dating back to his service in the Senate.

Based on our interviews, however, we do not believe that this was the case. The lunch meetings seem mostly used to brief the executive commissioner on events, but whatever their purpose, these meetings created a sense of “us vs. them” — the insiders versus the outsiders — within senior management. And as other events demonstrated, some of these individuals took advantage of their privileged position to take actions that reflected badly on HHSC, often while allegedly acting in the executive commissioner’s name.

That said, most interviewees called Dr. Janek an affable and knowledgeable boss, but one insulated from many issues by his immediate staff — and not always well served by them.

It is not unusual for any manager to rely on trusted staff members; that reliance, however, should not become a barrier to communication within the broader organization, or a source of morale problems among other managers. In this case, it was both. Our early interviews with staff, conducted in the midst of the publicity surrounding the 21CT controversy, were often marked by frustration. This remained evident, in varying degrees, throughout our time at the agency.

It is clearly true that certain decisions were made outside the formal organizational structure. For example, in several interviews we heard that many senior staff members and commissioners had no opportunity to comment in detail on the Sunset recommendations, with some of which they disagreed. The commissioner of State Health Services told us that DSHS knew nothing about the RFP seeking to outsource the Terrell State Hospital, one of its responsibilities, until very late in the process. This RFP subsequently became another major problem for HHSC and the subject of another State Auditor review.

Concerning the Sunset report and possible further consolidation, some deputy executive commissioners did not realize HHSC had formed a Transition Committee of employees from across the enterprise — including some of their own staff in some cases — until we showed them its organization chart.

It’s also clear that Dr. Janek was not served well by his immediate advisers. Among the employees who left the agency in the wake of the 21CT controversy, at least two — Erica Stick, the chief of staff, and Casey Haney, the deputy chief of state — were part of the informal “kitchen cabinet.” Haney, for example, was working on a graduate business degree at the University of Texas at Austin. His tuition was prepaid out of the HHSC budget, an unusual — and unusually large — tuition agreement. We were also told that Haney dealt with a specific member of the Human Resources staff in placing individuals for employment, bypassing the normal hiring process, and that among those hired through this unorthodox process was one of his personal friends.

Due to staff departures and a revised direction in agency management, the “kitchen cabinet” no longer exists, but incidents such as these have had a significant negative impact on morale among HHSC staff. In addition, in the other HHS agencies, these incidents have, based on our interviews, added to a view which already existed that the commission is being held to a different standard than the other agencies.

Staffing

Another important element that will be critically important to the HHS agencies going forward is maintaining and developing a strong staff. The HHS agencies have some excellent employees, but they face the same retention and development issues as other state agencies.

The average enterprise employee is more than 40 years old (Figure 8). This is a common-enough pattern in state and federal agencies, where concerns about the aging workforce have been discussed for a decade. This demographic situation, however, is likely to be exacerbated by other workforce trends. According to a recent report by Deloitte's public-sector consulting arm:

Four major trends — the aging government workforce, a shrinking talent pool, different job expectations of younger generations, and the need for a new set of skills in the public sector — will soon create a gap between the supply of and demand for skilled government workers in many Western countries. These trends will create a clear set of challenges for government agencies.¹⁰⁵

FIGURE 8: Age Distribution of the Health and Human Services Agencies Employees, August 31, 2014			
Agency	Number of Staff	Average Age	Average Hire Age
Health & Human Services Commission	12,042	44	38
Department of Family & Protective Services	11,883	40	34
Department of State Health Services	12,020	45	37
Department of Aging & Rehabilitation Services	2,899	47	41
Department of Assistive & Disability Services	15,764	43	35
HHSC System	54,558	43	36
Source: Texas Health and Human Services Commission.			

This problem has been a long time in the making, and Texas' HHS agencies will have to deal with it over time. Our central concern, as the HHS agencies head into possible consolidation, is the

¹⁰⁵ Deloitte Public Sector, "The Graying Government Workforce," 2007. Available at: https://www.deloitte.com/assets/DcomShared%20Assets/Documents/dtt_publicsector_snapshot_greygovt_113007.pdf

possibility of losing an enormous amount of executive experience at the top of the enterprise. Dr. David Lakey already has resigned as commissioner of State Health Services, a tremendous loss to the enterprise. The more pressing problem, however, is within HHSC. Based on personnel data, six of eight — 75 percent — of the deputy executive commissioners are currently eligible to retire and several told us they planned to retire soon. While the loss of six staff members in a 54,000-person enterprise may not sound imposing, it is better understood as the loss of half of the current deputy executive commissioner-level positions team and more than a hundred years in combined state service.

With the possibility of full consolidation of the five HHS agencies looming, with a very short timeline under the Sunset recommendations, HHSC may be under extreme pressure to plan and manage this change in coming months, and the loss of key employees could make this difficult. This problem can't be cured overnight or in the coming months, but the agency needs to build a stronger succession management plan and give time and attention to building the management teams it will need in the new model. As Deloitte puts it:

With the dramatic increase in public-private partnerships (PPPs), outsourcing, and inter-governmental collaboration in recent years, governments need more people who possess not only traditional planning and budgeting skills, but also a contemporary skill set. Today's employees need proficiency in project management, mediation, negotiation, the ability to collaborate across sectors and agencies, contract management, risk analysis, and other complex skills.¹⁰⁶

Creating the future of health and human services means not only shaping a vision, but also developing the structure and technological infrastructure needed to make it possible. It also requires a workforce that can function in a world where expectations are high and the demands are ever-increasing.

Findings

1. The Health and Human Services Commission needs a clearer vision for the direction of health and human services delivery in Texas. HHSC also lacks a flexible forward-thinking plan so that changes to programs, policies, procedures, and operations can be addressed efficiently and effectively, without disruptions to services.
2. With unclear strategic direction and an over-stressed organizational structure, management and operations are sluggish and often times ineffective. In the current organizational structure, the executive commissioner faces a nearly impossible challenge of effectively leading the HHSC staff and other HHS agencies and in responding to the enterprise's many stakeholders, as well as the Governor and Legislature. Many HHSC executives and staff are discouraged with the apparent constant upheaval and chaos as well as the lack of clear mission and direction. There is additional executive and staff frustration throughout the organization with the limited paths for reporting to and accessing decision makers.

¹⁰⁶ Deloitte Public Sector, "The Graying Government Workforce," 2007. Available at: https://www.deloitte.com/assets/DcomShared%20Assets/Documents/dtt_publicsector_snapshot_greygovt_113007.pdf

3. The strike force believes that some improvement has been made in the organizational structure at HHSC since the beginning of the year. The executive commissioner hired a new chief of staff and chief operating officer. There are recent indications that the chief deputy commissioner has assumed more direct line responsibilities for overall operations, not just Medicaid, and that is good. However, it is not enough.
4. Executive management at HHSC — and in any large organization — must be committed to constant strategic communication up and down the management structure. This is even more critical when multiple organizations are involved. The executive commissioner and his leadership team must work together to formulate and promote strong, clear policies as well as ethics, and the members of the executive team owe the executive commissioner the duty of informing him of problems as they arise. As the old saying goes, you can't fix problems you don't know about. Communication and teamwork, clichéd as that may be, are critical to making HHSC work the way its professional staff wants, and it will be absolutely vital if the health and human services agencies face future consolidation.
5. Information technology and outside contracts for large projects, like the TIERS, TMHP and 21CT contracts, inherently are large risks. The agency has had system failures before, but it also has processes in place and has had successes in the past. However, HHSC currently lacks the organizational discipline to plan for and execute on the processes in place. Too many large project contracts have been renewed or modified without rebid using the explanation that these services or technologies are so critical that a disruption in client services due to a rebid, award and implementation by a new vendor would be unacceptable, especially if correct procurement processes — which can take significant time — were followed. It is critical that this habit of operation change.
6. Like many Texas agencies and other state governments, HHSC faces the loss of many seasoned executives and key staff due to the aging of the workforce. Retention and succession strategies for key staff must be put in place and followed at HHSC.

Recommendations

1. **HHSC needs to develop a vision (reason for existing) and mission (where the enterprise is going) that is appropriate to the current health and human services system in Texas.**
2. **The agency should reinforce team building, starting with executive-level staff and cascade the effort through the organization, focus on creating a shared interest in accomplishing the HHS enterprise vision and mission.**

The organizational goals should provide the direction and a compass for reaching the vision and mission. The enterprise vision and mission should be used to keep the executive team moving in the same direction, at the same speed, working together to create as little friction and as efficient a journey as possible.

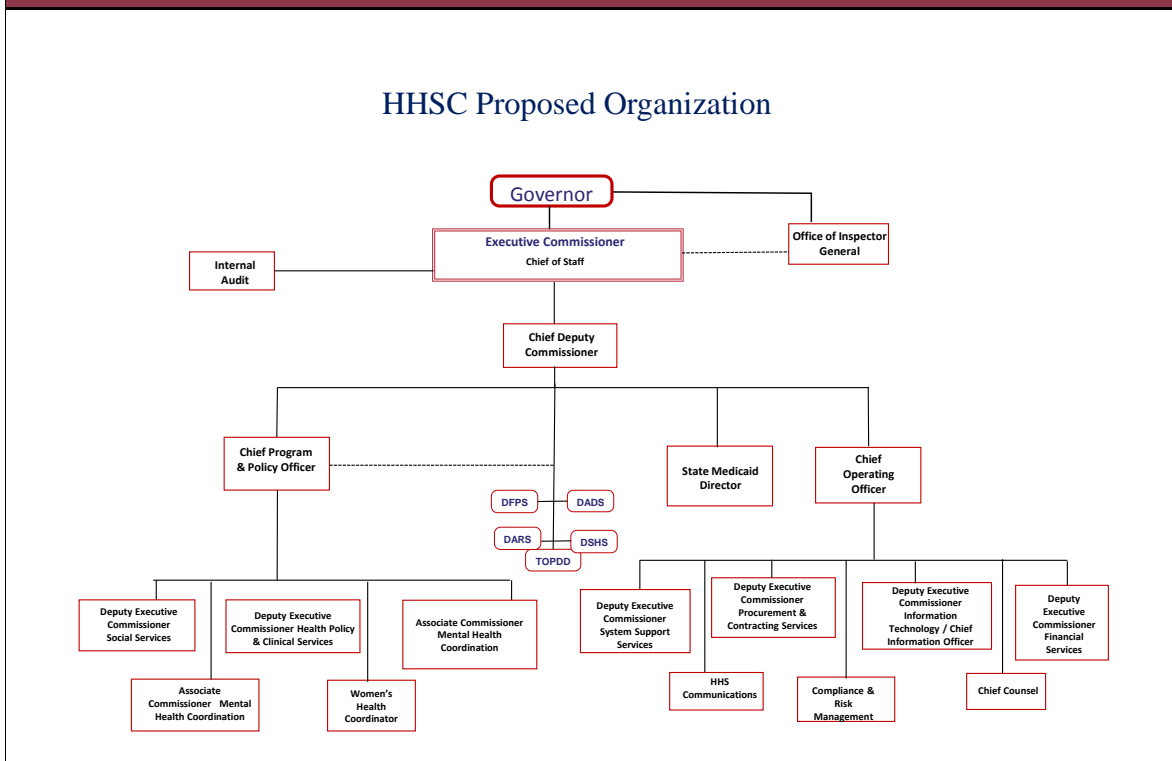
3. **HHSC should develop and maintain a communication strategy to keep all level of employees informed as the organization continues to implement administrative consolidation, the Sunset recommendations and other changes.**

It is critical to create an organization where good news and bad news is free to flow through the organization. In particular, when people can't communicate problems for fear of being ignored or punished, it creates, an environment where problems can fester and grow.

4. HHSC should restructure the agency to reduce the span of control problems within the current organization.

We believe upper management should be reorganized as shown in Figure 9. The organization would include:

FIGURE 9: Restructuring of HHSC Upper Management to Improve Communication and Reduce the Span of Control



- A chief deputy commissioner directly reporting to the executive commissioner and responsible for coordinating day-to-day operations of the enterprise and able to fill in on the executive commissioner's behalf with stakeholders, legislators and others as necessary. The chief deputy would function as the enterprise's "traffic cop," helping the executive commissioner manage the flow of information and decision making.
- A chief operations officer responsible for central administrative services, procurement, legal services, and information technology as is the case under the current organizational structure.
- The Medicaid-related functions should remain under the State Medicaid Director reporting to the chief deputy commissioner.

- d. A chief program and policy officer responsible for social services, health policy and clinical services, financial services and policy coordination across and among the health and human services agencies.

The goal of this expansion is not to add bureaucratic layers to the organization but to more effectively balance the enterprise's oversight and programmatic functions so they receive adequate ongoing attention. This should improve communication up and down the organization and make the decision process more effective, assuming the executive commissioner selects qualified managers with whom he can work on an ongoing basis.

5. HHSC should develop, monitor and update a central schedule for key technology and other system-related projects and their implementation.

This should include but not be limited to systematic reporting to executive management and other staff on these projects' length of contract, contracts starting and ending dates, dates for initiating a rebid process and milestones for each procurement step, implementation milestones, potential bidders, and risks with a rebidding process.

The executive commissioner and his deputies should meet at least quarterly to review the reporting and define an action plan for issues that develop from those meetings and ensure that very few technology projects be delayed on rebidding.

6. HHSC should develop and regularly update a succession plan to address the loss of executive and key staff.

The plan should include at a minimum the identification of key employees close to retirement and their positions, as well as employees considered as possible succession choices. HHSC should build redundancy in its potential succession candidates. HHSC should institute a training program that will identify specific needs to ensure that employees that are a key to a future succession are trained adequately. HHSC should use state university resources to provide as much training as available, as well as other state and national sources, like national conferences and certification programs.

7. HHSC should work to instill ethical leadership starting at the top of the organization and cascading through the enterprise.

The importance of practicing ethical leadership is part of setting the preferred tone at the top. Ethical leadership:

- models and sets clear expectations for ethical behavior for the organization,
- builds trust,
- brings credibility and respect, both for executive management and for the organization,
- leads to collaboration,

- creates a climate of accountability and integrity through transparent, consistent, fact-based decision making,
- allows executive management to occupy the moral high ground when faced with opposition, or strong support of a position, and
- promotes employee engagement with the enterprise's mission and operations, resulting in loyalty and improved organizational performance.¹⁰⁷

¹⁰⁷ Community Tool Box, Chapter 13: Orienting Ideas in Leadership, Section 8—Ethical Leadership. Available at: <http://ctb.ku.edu/en/table-of-contents>

6 | Consolidation

Texas' fragmented HHS enterprise has been an ongoing concern among policymakers for decades. Two significant studies in the 1970s, for instance, reached similar conclusions regarding the issue. In 1976, the Legislature's Joint Advisory Committee on Government Operations concluded that the state should design and implement HHS systems to focus more clearly on definable groups of people in need, and should meet those needs in a comprehensive fashion.¹⁰⁸ In 1980, the report of the Special Committee on Delivery of Human Services, created by the Legislature in 1978, included 72 recommendations aimed at making Texas' HHS programs more efficient and effective through improved planning and coordination.¹⁰⁹

The special committee's efforts led to the 1983 creation of the Texas Health and Human Services Coordinating Council (THHSCC) to "oversee human service coordination and policy planning in Texas." The council was not entirely effective. A March 1991 Sunset Advisory Commission report found that

...the current structure of the THHSCC, the broad reach of its mandates, and the diverse number of projects it has been assigned have not allowed it to serve as a definitive and practical forum for the coordination of health and human services.¹¹⁰

Later that same year, the Texas Performance Review found continuing problems with health and human service delivery:

Over the past 20 years, many allegations have been made in various forums that people with significant, complex problems are "slipping through the cracks" of our social welfare system: services are duplicated, inefficiencies exist, services are costing too much and basic objectives are not being met.¹¹¹

To deal with these issues, TPR recommended a consolidation of programs spread across 25 agencies to create what it called a "systems approach" to HHS delivery. The recommended model included the following elements:

- a single governing board for health and human services;
- a "continuum of care" for families and individuals;
- integration of services to improve client access;

¹⁰⁸ Texas Joint Advisory Committee on Government Operations, *Report of the Subcommittee on Health and Welfare*, January 1977.

¹⁰⁹ Texas Special Committee on Delivery of Human Services in Texas, *The Potential in the Patchwork*, November 1980, p. 86.

¹¹⁰ Texas Sunset Advisory Commission, *Report to the 72nd Legislature*, 1991. Available at: <https://www.sunset.texas.gov/public/uploads/files/reports/Report%20to%20the%2072%20Leg%201991.pdf>.

¹¹¹ Texas Comptroller of Public Accounts, Texas Performance Review, *Breaking the Mold: New Ways to Govern Texas*, Vol. II—Part 1, July 1991, p. HS 10.

- incentives to maximize the use of existing resources;
- effective use of management information systems;
- system-wide accountability measures;
- an environment promoting teamwork and accountability; and
- mechanisms to foster innovation within the agencies and at local levels.

In many ways, this is still a good list of goals for the state's HHS enterprise, and the next 20-plus years saw multiple efforts to realize them.

This process began in 1991, when the Legislature addressed these concerns by beginning the consolidation of the HHS enterprise. H.B. 7 did not, however, solve the key difficulties facing the enterprise. Eventually, continuing concerns with quality and effectiveness produced 2003's H.B. 2292, which created the current structure. And now, almost 12 years later, the Legislature is once again considering a further consolidation, based on the recommendations of the Sunset Advisory Commission, which would fully consolidate the five remaining health and human service agencies into one "mega-agency" encompassing more than 54,000 employees and more than a third of the state budget.

As we conducted our review of HHSC, two questions arose repeatedly. First, can the consolidation contemplated by Sunset be achieved successfully? And second, is full consolidation of all HHS programs in a single agency in the best interests of the recipients of these services, the state and the HHS agencies themselves?

These are difficult questions to answer, and ultimately, the decision rests with the Legislature and the Governor. In any case, though, changes are needed that go further than a rearrangement of boxes on an organization chart.

If the Legislature's solution is full consolidation, at the very least the HHS agencies should be given the time and resources needed to do the job right. The single-year consolidation timeline recommended by the Sunset Advisory staff is ambitious — and likely too ambitious, based on our review. History and the current management environment, as documented in this report, both suggest that this deadline cannot be met. Far more planning and a clearer strategy will be needed before such a disruptive shift in management structure could be undertaken.

The strike force does not believe the HHS agencies are ready for such rapid change. A brief review of past consolidation efforts illustrates the difficulties involved.

The 1991 Reorganization

The 1991 Legislature faced a substantial budget shortfall, and adopted H.B. 7 in its first called session to address the shortfall through a number of changes including HHS consolidation. The new law consolidated services in 25 agencies into 12 agencies and two free-standing councils, with the overarching goal of reducing administrative costs and improving service delivery.

H.B. 7 outlined seven major goals for the newly created Health and Human Services Commission, including:

- maximizing federal funds;

- providing prompt, comprehensive, effective services improving access that removed barriers;
- Promoting general health for Texans;
- Developing policies to promote client responsibility, productivity and self-sufficiency;
- Providing for those that cannot care for themselves;
- Protecting Texans' physical and emotional safety; and
- Coordinating and delivering children's services.

The bill changed HHSC from a simple policy guidance group to the nominal leader of the HHS enterprise. Under the legislation as adopted, however, HHSC lacked the authority to achieve its broader goals. As the Sunset Advisory Commission's staff noted in its report last year:

One of the problems with this structure was blurred lines of accountability because the 12 agencies were accountable to both the then-HHSC commissioner as well as governing boards of their own agencies. Such divided allegiance "made it difficult for the agencies to function as an integrated system in pursuit of a common vision."¹¹²

The 2003 Legislative Changes

Another budget crisis created a second opportunity to redefine the roles and structures of the HHS agencies. The 2003 Legislature's H.B. 2292 was intended to transform and redefine the structure and roles of HHSC, the HHSC executive commissioner (formerly commissioner) and the other HHS agencies. This legislation again reduced the number of agencies, from 12 plus two councils to five agencies including HHSC, and provided HHSC and its executive commissioner with stronger authority and control over the enterprise.

H.B. 2292 required HHSC to develop a transition plan by December 1, 2003, six months after enactment, for approval by a seven-member Transition Legislative Oversight Committee. The specific transition work plan included four phases: planning, integration, optimization and transformation. The new consolidated HHS enterprise was operating on September 1, 2004, nearly 15 months after the bill was signed into law. Not all of the transition goals were complete at this time, however. The Transition Legislative Oversight Committee dissolved before the next legislative session and the transformation envisioned in H.B. 2292 was never fully completed.

Under H.B. 2292, HHSC was required to:

- take responsibility for all rulemaking and rate-making functions.
- create centralized administrative support services for the HHS agencies. The bill defines these services to include strategic planning and evaluation, audit, legal services, human resources, information resources, purchasing, contract management, financial management, accounting and other services as HHSC determines.

¹¹² Texas Sunset Advisory Commission, *Health and Human Services Commission and System Issues, Staff Report with Commission Decisions*, p. 21.

- adopt rules and policies for the enterprise's operation and provision of HHS services.
- directly supervise the Medicaid program.
- provide information systems planning and management, either by HHSC personnel or through a contract, for all HHS agencies.
- monitor and ensure the effective use of all federal funds received by the enterprise.
- implement Texas Integrated Enrollment Services for CHIP, TANF, Medicaid, SNAP, long-term care services, community-based support services and other programs as deemed appropriate.
- implement programs intended to prevent family violence and provide services to victims of family violence.

In the last 12 years, HHSC has achieved some successes in consolidation, including some centralized support services and statewide integrated enrollment services. There also have been challenges, including continuing friction with the four other HHS agencies and the Office of Inspector General, the Medicaid managed care effort and the creation of an effective integrated eligibility system. Even after a dozen years, the consolidated, efficient system envisioned in H.B. 2292 has not yet been realized.

Current HHSC Organization

The functions of Texas' HHS agencies are divided as follows:

- *HHSC* provides oversight and support for the HHS agencies, administers Medicaid and other programs, sets policies and benefits, determines client eligibility and sets rates for major (but not all) programs.
- The *Department of Aging and Disability Services* provides long-term services and supports for persons with disabilities and those aged 60 and older. It also regulates the providers serving these programs. These programs are facing significant changes as the state moves to incorporate them in managed care.
- The *Department of Assistive and Rehabilitative Services* provides services for persons with disabilities and children with developmental delays intended to help them improve functionality, find employment and live independently.
- The *Department of State Health Services* oversees public health services and local health departments and manages the state's mental health hospitals, center for infectious disease and public health laboratory. It also provides services for persons with infectious diseases, substance use disorders, mental illness and certain other specific health conditions. It also regulates healthcare professions, facilities and consumer services and products.

- The *Department of Family and Protective Services* investigates allegations of abuse and neglect perpetrated against children, older adults and people with disabilities. It also operates the state's foster care system for children who can no longer stay in their own homes, and regulates childcare facilities.

HHSC also oversees the Texas Office for the Prevention of Developmental Disabilities and the Office of Inspector General. HHSC and its umbrella agencies operate more than 200 programs. HHSC itself operates and administers some of the largest (Figure 10).

FIGURE 10: Health and Human Services Programs and Functions	
HHSC Programs	HHSC Functions
Texas Medicaid Children's Health Insurance Program (CHIP) Temporary Assistance for Needy Families (TANF) Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps) Texas Women's Health Program Texas Home Visiting Program Medical Transportation Program 2-1-1 Texas Information and Referral Network Family Violence Program Immigration and Refugee Affairs Alternatives to Abortion Healthy Marriage Program - Twogether in Texas Disaster Assistance Disaster Case Management	Eligibility Determination Medicaid and CHIP Operations System Planning and Evaluation Policy Development and Rule-making Oversight and Investigation Fraud and Abuse Prevention and Detection Ombudsman Services Center for Elimination of Disproportionality and Disparities Border Affairs Early Childhood Coordination
Source: Texas Health and Human Services Commission, "Presentation to the House Committee on Human Services," February 23, 2015, p. 4.	

Naturally, the day-to-day operations of these large programs receive more attention from HHSC than those operated by the other agencies that have their own commissioners. Historically, these commissioners have been primarily responsible for their agencies' programs, with limited monitoring by the executive commissioner.

HHSC and the other four agencies each have their own nine-member councils. The Health and Human Services Council reports directly to the executive commissioner and assists him with rules, policies and operational improvements. The other four agencies' councils are advisory, since policy responsibilities lie with the executive commissioner.

The Sunset Advisory Commission Recommendations

The 2014 Sunset Advisory Commission staff review recommended that the consolidation initiated by H.B. 2292 be completed, merging all five HHS agencies into a single agency.

The staff recommendations, adopted by the commission, identified consolidation issues that were raised in similar forms at the time of the two previous consolidation efforts. These include blurred accountability among agencies and units; continued fragmentation of similar programs and services among agencies; and incomplete administrative service integration. All of these issues limit the efficiency and effectiveness of the enterprise and its services. According to the Sunset report:

Elimination of separate agency designations for other entities in the system clarifies lines of authority, improves accountability, and helps to reduce the silo mentality that the five-agency system reinforces. More importantly, achieving a more simplified, streamlined functional approach would improve the delivery of health and human services by reducing the fragmentation and inefficiency of the current structure.¹¹³

Sunset's report recognizes the difficulty of further consolidation:

Such a shakeup may be perceived as just the latest in a continuing flood of changes to wash over a system fatigued by constant disruptions in the ability to perform its important job. This effort may also be seen as creating an organizational behemoth that is practically impossible to govern and that could marginalize certain aspects of the system and harm the delivery of services.¹¹⁴

Sunset held, however, that these objections, while understandable, are not insurmountable, and that further consolidation could increase accountability and improve the efficiency and effectiveness of service delivery.

Sunset Issue 1 proposes the consolidation of all five HHS enterprise agencies into HHSC. DARS' functions related to vocational rehabilitation and federal disability determination would transfer to Texas Workforce Commission. The consolidated agency would be organized around divisions established along functional lines and reporting ultimately to the executive commissioner. Additional support units would be created within HHSC to tackle other problems Sunset identified, including a policy and performance office to focus on performance management systems, policy development and program and process improvements.

Issue 1 proposes that a broad transition plan be developed by December 1, 2015, including a detailed work plan to guide HHSC in setting up the new structure. The reorganization would be completed by September 1, 2016. Sunset also calls for a separate plan for consolidating administrative support services; a report on how the reorganization would affect information technology; and another report on how federal requirements related to the organizational placement of programs would be met.

To oversee the consolidation, Sunset proposes the creation of a Transition Legislative Oversight Committee, similar to the oversight created by H.B. 2292, comprising four legislative members — two appointed by the speaker and two by the Lieutenant Governor — and three public members appointed by the Governor, with the HHSC executive commissioner serving as an ex officio, nonvoting member. The committee would be required to meet at least quarterly through 2016 and then at least once a year through 2023, when it would disband. In addition, the new

¹¹³ Texas Sunset Advisory Commission, *Health and Human Services Commission and System Issues: Staff Report with Commission Decisions*, p. 33.

¹¹⁴ Texas Sunset Advisory Commission, *Health and Human Services Commission and System Issues: Staff Report with Commission Decisions*, p. 20.

agency would be subject to periodic Sunset review, with a new Sunset date of September 1, 2027, and a limited review (without an abolishment date) for the 2022-23 biennium.

Sunset's recommendations envision an organizational structure based upon functional divisions, including medical and social services, state institutions and facilities, family and protective services, public health services, regulatory services, centralized services and the inspector general, as a starting point. The executive commissioner can fill in and adjust organizational details as necessary. In addition, the proposed reorganization would:

- eliminate the Texas Office for the Prevention of Developmental Disabilities, Texas Council on Autism and Pervasive Developmental Disorders and the Texas Autism Research and Resource Center, while allowing the executive commissioner to create advisory committees by rule if needed.
- move administrative responsibility for the Office of Independent Ombudsman from DADS to HHSC.
- replace the five agency advisory councils with an executive council comprising the executive commissioner and division heads to take public comment on proposed rules, recommendations of advisory committees, legislative appropriations requests and related documents, the operation of agency programs and other system-wide issues.

In Issue 2, SAC recommends continuing the work of consolidating administrative services under HHSC, especially IT, contracting and rate-setting support. This recommendation includes the consolidation of all IT personnel under HHSC control for improved accountability, planning and integration. To improve contracting accountability, HHSC also is tasked with improving its procurement and contract monitoring processes.

In Issue 3, Sunset recommends the consolidation of Medicaid administration responsibilities at DSHS and DADS into HHSC, calling for development of a transition plan with timelines by January 1, 2016 and completion of the transfer by September 1, 2016. These recommendations are included in H.B. 2304 and S.B. 200, both introduced on March 4, 2015. H.B. 200 has been referred to the Senate Health and Human Services Committee; H.B. 2304 has not been referred to a committee at writing.

The strike force review of HHSC has had one advantage over Sunset's effort. When we began our review in mid-January, many HHSC problems that were not apparent at the time of Sunset's review had become glaringly so. Based on these developments and dozens of interviews with individuals inside and outside the enterprise over a six-week period, we came to a somewhat different conclusion about consolidation. The following summarizes our conclusions.

The HHS Agencies Are Not Ready for Consolidation

Streamlining HHS administrative operations and improving services for Texans has been a goal of Texas state government for many years. SAO's recommendations provide one approach to further these goals. As noted above, however, the Sunset report and recommendations were completed largely before the recent revelations about HHSC.

While many of Sunset’s recommendations might have remained unchanged had they known about these problems — agency contracting, for example, was a major focus of the Sunset report — the recent difficulties do raise important questions that should be addressed *before* the passage of consolidation legislation.

Based on our review, we conclude that the HHS agencies are not prepared for the consolidation recommended by Sunset, and that such a consolidation, if approved by the Legislature, could not be accomplished within the proposed one-year deadline. Consolidation could be mandated, and even accomplished on paper, but the results are not likely to meet the Sunset vision and are more likely to hamper the HHS agencies’ ability to execute their primary missions, as well as fixing the problems detailed in this report.

The leadership of the Sunset Advisory Commission, having seen the evidence of recent months, agrees. On March 18, Senator Jane Nelson, who chairs the Sunset Commission, said in a statement: “In light of recent events I propose that we implement these reforms over an extended timeline. This allows us more time to monitor the reorganization over the next two sessions.” The commission’s vice chair, Rep. Four Price agreed. “Utilizing a graduated approach for the development of these recommendations is wise so that more time can be devoted to proper implementation.”

Senator Nelson and Rep. Price are correct. A reorganization of this scope will require strong leadership with common goals. The executive commissioner, deputy commissioners, division directors and other staff members must have a common vision and share it with personnel throughout the enterprise. Thus the effort should start at the top, with a focus on how to accomplish the reorganization without disrupting the flow of services to Texans who depend on them. Given HHSC’s recent disruptions and its lack of internal managerial cohesion and communication, we see no evidence that the agency is prepared for this immense effort.

Moreover, as the Sunset report and this review have pointed out, the HHS agencies still have not completed the administrative consolidation mandated by H.B. 2292. While it may appear to be a relatively simple task compared to the larger reorganization, it is in fact a very difficult process that requires careful planning, considerable input and, in many cases, the development of information technology to make a consolidated operation fit together in a way that does not increase, rather than reduce, bureaucracy and inefficiency.

Ideally, the HHS agencies should be given time to complete the administrative consolidation, and to assess the best way to deploy shared services without impeding internal operations and service delivery. While the agency is working diligently to accomplish as much of this transition step as possible, it is not clear that their current efforts are employing the best practices possible; that decisions are generally available for review and comment by agency managers; or that full consolidation is even workable in the case of many services.

In this regard, legal services provide a good example. Although a central legal staff makes sound management sense, it is just as true that some specialized legal staff may need to stay closer to the actual work of specific functions. Public health attorneys, for instance, should be organizationally close to the commissioner of State Health Services, or any successor division, to provide support in times of public health crisis, such as the recent outbreak of the deadly Ebola virus in the Dallas area.

Full Consolidation Could Create as Many Problems as It Solves

An even more important issue is the question of whether full consolidation of the HHS agencies makes sense from the standpoint of efficient operation and service delivery. The Sunset report makes important observations about managerial problems within the current five-agency configuration, but the strike force is not persuaded that creating a single mega-agency will solve the problem.

A common assumption about governmental reorganization is that new organizational structures can change behavior — in other words, that performance will automatically improve if the reorganization gets the boxes on the org chart right. The emphasis, then, is on the straightforward evaluation of where these “boxes” fit best, who should report to whom and who should receive what resources.

A more fundamental question, however, is whether the people and programs affected by structural change will actually change their behavior. All too often, function does *not* follow form. As Robert Tobias has written of federal government reorganization efforts:

Intellectual clarity translated into great organization charts does not necessarily do the job. Reorganization cannot trump endemic organizational culture or guarantee success if those merged have no leadership to take them in a new direction.¹¹⁵

Furthermore, a single large bureaucracy may make HHS programs even *less* accessible and efficient than the current structure, even with its flaws. At the very least, any reorganization of this scale requires an immense amount of planning and a highly active effort at change management.

Full consolidation would create enormous potential problems with span of control and oversight for the executive commissioner, particularly in the current environment, in which some agency management decisions already have been publicly questioned in the media and the Legislature. Full consolidation would create what one writer, referring to the consolidation that created the Department of Homeland Security, called a “potpourri of unrelated activities.”¹¹⁶ The executive commissioner would be responsible for decisions ranging from public health problems to Medicaid strategy and direction, from state facilities management and oversight to the complex issue of child protective services.

Without a clear delegation of authority for various functions — essentially what the current structure creates with five separate agencies — the potential for a massive logjam of competing priorities at the top of the organization is significant if not inevitable.

It’s also an open question as to whether all HHS functions realistically fit under a single organization. Consider two examples, the public health function and family protective services.

¹¹⁵ Robert Tobias, “Leading Differently: Can Reorganization Change Things?” *The Public Manager*, Summer 2011. Available at: <https://www.american.edu/spa/key/upload/Pub-Mng-Article-Tobias-Leading-Differently.pdf>.

¹¹⁶ Charles Perrow, “The Disaster After 9/11: The Department of Homeland Security and the Intelligence Reorganization,” *Homeland Security Affairs*, Vol. II, No. 1, April 2006. Available at: <https://www.hsaj.org/articles/174>.

Both are very different from “normal” public welfare programs and one, protective services, is as much a law enforcement activity as it is a human service. Should these organizations be buried in a larger organization, most of whose budget is focused on Medicaid programs? How likely is the agency to lose focus on one of these critical functions?

Would, for example, a public health division within HHSC move as nimbly to confront a disease outbreak as the Department of Health Services did during the recent Ebola scare? Would the director of a family protective services division have the latitude needed to do his or her job without involving a chain of bureaucracy ultimately involving the executive commissioner? Could the agency even attract the talent needed to run these functions effectively if their leaders would no longer be commissioners, but division directors within a large agency?

At one time, the family and protective services function was housed as a division in the much larger Department of Human Services. As a small part of a large bureaucracy, family and protective services did not have the flexibility needed to provide critical services effectively in a difficult and challenging arena.

The Texas Performance Review outlined the logic for separating the function in its 1991 report:

The goal of creating the protective and regulatory services department is to allow for the separation of the investigative and social services aspects of child and adult abuse cases. Separating the investigative function from the social service function should strengthen each function... [T]he review indicated that the two functions deserved focused and separate attention. Maintaining the functions in the same agency makes the responsibility for providing social services to a family in need and investigating a report of abuse a nearly impossible situation in which to maintain objectivity and focus.¹¹⁷

Recognizing the problem, H.B. 7 placed family and protective services in its own department.

Public-sector transformations are more difficult than those in the private sector because public organizations must contend with more power centers and stakeholders, have less management flexibility and are under greater scrutiny. Furthermore, top officials typically are appointees who do not remain in their positions for long. Even in the private sector, more than 40 percent of executives in acquired companies leave within the first year and 75 percent within the first three years.¹¹⁸ Research suggests that it takes from five to seven years to make mergers and acquisitions work in the private sector, even with all of its advantages.

¹¹⁷ Texas Comptroller of Public Accounts, Texas Performance Review, *Breaking the Mold: New Ways to Govern Texas*, Vol. II—Part 1, July 1991, p. HS 10.

¹¹⁸ Charles Perrow, “The Disaster After 9/11: The Department of Homeland Security and the Intelligence Reorganization,” *Homeland Security Affairs*, Vol. II, No. 1, April 2006. Available at: <https://www.hsaj.org/articles/174>.

Clearly, consolidation can be a valuable, money-saving technique that may even improve service quality. The strike force's concern is simply that it is *not* an all-purpose solution to the HHS enterprise's problems. It should be preceded by rigorous analysis and planning.

Findings

1. The HHS agencies are not prepared for full consolidation under the timeline proposed by the Sunset Advisory Commission.
2. The strike force also questions the benefits of full consolidation as a method of improving the delivery of health and human services in Texas.
3. In any event, further consolidation needs to be approached with rigorous analysis and planning.
4. The Legislature should consider granting the agency time to thoroughly plan consolidation and centralization of services but should provide oversight over the process.

Recommendations

- 1. The Transition Oversight Committee should be formed as recommended by the Sunset Advisory Commission, with one exception.**

If the Legislature accepts the Sunset recommendations that certain functions currently the responsibility of the Department of Assistive and Rehabilitative Services be moved to the Texas Workforce Commission, then TWC executive director should be an ex-officio committee member.

- 2. HHSC should be directed to plan for and execute the remaining portions of the consolidation of administrative services as mandated under H.B. 2292, and determine, in consultation with the Transition Oversight Committee, which services to consolidate.**

This assessment should be completed and HHSC and the Transition Oversight Committee should report its conclusions to the Legislature by December 2017.

- 3. The health and human services agencies should form a work group to evaluate and plan for a final configuration of the HHS agencies with guidance and oversight of the Transition Oversight Committee.**

The work group should evaluate these possible options for consolidation:

- a. The current structure with additional administrative services consolidation.
- b. Full consolidation into a single agency as envisioned in the Sunset Advisory Commission report.

- c. A third option that would amount to a partial consolidation, including the following agencies: (1) HHSC as an oversight and policy agency responsible for rule making, policy, budget, consolidated administrative services, and eligibility determination; (2) a social services agency that merges the various HHS human services functions, including all of Medicaid into a single agency; (3) a public health agency; and (4) the Department of Family and Protective Services in its current form. Under this structure, the Department of Aging and Disability Services would be consolidated into the human services agency and the function of the Department of Assistive and Rehabilitative Services would be transferred to the Texas Workforce Commission.
- d. An alternative option that the HHS agencies and the Transition Oversight Committee agree provides the best and most cost effective alternative for structuring health and human services in Texas.

Note (1): The strike force favors the third option as offering a balance between consolidation of services and complete centralization. We believe the HHSC will function more effectively as the central oversight and services agency without conflicting program responsibility. We believe it is in the state's best interest to maintain separate public health and family and protective services departments with their own commissioners; however, all other health and human services should be consolidated into a separate social service agency. Under this approach, consolidation of DFPS and DSHS functions and administration could be considered by HHSC and the Oversight Committee in coordination with the Sunset Advisory Commission during its limited review in 2022-23, should that prove desirable.

Note (2): Under all configurations, the Office of Inspector General would remain a part of the Health and Human Services Commission with a change in the appointment process of the Inspector General as described the Section 3 of this report.

4. **The working group should report to the Legislature by December 31, 2016, prior to the next regular legislative session, on the results of its analysis, including how each option would be carried out, what its effects on costs and service quality would be, the impact on automated systems, the requirements and costs of system integration needed to make the consolidation, and all other issues that would need to be address to develop a final consolidation plan.**

The work group, with the approval of the Executive Commissioner and HHS commissioners should develop a timeline with verifiable milestones for each of the consolidation plans. The health and human services agencies should be ready to execute the final plan upon passage of legislation detailing the Legislature's chosen approach to consolidation.

5. **The Transition Oversight Committee should oversee the health and human services agencies planning process and should also take public testimony on health and human services consolidation from affected stakeholder groups during the legislative interim.**
6. **The Transition Oversight Committee should report by December 31, 2016, prior to the next regular legislative session, on its findings and recommendations with regard to further consolidation of the health and human services agencies.**

7. **The Transition Oversight Committee should continue to oversee the transition as provided for in the Sunset recommendations.**

7 | Vision and Leadership

Success and failure are often thought of as flip sides of the same coin. They aren't.

Failure is not a single event. When closely examined, as we have sought to do in this report, failure normally is the end result of a series of events. It often has a long lead time and culminates in some event that brings the failure to light. Mark Bovens and Paul 't Hart in their book on program failure call these “policy fiascoes.”¹¹⁹

Based on the evidence we have examined, the 21CT controversy — and therefore HHSC's current predicament — is an example of a policy fiasco. The 21CT agreement as it developed could have been stopped by one correct decision at several points along the way, but it was not. In the wake of this failure, it is critical to understand the key lesson to be taken from it: Correcting a bad procurement resulting from bad judgment is important, but not as important as understanding and fixing the organizational defects that allowed it to happen in the first place.

In this regard, programs often fail in a sequence that is clear in retrospect: Something unexpected happens, and managers are unprepared for it. They do not see the problem coming, and when it arrives, they overreact, under-react or chose the wrong strategy for dealing with it, often making the situation worse. Failure is the result. In the aftermath, a fix generally is possible, but it often depends on understanding the failure's multiple causes and then changing the system to avoid them in the future.

Success is the achievement of a program's or organization's goals over time. People tend to seek individual factors to explain success — the one action, one individual or one decision that made the difference. However, like failure, success is a more complex. Success doesn't mean that nothing bad or unexpected happens. It means that the organization — by luck or thoughtful management — avoids the cascade of negative events before they end in failure. Success, as the scientist and author Jared Diamond has written, involves “avoiding the many separate causes of failure.”¹²⁰

HHSC has experienced a program failure. The organization and its reputation are damaged, even though, in the main, its underlying fundamentals remain sound. Programs are administered. People receive services. Things are done. However, the agency is at a point in the recovery process where it is important to re-evaluate the events that led to the failure and make changes to eliminate the possibility of a recurrence in the future. This process should be completed before the HHS agencies move in a new direction—and particularly if that move is toward full consolidation over whatever time period.

Whatever the HHS agencies' future course, success is clearly possible, but to achieve eventual success, HHSC's ship must be righted now. The agency's management must work together as a cohesive team to correct the current deficiencies and, of equal importance, demonstrate the capacity to address its problems with an honesty and clarity that will regain the confidence of the Governor, the Legislature and the people of Texas. State agencies, like any other organization, have

¹¹⁹ Mark Bovens and Paul 't Hart, *Understanding Policy Fiascoes*, New Brunswick, New Jersey: Transaction Publishers, 2005.

¹²⁰ Jared Diamond, *Guns, Germs, and Steel*, New York: W.W. Norton & Company, 2005 (first published in 1997).

problems. The key is to understand how the problems evolved, to develop a clear, consistent plan for addressing them, and to follow through.

Based on our review of the HHS agencies, we believe 10 steps should be taken to set a firm foundation for organizational recovery. All of these steps are detailed elsewhere in this report, but in summary they include:

1. Reorganize the HHSC management structure along the lines we have outlined to reduce the upper management span of control problems and provide better lines of communication within the organization and among the HHS agencies.
2. Improve the quality of communications among the agency's senior management and extend communication efforts to all levels of the organization and across the enterprise.
3. Develop a change management process so that future changes in agency direction and policy is fully communicated to agency employees, the other HHS agencies, stakeholders, clients and the Legislature. This will be particularly critical to beginning any process of consolidation. Any consolidation plan should engage not only senior managers but also employees, stakeholders and others. Change must begin with purpose. Purpose is established by understanding.
4. Continue reforms to agency contracting policy already begun in line with Governor Abbott's January 28 letter to agencies and consistent with legislative directives contained in S.B. 20 or whatever final changes the Legislature makes in state procurement policy. Progress on these reforms should be closely monitored by agency management until they are all satisfactorily accomplished. A good start is not necessarily a good finish.
5. Develop and implement a more comprehensive, forward-looking process for contract planning that avoids future "emergencies" and plans for re-procurements in a systematic way.
6. Implement an improved contract monitor process with the understanding that the agency's future is built not on service delivery but on the fair, effective management of service providers.
7. Continue the information technology reforms already in progress. If contracting for services is one of the pillars that underpin the future of health and human services delivery in Texas, effective information technology is the other.
8. Continue development of a comprehensive enterprise performance reporting and risk management system. You can't fix problems you don't know exist. You can, however, stop problems that are identified as they develop. The agency needs to stop being reactive and start addressing problems before they reach a critical tipping point.
9. Develop and refine a succession planning process that prepares the agency for the loss of top talent and which finds new talent to continue the agency's work.
10. Recognize that for an enterprise as large, complex and vital as the health and human service agencies, management is important but leadership is more important.

Many of these recommendations and others in this report could have been implemented and carried out under the current authority of the HHSC executive commissioner but weren't. It is a responsibility of executive leadership to chart a course where many if not all of the enterprise's current issues would not exist. Accomplishing these steps now in the current environment — and carrying the agency and the HHS enterprise successfully into the future — will require both sound management and strong leadership.

People often use the terms “management” and “leadership” interchangeably. However, they are not the same thing. Over time, the tools and techniques of public management have evolved to help ensure that public agencies are generally stable, follow the laws and rules that govern them and produce predictable, if sometimes uninspired, results. Government agencies have developed planning and budgeting systems, formal decision making processes and other structures to help maintain this pattern of consistent, predictable performance. When an agency has management problems, the remedies can often be found by rearranging boxes on the organization chart, removing outmoded or unnecessary steps in administrative processes, or implementing more effective tools for monitoring and evaluating performance.

Important as they are, the tools of modern management are not adequate to meet the challenges that confront today's public agencies. Agencies operate in a current environment of rapidly changing demands, resource limitations and sometimes conflicting policy directions. Their decisions are made in a world that demands transparency and accountability and generally is unforgiving of deviations from expectations. Normal management techniques, honed to produce consistent, predictable results, are often inadequate in dealing with a world where few things are consistent or predictable.

That is where leadership comes in. Effective leadership is concerned with the implementation of sound managerial principals, but it is more concerned with charting the organization's direction, fostering its core values and communicating the organization's goals to those inside the organization and outside it. In this regard, the skills of the effective leader include:

1. Establishing and maintaining the enterprise's vision, direction and guiding principles.
2. Creating and maintaining desired core values, culture and environment.
3. Serving as a role model of the core values: integrity, trust, performance expectations, accountability, and so on for others in the enterprise and for external stakeholders.
4. Communicating a clear sense of direction and purpose.
5. Developing a team to achieve objectives.
6. Delegating appropriate responsibility to next layer of management or to appropriate employees to distribute work and make the organization more efficient and effective.
7. Developing the skills of those reporting to the executive commissioner.

8. Confronting problems as they arise with disciplined, consistent problem solving and decision making.

The scope of the HHS enterprise and the inherent responsibilities and risks that accompany that scope require enterprise executive leadership that possesses significant, demonstrated leadership skills. Even with those, achieving the enterprise's expansive mission and the high level of performance expected by the executive and legislative branches will be challenging. Without skilled leadership, the risk of future failure is high. The 21CT controversy represented a failure of HHSC's management oversight and controls. The agency's recovery and future success depends heavily on how well its leadership functions from this point forward.