Rolling Audit and Inspections Plan

September 2020

Inspector General

Texas Health and Human Services

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INTRODUCTION

Role of OIG

In 2003, the 78th Texas Legislature created the Office of Inspector General (OIG) to strengthen the Health and Human Services Commission's (HHSC) capacity to combat fraud, waste, and abuse in publicly funded state-run Health and Human Services (HHS) programs.

OIG's mission, as prescribed by statute, is the "prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services in the state, including services through any state-administered health or human services program that is wholly or partly federally funded, or services provided by the Department of Family and Protective Services (DFPS) and the enforcement of state law relating to the provision of these services."

OIG's primary tools for detecting, deterring, and preventing fraud, waste, and abuse are audits (conducted under the Generally Accepted Government Auditing Standards, "Yellow Book" standard); investigations (conducted pursuant to generally accepted investigative policies); inspections (conducted under the federal "Silver Book" standard); and reviews (conducted under the Principles and Standards for Offices of Inspector General developed by the Association of Inspectors General, also known as the Green Book).

OIG Principles

Vision

Promoting the health and safety of Texans by protecting the integrity of state health and human services delivery.

Values

Accountability. Integrity. Collaboration. Excellence.

Mission

Prevent, detect, audit, inspect, review, and investigate fraud, waste, and abuse in the provision and delivery of all state health and human services, and enforce state law related to the provision of those services.

AUDIT AND INSPECTIONS AUTHORITY

Texas Government Code Section 531.102 created OIG in 2003 and gives OIG the responsibility to audit fraud, waste, and abuse in the provision and delivery of all health and human services in the state, including services through any state-administered health or human services program that is wholly or partly federally funded or services provided by DFPS.[1]

Section 531.102(h)(4) permits OIG to audit the use and effectiveness of state and federal funds, including contract and grant funds, administered by a person or state agency receiving the funds from a health and human services agency.[2]

Section 531.1025(a) permits OIG to conduct a performance audit of any program or project administered or agreement entered into by the commission or a health and human services agency.[3]

Section 531.113(d-1) mandates that OIG investigate, including by means of regular audits, possible fraud, waste, and abuse by managed care organizations.[4] Section 531.102(s) also establishes OIG's authority to utilize a peer-reviewed sampling and extrapolation process when auditing provider records.[5]

[1] Tex. Gov. Code § 531.102(a) (Sept. 1, 2017).

[2] Tex. Gov. Code § 531.102(h)(4) (Sept. 1, 2015).

[3] Tex. Gov. Code § 531.1025(a) (Sept. 1, 2015).

[4] Tex. Gov. Code § 531.113(d-1) (Sept. 1, 2015).

[5] Tex. Gov. Code § 531.102(s) (Sept. 1, 2015); See also 1 Tex. Admin. Code § 371.35 (May 15, 2016) wherein OIG adopted RAT/STATS, statistical software available from the United States Department of Health and Human Services Office of Inspector General and policies and procedures consistent with the mathematical processes for sampling and overpayment estimation described in the Centers for Medicaid and Medicare Services Medicare Program Integrity Manual.

AUDIT AND INSPECTIONS UNIVERSE

The audit and inspections universe represents an inventory of all potential areas that can be audited and inspected. The OIG Audit and Inspections Division defines its audit and inspections universe as the departments, programs, functions, and processes within the HHS System and DFPS, including services delivered through managed care and services delivered through providers and contractors.

Health and Human Services System

Administrative Services

- Financial Services
- Information Technology
- Internal Audit
- Legal
- Ombudsman
- Policy and Performance
- Procurement and Contracting Services
- System Support Services

Divisions

- Health and Specialty Care System
- Regulatory Services
- Access and Eligibility Services
- Health, Developmental and Independence Services
- Intellectual and Developmental Disabilities and Behavioral Health Services
- Medicaid and CHIP Services
- Department of State Health Services (DSHS)
    - Community Health Improvement
    - Consumer Protection
    - Laboratory and Infectious Disease Services
    - Program Operations
    - Regional and Local Health Operations

Department of Family and Protective Services

- Administrative Services
- Adult Protective Services
- Child Protective Services
- Investigations
- Prevention and Early Intervention
- Statewide Intake

Medicaid Managed Care

Managed Care Entities and Subcontractors

- Managed Care Organizations (MCO)
- Dental Maintenance Organizations
- Medical Transportation Organizations
- Behavioral Health Organizations
- Pharmacy Benefit Managers (PBM)
- Third Party Administrators

Managed Care Programs

- Children's Health Insurance Program (CHIP)
- Children's Medicaid Dental Services
- CHIP Dental
- Texas Dual Eligible Integrated Care Project (Medicare-Medicaid Plans)
- State of Texas Access Reform (STAR)
- STAR+PLUS
- STAR Kids
- STAR Health

Services Delivered Through Providers and Contractors

The audit and inspections universe includes the services delivered through providers and contractors that support the HHS System programs and managed care sections listed above. These services are categorized into two groups: (a) Medicaid and CHIP services and (b) other services.

Medicaid and CHIP Services

The list of Medicaid and CHIP services was compiled by reviewing the Medicaid and CHIP expenditures included in the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) 64 reports and CMS 21 reports.

- Behavioral Health Services
- Case Management (Primary Care and Targeted)
- Clinic Services
- Critical Access Hospital Services
- Dental Services
- Diagnostic Screening and Preventative Services
- Emergency Hospital Services
- Emergency Services for Undocumented Aliens
- Family Planning
- Federally Qualified Health Center Services
- Freestanding Birth Center Services
- Health Home for Enrollees with Chronic Conditions
- Health Services Initiatives
- Home and Community-Based Services
- Home Health Services
- Hospice
- Inpatient Hospital Services
- Inpatient Mental Health Facility Services
- Intermediate Care Facility Services (Private and Public)

- Laboratory and Radiological Services
- Medical Equipment
- Medical Transportation
- Non-Emergency Medical Transportation
- Nurse Midwife
- Nurse Practitioner Services
- Nursing Facility Services
- Occupational Therapy
- Other Care Services
- Other Practitioners' Services
- Outpatient Hospital Services
- Outpatient Mental Health Facility Services
- Personal Care Services
- Physical Therapy
- Physician and Surgical Services
- Prescribed Drugs
- Private Duty Nursing
- Programs of All-Inclusive Care for the Elderly
- Prosthetic Devices, Dentures, and Eyeglasses
- Rehabilitative Services (Non-School-Based)
- Rural Health Clinic Screening Services
- School-Based Services
- Screening Services Component of Early and Periodic Screening, Diagnosis, and Treatment Services
- Services for Speech, Hearing, and Language
- Sterilizations
- Therapy Services
- Tobacco Cessation for Pregnant Women
- Translation and Interpretation
- Vision Services

Other Services

Other services include services provided by the HHS System and DFPS programs that are delivered through providers and contractors for which there is no federal financial participation through Title XIX (Medicaid) or Title XXI (CHIP). Examples include:

- Adoption and Permanency Services
- Autism Program
- Child Advocacy Programs
- Deaf and Hard of Hearing Services
- Emergency Medical Services (EMS)
- Family Violence Services
- Foster Care
- Guardianship
- HIV/STD Prevention Services
- Population-Based Services
- Prevention and Early Intervention Services
- Public Health Preparedness
- Substance Abuse, Prevention, Intervention, and Treatment
- Supplemental Nutrition Assistance Program (SNAP)
- Temporary Assistance for Needy Families
- Women, Infants, and Children (WIC)

RISK ASSESSMENT

The OIG Audit and Inspections Division conducts a continuous risk assessment to identify potential audit topics for inclusion in its Rolling Audit and Inspections Plan. Potential audit and inspections topics consist of programs, services, providers, and contractors with an elevated potential for fraud, waste, and abuse.

We identify potential audit and inspections topics from a variety of methods, such as:

- Coordinating with:
  - HHS System Internal Audit Division
  - DFPS Internal Audit Division

- Reviewing past, current, and planned work performed by external organizations, including:
  - Texas State Auditor's Office (SAO)
  - U.S. Department of Agriculture Office of Inspector General (USDA OIG)
  - U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS)
  - U.S. Department of Health and Human Services Office of Inspector General (HHS OIG)
  - U.S. Government Accountability Office (GAO)

- Conducting interviews with HHS System and DFPS management and staff, and external stakeholders.

- Coordinating with the OIG Inspections and Reviews Division.

- Reviewing the results of external reviews conducted on managed care organizations.

- Analyzing data of services delivered through providers and contractors.

- Monitoring relevant Texas House and Senate legislative committee hearings.

- Requesting referrals from within OIG, the HHS System, DFPS, and the public.[6]

- Considering impacts of emergency events or extenuating circumstances, such as the COVID-19 pandemic.

[6] Members of the public are encouraged to report suspected fraud, waste, or abuse by recipients or providers in Texas HHS programs by calling the OIG toll-free Integrity Line at 1-800-436-6184 or submitting a referral online via ReportTexasFraud.com.

After compiling the list of potential audit and inspections topics, the OIG Audit and Inspections Division considers several factors to select audits for its Rolling Audit and Inspections Plan including:

- Requests from the legislature and executive management
- Current oversight activities, including internal and external audits
- Public interest
- Available resources
- Potential financial and client impact

TYPES OF AUDITS AND INSPECTIONS

The OIG Audit and Inspections Division conducts risk-based performance audits related to (a) services delivered through medical providers and contractors and (b) programs, functions, processes, and systems within the HHS System and DFPS, to help identify and reduce fraud, waste, and abuse. While variations occur for which audit type is performed, those audit types are generally defined as follows:

- HHS and DFPS System Audits—Review the effectiveness and efficiency of HHS System and DFPS program performance and operations.

- Provider Audits—Assess medical service provider compliance with criteria contained in statute, rules, guidance, or contracts, and determine whether funds were used as intended.

- Contractor Audits—Evaluate contractor performance for compliance with contract requirements and determine whether funds were used as intended.

- Information Technology Audits—Assess compliance with applicable information technology requirements and examine the effectiveness of general and application controls for systems that support HHS System and DFPS programs or are used by contractors or business partners who process and store information on behalf of HHS and DFPS programs.

- Inspections—Conducts inspections of HHS programs, systems, and functions, including inspections of contractors, vendors, and providers.

Audits and inspections may result in recommendations to improve the provision and delivery of health and human services in the state. Recommendations may include options for how funds may be utilized in a more efficient and effective manner or for information technology control improvements to mitigate security vulnerabilities. They may also identify questioned or unsupported costs and include recoveries, liquidated damages, and penalties or other sanctions.

CARRY-OVER AUDITS IN PROGRESS

The following audit projects were initiated by OIG before September 2020 and were in progress as of August 31, 2020.

HHS System Audits

TIERS Data Processing and Integrity

An audit of a contractor's compliance with certain performance measures is ongoing and was initiated in fiscal year 2020.

Objective

To determine whether the TIERS system and process controls are adequate to reasonably ensure that Medicaid eligibility determinations are accurate based on selected eligibility requirements.

Contractor Audits

Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments

Audits of two MCOs were initiated in fiscal year 2019 and fiscal year 2020. Both audits are ongoing.

Objective

To determine whether selected STAR+PLUS MCOs accurately and timely adjudicated qualified nursing facility provider clean claims in compliance with selected criteria.

Selected Substance Use Disorder Contracts

Two audits of selected contractors are ongoing and were initiated in fiscal year 2020. The objectives for these audits vary slightly.

Objective

To determine whether (a) contract funds were used as intended and (b) contractor billing and performance was in accordance with federal or state rules and guidelines, and applicable contractual requirements.

Objective

To evaluate whether the contractor's treatment services (a) were provided in accordance with the contractual requirements; (b) were provided by qualified staff; and (c) supported the payment received.

Selected MCO Financial Data

An audit of a selected MCO is ongoing and was initiated in fiscal year 2020.

Objective

To determine whether the MCO accurately reported selected administrative expenses to HHSC.

Selected MCO's Delivery of Pharmacy Benefit Services Through a PBM Focused on Spread Pricing

An audit of a MCO's pharmacy benefit services is ongoing and was initiated in fiscal year 2020.

Objective

To determine whether selected MCOs and their subcontracted PBM have processes and controls in place to ensure that MCO reimbursements to PBMs are based on actual amounts paid to pharmacies and comply with the UMCM and other applicable requirements related to reimbursement methods and spread pricing.

Selected Family Planning Grant Program and Healthy Texas Women's Grant Program Contractors

An audit of a selected contractor is ongoing and was initiated in fiscal year 2020.

Objectives

To determine whether:

- Expenses paid to subcontractors were allowable under the terms of the grants
- Expenses, payroll, and fringe benefits were apportioned properly under the terms of the contracts
- Expenses charged were within the contract funding period
- All charges were made within the scope of the contract
- Subcontractor contracts existed for service delivery

Selected Third Party Administrators' Compliance with Affiliate Reporting Exception Requirements

An audit of a selected contractor is ongoing and was initiated in fiscal year 2020.

Objectives

To determine whether the:

- Affiliate reporting exception met state and contractual requirements
- MCO's affiliate third-party administrator expenses were accurately reported to HHSC and allowable

Provider Audits

Selected Durable Medical Equipment (DME) Providers

An audit of a selected provider is ongoing and was initiated in fiscal year 2020.

Objective

To determine whether documentation to support the authorization and delivery of fee-for-service DME and supplies associated with Medicaid claims submitted by and paid to the provider existed and were completed in accordance with state laws, rules, and guidelines.

CARRY-OVER INSPECTIONS IN PROGRESS

Mental Health Targeted Case Management (MHTCM) and Rehabilitative Services (MHR)

Objective

To determine if certain eligible Medicaid members receive MHTCM and MHR Services in accordance with requirements.

Telemonitoring

Objective

To determine if prior authorizations for telemonitoring claims meet Texas Administrative Code requirements.

State Supported Living Centers (Series I and II)

Objective

To review the processes used by State Supported Living Centers (SSLCs) for hiring and training direct support professionals.

Children and Adolescent Needs and Strengths (CANS) 2.0 Assessment

Objectives

To understand:

- If the provider conducts CANS 2.0 assessments for children in community-based care as required by the DFPS.
- If the provider delivers services to children in community-based care consistent with the CANS 2.0 assessment.

Overlap of Certain Home and Health Claims During Hospital Stays

Objectives

To determine:

- Whether MCOs have effective processes to identify overlapping claims for Medicaid members
- How MCOs recoup and report identified overlapping claims for Medicaid members

Local Mental Health Authorities

Objective

To determine whether Local Mental Health Authorities complied with selected Texas Administrative Code requirements and the Texas Resilience and Recovery Utilization Management Guidelines (TRRUMG).

FISCAL YEAR 2021 AUDIT PLAN

The HHS System has over 41,000 employees responsible for managing approximately $44.9 billion each year,[7] and DFPS has over 12,000 employees responsible for managing approximately $2.2 billion each year.[8] Collectively, the HHS System and DFPS have over 200 programs providing needed services to millions of Texans. These programs are subject to (a) federal and state regulations, statutes, and rules and (b) agency and program policies. The programs, and the administrative and technical support that enables them to function, are subject to funding constraints, policy changes, and changing priorities. As a result, risks associated with functions within the HHS System and DFPS are constantly changing.

In an effort to be responsive to continuously changing risks and an evolving environment and accommodate requests for audit services, the audit projects listed in the section titled "Fiscal Year 2021 Audit Plan" will be updated periodically. Audit projects will be planned and initiated based on current priorities and availability of audit staff members needed to form audit teams.

The audit projects that OIG plans to initiate or has initiated since August 2020 are listed below. While OIG anticipates it will initiate all audits listed below, changing risks and priorities could result in some of the planned audits not being initiated or in other audits, not listed below, being initiated. The OIG Audit and Inspections Division will periodically update the list of audit projects.

HHS System Audits

Licensing of Home Health Agencies

Preliminary Objective

To determine whether Home and Community Support Services Agencies are licensed in accordance with applicable statutes, rules, and procedures.

Fee-for-Service Payments for Services Covered by MCOs

Preliminary Objective

To determine if HHS has processes and controls in place to ensure that payments for services in selected programs that are administered and paid for within the fee-for-service model are made only for eligible services not covered by a managed care plan.

[7] $41.78 billion represents the sum of the fiscal year 2020 appropriations reported in House Bill 1, General Appropriations Act for 2020–21 Biennium (May 2019) for DSHS and HHSC, which is approximately $38.9 billion, in addition to the amount reported for SNAP benefits in the State of Texas Schedule of Expenditures of Federal Awards for the year ended August 31, 2018, which is approximately $6.0 billion.

[8] $2.19 billion represents the sum of the fiscal year 2020 appropriations reported in House Bill 1, General Appropriations Act for 2020–21 Biennium (May 2019) for DFPS.

Fee-for-Service Payments for Retroactively Enrolled MCO Members

Preliminary Objective

To assess the adequacy of HHS' controls for detecting and recouping fee-for-service payments for members who were retroactively enrolled in a managed care plan.

STAR Kids Medical Necessity Determination Processes

Preliminary Objective

To examine the medical necessity eligibility determination process for STAR Kids and to determine whether assessments are (a) conducted consistently and in compliance with contract requirements and (b) communicated timely.

Home and Community Based Services (HCBS) Health and Safety

Preliminary Objectives

To understand:

- The effectiveness of HHS processes and controls related to oversight of health and safety in HCBS assisted living facilities.

- If HHS and providers operating under 1915(c) waivers are complying with federal and state health and safety requirements, including those involving Medicaid beneficiaries with Intellectual and Developmental Disabilities residing in individualized supported living and group home settings.

Co-Therapy Billing Guidelines

Preliminary Objective

To determine if billing for co-therapy services is in accordance with applicable statutes, rules, and procedures.

Inpatient Psychiatric Hospitalization

Preliminary Objective

To determine if admission and commitment practices for STAR+PLUS members receiving services at inpatient psychiatric hospitals are in accordance with federal and state regulations, rules, and guidelines.

Telecommunications

Preliminary Objectives

- To determine if HHS and contracted MCOs have adequate monitoring and oversight controls of selected services provided via telecommunications
- To review cybersecurity issues related to telehealth

Contractor Audits

Selected Agency and Program Contracts

- Department of Family and Protective Services
- Department of State Health Services
- Health, Developmental and Independence Services

Preliminary Objective

To determine whether a selected contractor is in compliance with contract terms.

MCO Special Investigative Units (SIU)

Preliminary Objective

To evaluate the effectiveness of MCO SIU performance in (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to HHS.

Selected HHS Substance Abuse Contracts

Preliminary Objective

To determine whether client eligibility determinations, treatment stays, discharge events, and corresponding paid claims to a selected provider for detoxification, intensive residential, and HIV residential services were processed in accordance with applicable federal or state rules and contractual requirements.

State Supported Living Centers

Preliminary Objective

To determine if selected state supported living centers are operating in compliance with state laws.

Home-Delivered Meals Program

Preliminary Objectives

- To evaluate contractor compliance with contract requirements
- To determine whether funds were used as intended

Enrollment Broker (MAXIMUS)

Preliminary Objective

To examine MAXIMUS' processes to ensure that services are being provided in a timely manner and in accordance with contract requirements.

MCO Oversight of DME

Preliminary Objectives

To determine whether sufficient processes are in place to ensure the provision of needed DME and supplies for members and oversight of contracted DME providers.

MCO Utilization Management of Services for Selected Programs and Populations

Preliminary Objective

To determine if MCOs are performing retrospective utilization management to ensure the services provided were appropriate and complied with state and federal requirements.

Provider Audits

Emergency Ambulance Services

Preliminary Objective

To determine whether emergency ambulance and air ambulance services that are provided and billed in the managed care and fee-for-service environment are conducted in accordance with applicable statutes, rules, and procedures.

Selected Vendor Drug Program (VDP) Providers

Preliminary Objective

To determine whether the vendor properly billed Texas Medicaid VDP and complied with contractual requirements and federal and state regulations, including Texas Administrative Code requirements.

Selected DME Providers

Preliminary Objective

To determine whether documentation to support the authorization and delivery of DME and supplies associated with Medicaid claims submitted by and paid to the provider existed and were completed in accordance with state laws, rules, and guidelines.

Oversight of Personal Care Services

Preliminary Objective

To determine whether claims for personal care services delivered through selected home and community support services agencies were paid in accordance with applicable statutes, rules, and guidelines.

Information Technology Audits

IT Security Controls and Business Continuity and Disaster Recovery Processes

Preliminary Objectives

- Assess the design and effectiveness of selected security controls over HHS System confidential information stored and processed.

- Evaluate the design and effectiveness of business continuity and disaster recovery plans and related activities.

Electronic Visit Verification (EVV) Contractor Performance

Preliminary Objective

To examine issues previously identified by OIG, Federal OIG,[9] and GAO[10] as well as new processes and controls in place related to EVV.

Oversight of Nursing Facility Staffing Levels

Preliminary Objective

To determine whether nursing facility staffing levels are in compliance with state and federal law.

1915(k) Community First Choice (CFC)

Preliminary Objective

To understand how the 1915(k) CFC program is operating and what oversight activities are being conducted.

MCO Enrollment Data to Subcontractors

Preliminary Objective

To understand whether delays exist in MCOs providing enrollment reports to subcontractors, particularly PBMs and the causes of those delays.

National Correct Coding Initiative (NCCI) Edits and MCO Compliance

Preliminary Objective

To understand whether MCOs have processes in place for the deployment of current NCCI edits and how often those edits are updated in the claims system.

[9] https://oig.hhs.gov/reports-and-publications/compendium/files/compendium2019.pdf

[10] https://www.gao.gov/assets/690/684424.pdf

Clinical Laboratory Improvement Amendments (CLIA)

Preliminary Objective

To determine if MCOs have processes to ensure that payments to clinical laboratories comply with established standards and are made only to certified laboratories.

Delivery Supplemental Payments

Preliminary Objective

To understand whether MCS has implemented processes to help ensure that delivery supplemental payments claims are processed in accordance with applicable requirements.

Medicaid Payments for Deceased Clients

Preliminary Objective

To understand whether Access and Eligibility Services has implemented processes to ensure that Medicaid capitation payments are not made to MCOs for deceased clients.

Provider Designation to Billing Comparison

Preliminary Objective

To determine if sufficient documentation is maintained to support provider designations and if those designations are accurate based on requirements and reimbursement actions.

Controls Related to Electronic Benefits Transfer (EBT) Cards

Preliminary Objective

To evaluate the system edits, checks, and other controls intended to prevent distribution of SNAP benefits to ineligible applicants.

FISCAL YEAR 2020 AUDIT AND INSPECTIONS REPORTS ISSUED

OIG issued the following audit reports between September 1, 2019, and August 31, 2020.

Audit	Report Issue Date	Key Findings
Summary of Results: Audits of Texas Medicaid Medical Transportation Organizations (MTOs)	December 3, 2019	• MTOs did not always use the standard Driver's Log or ITP Service Record forms that had complete information. • MTOs encountered challenges in efficiently and effectively managing complaints, accidents, and incidents, and monitoring of transportation providers.
Security Controls Over Confidential HHS System Information: Children's Medical Center (CMC) Health Plan	December 20, 2019	• CMC did not effectively manage user access to information systems that contained confidential HHS System information by timely disabling user accounts after 90 days for non-privileged accounts. • CMC did not consistently provision user accounts based on the established control processes. • CMC did not conduct an annual internal risk assessment to identify the risks and vulnerabilities associated with MIS and to implement appropriate controls.
Audit of DentaQuest USA Insurance Company: A Texas Medicaid and CHIP Dental Maintenance Organization	January 9, 2020	• DentaQuest included unsupported, overstated, or unallowable expenses in its 2017 Administrative Expenses financial statistical report (FSR). • DentaQuest did not promptly remove four accounts from its financial and claims system, which had access to confidential Texas HHS System information and financial information relied upon by HHSC to monitor and oversee DentaQuest performance.
Audit of City Drug Company: A Texas Vendor Drug Program Provider	February 20, 2020	• City Drug did not always bill VDP properly or comply with other contractual or Texas Administrative Code requirements related to claims validity and National Drug Code usage. • City Drug did not always comply with contractual requirements to maintain all records related to prescription services for VDP claims.
Easter Seals Rio Grande Valley: A Texas DFPS Contractor	February 26, 2020	• OIG did not identify any significant reportable issues.
Collin County MHMR Center: A Local Intellectual and Developmental Disability Authority Performance Contract	February 28, 2020	• Collin County Mental Health and Mental Retardation (MHMR) Center did not always develop and retain documentation in accordance with requirements. • Service Coordinators for general revenue (GR)-funded, Home and Community-based Services (HSC), and Texas Home Living (TxHmL) programs did not perform all required face-to-face contacts.

Audit	Report Issue Date	Key Findings
STAR+PLUS Waiver Program Assessments and Services Delivered: Amerigroup Insurance Company	February 28, 2020	• Amerigroup did not pay any claims for certain members enrolled in the HCBS Waiver program between September 2016 and August 2017. • Amerigroup did not always submit initial assessments and ISPs timely. • Amerigroup did not always maintain documentation for its HCBS Waiver members in accordance with requirements or the documentation was not always complete.
Medicaid STAR+PLUS Nursing Facility Risk Groups: Reporting Errors Affected Risk Group Assignments	March 30, 2020	• HHSC incorrectly paid managed care capitation payments totaling approximately $1.4 million for certain fee-for-service Medicaid recipients. • HHSC made nursing facility risk group payments to MCOs for members who were not residing in a nursing facility. • HHSC made non-nursing facility risk group payments to MCOs for members that resided in nursing facilities.
Security Controls Over Confidential HHS System Information: El Paso Health	April 24, 2020	• El Paso Health did not always comply with HHS Information Security Controls (IS-Controls) requirements for user account management, configuration management, and media protection.
Tarrytown Expocare, LLC: A Texas Vendor Drug Program Provider	May 11, 2020	• Tarrytown did not always bill VDP properly or comply with other contractual or Texas Administrative Code requirements related to validity, quantity, and refills.
Audit of Medicaid and CHIP MCO Special Investigative Units: Molina Healthcare of Texas	May 22, 2020	• Molina's member website did not include all information required by its fraud, waste, and abuse plan. • Molina did not always comply with timeliness requirements for initiating preliminary investigations and reporting referrals to OIG.
Infinity Pharmacy Solutions: A Texas Vendor Drug Program Provider	June 23, 2020	• Infinity did not always bill VDP properly or comply with other contractual or Texas Administrative Code requirements related to claims validity, refills, and quantity.
Alamo Area Council of Governments (AACOG): Local Intellectual and Developmental Disability Authority Performance and Medicaid Contracts	July 29, 2020	• AACOG did not always ensure that service coordination progress notes included all required elements and that Person-Directed Plans (PDPs) were renewed timely.
Fee-for-Service Claims Submitted by Aveanna Healthcare Medical Solutions: A Texas Medicaid Durable Medical Equipment and Supplies Provider	July 30, 2020	• Aveanna did not always meet authorization requirements for DME and supplies. • Aveanna did not always maintain the appropriate proof of delivery documentation for Medicaid fee-for-service claims.
Audit Report of Durable Medical Equipment Delivered to Deceased Medicaid Beneficiaries: All Star Medical Equipment and Supply, Inc.	August 14, 2020	• OIG did not identify any significant reportable issues.

Audit	Report Issue Date	Key Findings
Audit Report of Durable Medical Equipment Delivered to Deceased Medicaid Beneficiaries: Nextra Health, Inc.	August 20, 2020	• OIG did not identify any significant reportable issues.
Audit Report on Security Controls Over Confidential HHS Information: Aetna Better Health of Texas	August 24, 2020	• Aetna did not ensure that claims management application user accounts with access to confidential HHS System information were reviewed and disabled when user access was no longer required.
Audit Report of Durable Medical Equipment Delivered to Deceased Medicaid Beneficiaries: Longhorn Health Solutions	August 25, 2020	• OIG did not identify any significant reportable issues.
Audit Report on Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments: Cigna-HealthSpring Life and Health Insurance Company, Inc.	August 26, 2020	• Cigna-HealthSpring did process all nursing facility utilization review RUG rate adjustments. • Cigna-HealthSpring did not process other retroactive claims adjustments timely.
Audit Report on Pharmacy Benefits Manager Navitus Health Solutions LLC: Community First Health Plans	August 26, 2020	• Community First did not always ensure that Navitus adhered to the Medicaid and CHIP formularies. • Community First did not always ensure that Navitus adhered to the Medicaid preferred drug list. • Community First did not ensure that Navitus properly approved and rejected claims.
Audit Report on Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments: Amerigroup Texas, Inc., and Amerigroup Texas Insurance Company	August 28, 2020	• Amerigroup did not process all nursing facility utilization review Resource Utilization Group (RUG) rate adjustments. • Amerigroup did not process other retroactive claims adjustments timely.
Audit Report on Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments: UnitedHealthcare Community Plan	August 28, 2020	• UnitedHealthcare did not process all nursing facility utilization review RUG rate adjustments. • UnitedHealthcare did not process other retroactive claims adjustments timely.
Audit Report on Pharmacy Benefits Manager Navitus Health Solutions LLC: Community Health Choice	August 31, 2020	• Community Health Choice did not always ensure that Navitus adhered to the Medicaid and CHIP formularies. • Community Health Choice did not always ensure that Navitus adhered to the Medicaid preferred drug list. • Community Health Choice did not ensure that Navitus properly approved and rejected claims.
Audit Report on Pharmacy Benefits Manager Navitus Health Solutions LLC: Parkland Community Health Plan	August 31, 2020	• Parkland did not always ensure that Navitus adhered to the Medicaid and CHIP formularies. • Parkland did not always ensure that Navitus adhered to the Medicaid preferred drug list. • Parkland did not ensure that Navitus properly approved and rejected claims.

The CMS Unified Program Integrity Contractor completed audits of the following providers between September 1, 2019, and August 31, 2020:

Audit	Report Issue Date
Symphony Diagnostic Services No. 1 LLC	September 25, 2019
Texas General Hospital	September 30, 2019
Cochran Memorial Hospital	December 18, 2019
Henderson Hospital LLC (formerly East Texas Medical Center)	December 18, 2019
Lynn County Hospital District	December 18, 2019
Seton Family of Hospitals (Seton Southwest Hospital)	January 15, 2020
Texas Health Harris Methodist Hospital Alliance	July 16, 2020

The OIG Audit and Inspections Division contracted with Myers & Stauffer, LC, which completed audits of the following providers between September 1, 2019, and August 31, 2020:

Audit	Report Issue Date
Bradley Frank	June 15, 2020
Elgin Pharmacy	August 21, 2020
Ennis Pharmacy	August 21, 2020

OIG issued the following inspections reports between September 1, 2019, and August 31, 2020.

Inspection	Report Issue Date	Key Findings
Member Complaints Received by Texas Medicaid Managed Care Organizations: Series II	October 4, 2019	• The Uniform Managed Care Contract MCO Internal Member Complaint Process contract provisions require limited investigation documentation and resolution reporting. • MCOs did not always accurately complete information in the complaint report form.
Unclaimed Funds: Inspection of the Process to Recover HHSC Funds from the Texas Comptroller's Unclaimed Property Program	November 20, 2019	• Texas Medicaid Healthcare Partnership (TMHP) – Third Party Liability (TPL) searches for funds owed to HHSC using a limited process. • HHSC entities may not forward all checks to HHSC – Accounts Receivable for deposit.