TEXAS HEALTH AND HUMAN SERVICES COMMISSION
OFFICE OF INSPECTOR GENERAL

ROLLING AUDIT PLAN

February 2020

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INTRODUCTION

The 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 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 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); and inspections (conducted under the federal "Silver Book" standard).

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 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 the Department of Family and Protective Services (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 recognizes 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 Program Integrity Manual.

AUDIT UNIVERSE

The audit universe represents an inventory of all potential areas that can be audited, which are commonly referred to as auditable units. The OIG Audit Division defines its audit universe as the departments, programs, functions, and processes within the Health and Human Services (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
    - 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
- Dental Maintenance Organizations
- Medical Transportation Organizations
- Behavioral Health Organizations
- Pharmacy Benefit Managers
- 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 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
- EPSDT Screening Services
- 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 Elderly
- Prosthetic Devises, Dentures, and Eyeglasses
- Rehabilitative Services (Non-School-Based)
- Rural Health Clinic Screening Services
- School Based Services
- Services for Speech, Hearing, and Language
- Sterilizations
- Therapy Services
- Tobacco Cessation for Pregnant Women
- Translation and Interpretation
- Vision

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:

- Autism Program
- Adoption and Permanency Services
- 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 Division conducts a continuous risk assessment to identify potential audit topics for inclusion in its Rolling Audit Plan. Potential audit topics consist of programs, services, providers, and contractors with an elevated potential for fraud, waste, and abuse.

We identify potential audit 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, which include
  - Texas State Auditor's Office (SAO)
  - U.S. Department of Health and Human Services Office of Inspector General (DHHS OIG)
  - U.S. Department of Agriculture Office of Inspector General (USDA OIG)
  - U.S. Government Accountability Office (GAO)
  - U.S. DHHS Centers for Medicare and Medicaid Services (CMS)
- Conducting interviews with HHS System and DFPS management and staff, and external stakeholders
- Coordinating with the OIG Inspections and Investigations Division and OIG Medicaid Program Integrity Division
- Reviewing the results of external reviews conducted on managed care organizations
- Analyzing data of services delivered through providers and contractors
- Viewing relevant Texas Legislature hearings
- Requesting referrals from within OIG, the HHS System, DFPS, and the public[6]

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

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

[6] 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.

TYPES OF AUDITS

The OIG Audit 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 there are sometimes variations in which audit type is performed for a given entity being audited, the categories are generally defined as follows.

- HHS and DFPS System Audits—Review the effectiveness and efficiency of HHS System and DFPS program performance and operations. The OIG Audit Division makes recommendations to mitigate performance gaps and risks that could prevent HHS System and DFPS programs from achieving their goals and objectives. These audits may make recommendations that funds be put to better use.

- Provider Audits—Assess medical service provider compliance with criteria contained in legislation, rules, guidance, or contracts, and to determine whether funds were used as intended. These audits may identify questioned costs or unsupported costs.

- Contractor Audits—Evaluate contractor performance for compliance with contract requirements and determine whether funds were used as intended. These audits may identify questioned costs or unsupported costs, or make recommendations that result in liquidated damages assessments or contract changes.

- 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. These audits may make recommendations for information technology control improvements and to mitigate security vulnerabilities. Instances of noncompliance with contract requirements may be subject to administrative enforcement measures.

CARRY-OVER AUDITS IN PROGRESS

The audit projects in progress that OIG initiated before September 2019 follow. These projects were in progress as of January 31, 2020.

HHS and DFPS System Audits

Medicaid Payments to STAR+PLUS Managed Care Organizations for Nursing Facility Risk Groups

Objective

Determine whether (a) selected STAR+PLUS members are properly categorized in nursing facility risk groups and (b) related capitation payments are appropriate.

Scope

The scope of the audit includes HHSC capitation payments to managed care organizations (MCOs) for STAR+PLUS members, and encounters for nursing facility services, from the period of March 1, 2015, through December 31, 2016. It also includes HHS System, MCO, and nursing facility activities and systems related to the assignment of STAR+PLUS members in nursing facility risk groups, and HHSC processes for making MCO capitation payments.

Contractor Audits

STAR+PLUS Waiver Program Managed Care Organization Assessments and Services Delivered

An audit of one health plan is ongoing and was initiated in fiscal year 2018.

Objective

Determine whether HCBS Waiver members (a) were assessed timely, (b) were assessed at least one institutional level of care need, and (c) timely received planned services.

Scope

The audit scope is fiscal year 2017.

Medicaid and CHIP Managed Care Organization Special Investigative Units

An audit of one health plan is ongoing and was initiated in fiscal year 2019.

Objective

Evaluate the effectiveness of the MCO's special investigative unit (SIU) performance in (a) detecting and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to HHSC.

Scope

The scope of the audit covers the period of September 1, 2017, through August 31, 2019.

MCO Clean Claims for Nursing Facility Providers

Audits of three health plans are ongoing and were initiated in fiscal year 2019.

Objective

Determine whether selected STAR+PLUS MCOs accurately and timely adjudicated qualified nursing facility provider clean claims in compliance with selected criteria, including criteria for payment timeliness.

Scope

The scope of the audit covers the period of September 1, 2017, through August 31, 2018, including adjusted payment run-out through April 13, 2019.

Selected Local Intellectual and Developmental Disability Authority Contractors

Audits of two contractors are ongoing and were initiated in fiscal year 2019.

Objective

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

Scope

The scope of the audit covers the period of September 1, 2017, through August 31, 2018, or September 1, 2018, through August 31, 2019.

Selected DFPS Contracts

An audit of one contractor is ongoing and was initiated in fiscal year 2019.

Objective

Determine whether (a) controls over contract funds for salaries, mileage reimbursements, and fringe benefits were in place and operating effectively, and (b) data reported to DFPS was accurate, supported, and in accordance with contract terms.

Scope

The scope of the audit includes a review of DFPS contracts under the Health Outcomes through Prevention and Early Support (HOPES) and Maternal Infant Early Childhood Home Visiting (MIECHV) programs, in effect between September 1, 2017, and August 31, 2019, and contractor performance and internal controls over salaries and related expenses.

Selected Managed Care Organizations' Delivery of Pharmacy Benefit Services Through a Pharmacy Benefit Manager

An audit of a managed care organization's pharmacy benefit manager is ongoing and was initiated in fiscal year 2019.

Objective

Determine whether selected MCOs and their subcontracted pharmacy benefit manager administered the formulary, the Medicaid Preferred Drug List, and prior authorizations in accordance with the Uniform Managed Care Contract, the Uniform Managed Care Manual, and applicable state rules and statute

Scope

Pharmacy claims that required prior authorizations for the period from September 1, 2017, through August 31, 2018.

Provider Audits

Selected Vendor Drug Program Pharmacy Providers

Audits of two pharmacies are ongoing and were initiated in fiscal year 2019.

Objective

Determine whether the vendor properly billed the Texas Medicaid Vendor Drug Program and complied with contractual requirements and federal and state regulations, including Texas Administrative Code rules.

Scope

The scope of the audit includes paid claims for the period from March 1, 2014, through August 31, 2016, or July 1, 2014, through May 31, 2017, or September 1, 2014, through August 31, 2017.

Selected Durable Medical Equipment Providers

An audit of one provider is ongoing and was initiated in fiscal year 2019.

Objective

Determine whether documentation to support the authorization and delivery of fee-for-service durable medical equipment 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.

Scope

The scope of the audit includes Medicaid fee-for-service claims for the period from September 1, 2017, through August 31, 2018.

FISCAL YEAR 2020 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 $2.19 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 federal and state regulations, statutes, and rules, and 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 called "Fiscal Year 2020 Planned Audits" 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 OIG plans to initiate or has initiated since September 2019 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 Division will periodically update the list of audit projects.

Performance Audits

- Licensing of Home and Community Support Services Agencies

  Preliminary Objective

  Evaluate the home and community support services agencies licensure process for compliance with state and federal regulations.

[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 the Department of State Health Services and the Health and Human Services Commission, which is approximately $38.9 billion, in addition to the amount reported for Supplemental Nutrition Assistance Program (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 the Department of Family and Protective Services.

Contractor Audits

- Performance of Contractors Supporting TIERS

  Preliminary Objective

  Determine whether TIERS system and process controls are adequate to reasonably ensure:
  - Accuracy of eligibility determinations and the calculation of benefits
  - Confidentiality, integrity, and availability of client eligibility data

- MCO Special Investigative Units (SIU)

  Preliminary Objective

  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 HHSC.

- MCO Clean Claims for Nursing Facility Providers

  Preliminary Objective

  Determine whether STAR+PLUS MCOs accurately and timely adjudicated qualified nursing facility provider clean claims in compliance with selected criteria, including criteria for payment timeliness.

- Selected MCOs' Delivery of Pharmacy Benefit Services Through a Pharmacy Benefit Manager focused on formularies, prior authorizations, and the Medicaid Preferred Drug List.

  Preliminary Objective

  Determine whether selected MCOs and their subcontracted pharmacy benefit manager (PBM) effectively delivered pharmacy benefits and complied with criteria contained in the Uniform Managed Care Contract, the Uniform Managed Care Manual, and applicable state rules and statutes.

- Selected MCOs' Delivery of Pharmacy Benefit Services Through a Pharmacy Benefit Manager focused on spread pricing.

  Preliminary Objective

  Determine whether selected MCOs and their subcontracted pharmacy benefit manager (PBM) effectively delivered pharmacy benefits and complied with criteria contained in the Uniform Managed Care Contract, the Uniform Managed Care Manual, and applicable state rules and statutes.

- Utilization and Access to Care

  Preliminary Objective

  - Determine the effectiveness of MCO performance in administering services through selected programs or risk groups.
  - Evaluate the management of (a) Medically Dependent Children Program (MDCP) population and enrollment, and (b) MDCP interest list.
  - Evaluate the claims administrator medical necessity determination process for the STAR Kids program.

- MCO Prior Authorizations

  Preliminary Objective

  Determine whether (a) selected MCOs effectively monitor their subcontractors' prior authorization processes in accordance with the Uniform Managed Care Contract and the Uniform Managed Care Manual, and (b) prior authorization processes performed by the subcontractor comply with state regulations and contractual requirements.

- Cost Allocation of MCO Shared Services

  Preliminary Objective

  Evaluate selected MCOs' allocation practices and determine whether allocations are accurately calculated and made in accordance with the HHSC Uniform Managed Care Contract and the Uniform Managed Care Manual.

- Selected MCO or DMO Third-Party Administrator Contracts

  Preliminary Objective

  Determine whether selected MCOs or DMOs and their subcontracted third-party administrator comply with selected financial reporting requirements.

- Fee-for-Service Payments for Services Covered by MCOs

  Preliminary Objective

  Evaluate the effectiveness of controls to detect and deny fee-for-service (FFS) claims for services covered by managed care health plans and determine if inappropriate FFS payments were made for services covered by managed care health plans.

- Fee-For-Service Payments for Retroactively Enrolled MCO Members

  Preliminary Objective

  Assess the adequacy of controls for detecting and recouping FFS payments for members who were retroactively enrolled in a health plan.

Selected Contractors

- Selected Local Intellectual and Developmental Disability Authority Contracts
- Selected DFPS and DSHS Contracts
- Selected Substance Use Disorder Contracts
- Selected State Supported Living Center or State Hospital Contracts
- Selected HHSC Grant Recipients

  Preliminary Objective

  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.

Provider Audits

- Selected Vendor Drug Program Pharmacy Providers
- Selected Durable Medical Equipment Providers
- Selected Personal Care Services and Home and Community-based Services Providers
- Selected Behavioral Health Services Providers

  Preliminary Objective

  Determine whether the vendor accurately billed for services provided and complied with contract requirements and Texas Administrative Code rules.

Information Technology Audits

- IT Security Controls and Business Continuity and Disaster Recovery Processes

  Preliminary Objective

  - 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.

AUDIT REPORTS ISSUED IN FISCAL YEAR 2019

OIG issued the following audit reports between September 1, 2018, and August 31, 2019.

Audit	Report Issue Date	Key Findings
Medicaid and CHIP MCO Special Investigative Units: Blue Cross and Blue Shield of Texas	September 28, 2018	• BCBS did not report all preliminary investigations to OIG as required.
Coastal Plains Community Center: A Texas Medicaid Home and Community-Based Services Program Provider	October 15, 2018	• Audit results found no exceptions for the claims tested and that Coastal Plains complied with applicable Texas Medicaid requirements.
Cystic Fibrosis Services, Inc.: A Texas Vendor Drug Program Provider	November 26, 2018	• Audit results found no exceptions for the claims tested and that Cystic Fibrosis Services complied with applicable Texas Medicaid requirements.
Avita Drugs: A Texas Vendor Drug Program Provider	November 30, 2018	• Avita Drugs did not bill the Vendor Drug Program properly, or comply with other contractual or TAC requirements, for 16 of 187 claims tested. The dollar value of the exceptions totaled $3,078.96, which after extrapolating, represented an overpayment of $14,561.
Passage of Youth Family Center, Inc.: Child-Placing Agency Residential Child-Care Contract with the Texas Department of Family and Protective Services	November 30, 2018	• Passage of Youth's case managers did not always timely review and update children's service plans. • Passage of Youth did not include all required documents in each foster family home's master record and each child's master record. • Payments were made to foster homes that were inconsistent with DFPS records for the number of days and level of service.
Mission Road Developmental Center: A Texas Medicaid Home and Community-Based Services Program Provider	November 30, 2018	• Mission Road did not have sufficient documentation to support 14 of the 398 claims associated with the written service logs tested, which resulted in an overpayment of $2,081.50.

Audit	Report Issue Date	Key Findings
Security Controls Over Confidential HHS System Information: Amerigroup Texas, Inc.	November 30, 2018	• Amerigroup did not provide requested information and evidence needed to achieve the audit objective, as required by contract, until after the on-site field visit was conducted. • Amerigroup conducted quarterly reviews of data center access. HHS Information Security Standards and Guidelines requires monthly reviews of access logs.
Lakes Regional MHRM Center: A Texas Medicaid Home and Community-Based Services Program Provider	November 30, 2018	• Lakes Regional did not have did not have sufficient documentation to support 39 of the 407 claims associated with the written service logs tested, which resulted in an overpayment of $5,475.02.
Bethesda Lutheran Home and Services: A Texas Medicaid Home and Community-Based Services Program Provider	December 14, 2018	• Bethesda Lutheran did not bill correctly for the units of service provided on 41 of 395 claims. As a result, HHSC overpaid Bethesda Lutheran by a net amount of $478.49.
Metscript Pharmacy #2: A Texas Vendor Drug Program Provider	February 11, 2019	• Audit results found no exceptions for the claims tested and that Metscript complied with applicable Texas Medicaid requirements.
Cook Children's Teddy Bear Transport: A Texas Medicaid Air Ambulance Provider	February 26, 2019	• Teddy Bear Transport did not bill the correct mileage for 15 of 238 air ambulance claims tested. In addition, Teddy Bear Transport did not ensure prior authorization was obtained for one out-of-state transport service. The 16 claims identified as exceptions resulted in an overpayment of $19,521.50.
UnitedHealthcare Encounter Data: Records of Provider Services Delivered Under a Sub-Capitated Agreement Were Coded Incorrectly	February 26, 2019	• UnitedHealthcare incorrectly coded encounter data for supplies delivered under a sub-capitated agreement, which is a contract and program violation. Because of the coding errors, sub-capitated activity could not be distinguished from claims-based activity.
Epic Pediatric Therapy: A Texas Medicaid Speech Therapy Provider	February 26, 2019	• Epic did not always meet requirements related to the accuracy of speech therapy claims billing. Of the 2,572 claims tested, Epic billed 5 claims with incorrect procedure codes, which resulted in an overpayment of $174.00.

Audit	Report Issue Date	Key Findings
Pharmacy Alternatives: A Texas Vendor Drug Program Provider	April 25, 2019	• Pharmacy Alternatives did not bill the Vendor Drug Program properly, or comply with other contractual or TAC requirements, for 16 of the 120 initial fill claims and for 59 of the 111 refill claims tested. The 16 initial fill claims resulted in $7,083.60 reimbursed in error. The 59 refill claims resulted in $22,583.23 identified for recoupment, which after extrapolating, represented an overpayment of $256,938.21. The total amount due to the State of Texas is $264,021.81. In addition, errors were identified for 75 claims that may be subject to the assessment of penalties.
Fee-for-Service Claims Submitted by Longhorn Health Solutions: A Texas Medicaid Durable Medical Equipment and Supplies Provider.	May 9, 2019	• Longhorn submitted and was reimbursed for 39 claims totaling $1,784 with service dates more than 30 days after the beneficiaries' date of death. Additionally, Longhorn did not meet authorization requirements for DME and supplies for 839 of 2,003 claims in the general population, and 1,680 of 3,403 claims in the deceased population. The 839 general population claims with authorization issues resulted in $34,128 reimbursed in error. The 1,680 deceased population claims with authorization issues resulted in $61,010 reimbursed in error. As a result, the exceptions resulted in an overpayment of $96,922.
Financial Impact of Clustering Therapy Services During MDS Assessment Look-Back Periods for Texas Medicaid Residents of Long-Term Care Nursing Facilities	June 6, 2019	• Audit results indicated that the practice of clustering therapy sessions allowed nursing facilities to bill MCOs an estimated $39.2 million more for resident daily care in 2017 than what would have been billed if the practice were prohibited by Texas Medicaid policy. • Nursing facilities sometimes performed Minimum Data Set (MDS) assessments just before a resident's therapy order expired, which resulted in the facilities receiving daily care payments from MCOs for as many as 92 days without delivering any therapy to the resident.

Audit	Report Issue Date	Key Findings
American Medical Response, Inc.: A Texas Medicaid Medical Transportation Organization	June 18, 2019	• Information American Medical Response (AMR) relied on to pay Demand Response and Individual Transportation Provider claims were sufficient to support the claims but did not always include all required information or use required forms.
STAR+PLUS Service Coordination: UnitedHealthcare Community Plan	June 26, 2019	• For 24 of 113 sampled members, United did not provide one or more of the required service coordination activities, which include conducting face-to-face visits, following up on member receipt of approved services, and performing an assessment of members entering nursing facilities.
Best Med, Inc.: A Texas Vendor Drug Program Provider	July 3, 2019	• Best Med did not bill the Vendor Drug Program properly, or comply with other contractual or TAC requirements, for 18 of the 120 claims tested. The 18 claims resulted in $15,674.94 identified for recoupment, which after extrapolating, represented an overpayment of $$96,892.92. Additional errors were identified for 91 claims that may be subject to the assessment of penalties.
STAR+PLUS Service Coordination: Amerigroup Texas, Inc. and Amerigroup Texas Insurance Company	July 15, 2019	• For 44 of 113 sampled members, Amerigroup did not provide one or more of the required service coordination activities, which include conducting face-to-face visits, following up on member receipt of approved services, and performing an assessment of members entering nursing facilities.
Child Specific Contracts: Texas Department of Family Protective Services	July 15, 2019	• Audit results found from September 1, 2016, through May 31, 2018, there were 966 days of service paid by both DFPS and Superior for foster children inpatient psychiatric hospital stays. This resulted in duplicate payments to psychiatric hospitals of $587,489.

Audit	Report Issue Date	Key Findings
Medical Transportation Management, Inc.: A Texas Medicaid Medical Transportation Organization	July 18, 2019	• Information Medical Transportation Management (MTM) relied on to pay Demand Response and Individual Transportation Provider claims did not always include required information or use required forms, and some of the reported encounters included incorrect amounts. Additionally, MTM did not always comply with all requirements for managing complaints, accidents and incidents.
Texas Medicaid and CHIP Pharmacy Benefit Services Delivered by Molina and Its Pharmacy Benefit Manager, Caremark	July 19, 2019	• Molina's Medicaid and CHIP formularies did not match the HHS Vendor Drug Program (VDP) Medicaid and CHIP formularies, resulting in members being delayed or denied access to needed prescription drugs or supplies. • An average of 8.3 percent of drugs on selected Molina Medicaid preferred drug lists (PDLs) did not match the drugs on VDP Medicaid PDLs for the periods tested, resulting in prior authorization being required for preferred drugs incorrectly classified as non-preferred drugs. • Molina's maximum allowable cost (MAC) lists improperly included 65 drugs that both appeared on VDP Medicaid PDLs and were brand name drugs, which inappropriately reduced reimbursement amounts to network pharmacies.
Project Amistad: A Texas Medicaid Medical Transportation Organization	July 23, 2019	• Information Project Amistad relied on to pay Demand Response and Individual Transportation Provider claims did not always include required information or the correct version of the driver log.
Security Controls Over Confidential HHS System Information and Business Continuity and Disaster Recovery Plans: Texas Children's Health Plan	July 31, 2019	• Texas Children's Health Plan did not always comply with HHS Information Security Standards and Guidelines requirements for user account management and risk management.

Audit	Report Issue Date	Key Findings
LogistiCare Solutions: A Texas Medicaid Medical Transportation Organization	August 22, 2019	• Exceptions were identified related to Demand Response driver logs, Individual Transportation Provider mileage reimbursement forms, and LogistiCare's management of complaints, accidents, and incidents. Additionally, LogistiCare did not comply with all contract requirements for managing complaints, accidents and incidents.
STAR+PLUS Service Coordination - HealthSpring Life and Health Insurance Co., Inc. (doing business as Cigna-HealthSpring)	August 22, 2019	• For 43 of 113 sampled members, Cigna-HealthSpring did not provide one or more of the required service coordination activities, which include conducting face-to-face visits, following up on member receipt of approved services, and performing an assessment of members entering nursing facilities.
Medicine Man Pharmacy: A Texas Vendor Drug Program Provider	August 22, 2019	• Medicine Man did not comply with the contractual requirement to maintain all records related to prescription services, including medication invoices, for all Vendor Drug Program claims. As a result, 32 claims resulted in $3,953.42 identified for recoupment, which after extrapolating, represented an overpayment of $88,120.04.
United Way of Metropolitan Dallas: A DFPS Contractor	August 28, 2019	• No significant reportable issues were identified during the audit.
MCNA Insurance Company: A Texas Medicaid and CHIP Dental Maintenance Organization	August 30, 2019	• MCNA's 2017 Administrative Expenses financial statistical report (FSR) included unsupported, overstated, or unallowable expenses. • MCNA did not request or obtain advance approval from HHSC for a July 2012 administrative services fee increase, or for the affiliate reporting exception implemented for its affiliate third-party administrator, as required by the Uniform Managed Care Manual.
Selected Services to STAR Health Members in the Medically Dependent Children Program: Cook Children's Health Plan	August 30, 2019	• Audit results indicated members did not receive all required monthly contacts or quarterly visits, and prior authorization determinations were not always timely. Some members had service plans that were (a) incomplete, (b) inconsistent, (c) documented in the incorrect section of the form, or (d) included conflicting information.

Audit	Report Issue Date	Key Findings
Selected Services to STAR Health Members in the Medically Dependent Children Program: Superior HealthPlan	August 30, 2019	• Audit results indicated members did not always receive required monthly service management contacts, and prior authorization determinations were not always timely. Some members had service plans that were (a) incomplete, (b) inconsistent, (c) documented in the incorrect section of the form, or (d) included conflicting information.
Management of the STAR Kids and STAR Health Programs through Monitoring Contract Activities: Medicaid and CHIP Services, a Texas Health and Human Services Commission Division	August 30, 2019	• HHSC Medicaid and CHIP Services (MCS) did not develop consistent policies and procedures for the receipt, review, and use of the tested contract deliverables. By not (a) verifying completeness or accuracy, (b) providing consistent guidance on report deliverable requirements, and (c) using the information submitted for contract enforcement or program improvement, MCS did not effectively use the contract deliverables related to service coordination, service planning, and utilization of services for the STAR Kids and STAR Health programs.

The CMS Unified Program Integrity Contractor completed audits of the following providers:

- Christus Health Ark-La-Tex
- Christus Health Southeast Texas 9707
- Christus Health Southeast Texas 7888
- APC Home Health Services, Inc.

AUDIT REPORTS ISSUED IN FISCAL YEAR 2020

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

Audit	Report Issue Date	Key Findings
Summary of Results: Audits of Texas Medicaid Medical Transportation Organizations	December 3, 2019	In general, MTOs: • Provided transportation services to members for selected transportation encounters. • Did not always use the standard Driver's Log or ITP Service Record forms that had complete information. • 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.
DentaQuest USA Insurance Company: A Texas Medicaid and CHIP Dental Maintenance Organization	January 9, 2020	• DentaQuest's 2017 Administrative Expenses FSR included Administrative Expenses financial statistical report (FSR) included unsupported, overstated, or unallowable expenses. • 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.

The CMS Unified Program Integrity Contractor completed audits of the following providers:

- Symphony Diagnostic Services No. 1 LLC
- Texas General Hospital
- Cochran Memorial Hospital
- East Texas Medical Center (now Henderson Hospital LLC)
- Lynn County Hospital District