

TEXAS HEALTH AND HUMAN SERVICES COMMISSION
INSPECTOR GENERAL

TWO-YEAR ROLLING AUDIT PLAN

Fiscal Years 2017 - 2018



April 2017

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INTRODUCTION

The Role of IG

In 2003, the 78th Texas Legislature created the Office of Inspector General 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.

The Inspector General's (IG) 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, and the enforcement of state law relating to the provision of these services."

IG's primary tools for detecting, deterring, and preventing fraud, waste, and abuse are audits (conducted under the federal "Yellow Book" standard); investigations (conducted pursuant to generally accepted investigative policies); and inspections (conducted under the federal "Silver Book" standard).

IG Principles

Vision

To become the leading state IG in the country.

Values

Professionalism, Productivity, Perseverance.

Mission

To detect, prevent, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used to deliver health and human services in Texas.

AUDIT AUTHORITY

Texas Government Code Section 531.102 creates the IG, and gives the IG 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.¹

Section 531.102(h)(4) permits the IG 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 the IG 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 the IG investigate, including by means of regular audits, possible fraud, waste, and abuse by managed care organizations.⁴ Section 531.102(s) also recognizes the IG'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, 2015)

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 the IG 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 IG Audit Division defines its audit universe as the departments, programs, functions, and processes within the Health and Human Services (HHS) System, including services delivered through managed care, and services delivered through providers and contractors.

HHS System⁶

Administrative Services

- Information Technology
- Financial Services
- Procurement and Contracting Services
- System Support Services
- Legal

Programs

- Medical and Social Services
- Policy and Performance
- Transformation
- Department of Aging and Disability Services
 - Regulatory Services
 - State Supported Living Centers
 - Program Operations
- Department of Family and Protective Services
 - Child Protective Services
 - Adult Protective Services
 - Statewide Intake
 - Prevention and Early Intervention
 - Child Care Licensing
 - Program Operations
- Department of State Health Services
 - Regulatory Services
 - Disease Control and Prevention Services
 - Regional and Local Health Services
 - Family and Community Health Services
 - State Hospitals
 - Program Operations

⁶ Based on the HHS System organizational charts effective September 1, 2016.

Managed Care

Managed Care Entities and Subcontractors

- Managed Care Organizations
- Dental Maintenance Organizations
- Behavioral Health Organizations
- Pharmacy Benefit Managers
- Third Party Administrators

Managed Care Programs

- Children's Health Insurance Program (CHIP)
- Texas Dual Eligible Integrated Care Project (Medicare-Medicaid Plans)
- 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 & 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 & Public)
- Laboratory and Radiological Services
- Medical Equipment
- Medical Transportation
- Non-Emergency Medical Transportation
- Nurse Mid-Wife
- 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 Devices, 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 includes services provided by the HHS System programs that are delivered through providers and contractors for which there is no federal financial participation through Title XIX (Medicaid) or Title XXI (CHIP).

RISK ASSESSMENT

The IG Audit Division conducts a continuous risk assessment to identify potential audit topics for inclusion in its Two-Year 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 the HHS System Internal Audit Divisions
- 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 management and staff, and external stakeholders
- Coordinating with the IG Inspections Division and IG Investigations 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 the IG, the HHS System, and the public⁷

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

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

⁷ The public are encouraged to report suspected fraud, waste, or abuse by recipients or providers in Texas HHS programs by calling the IG toll-free Integrity Line at 1-800-436-6184 or submitting a referral online: <https://oig.hhsc.texas.gov/report-fraud>

TYPES OF AUDITS

The IG Audit Division conducts risk-based performance, provider, and information technology audits related to (a) services delivered through medical providers and contractors and (b) programs, functions, processes, and systems within the HHS System, to help identify and reduce fraud, waste, abuse, and mismanagement. While there are sometimes variations in which audit type is performed for a given entity being audited, the categories are generally defined as follows.

- Performance Audits - Review the effectiveness and efficiency of HHS System program performance and operations. The IG Audit Division makes recommendations to mitigate performance gaps and risks that could prevent HHS System programs from achieving their goals and objectives. These audits may make recommendations that funds be put to better use.
- Provider Audits - Assess contractor or 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.
- 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 programs or are used by contractors or business partners who process and store information on behalf of HHS programs. These audits may make recommendations for information technology control improvements and to mitigate security vulnerabilities.

AUDITS IN PROGRESS

Performance Audits

Utilization Management in Managed Care Organizations

An audit of one health plan is being performed.

Objective

Evaluate the effectiveness of acute care utilization management practices at selected Managed Care Organizations (MCO) in ensuring that health care services provided were (a) medically necessary, (b) efficient, and (c) comply with state and federal regulations.

Scope

- Acute care utilization management practices and processes effective during the period September 2013 through August 2015.
- Activities of subcontractors involved with, or contracted to perform, utilization management practices and processes on behalf of the MCO.

Dental Service Organizations (Informational Report)

To provide information to management about Dental Service Organizations (DSOs), DSO regulation and oversight, and Texas Medicaid and CHIP expenditures for the utilization of dental services.

HHSC Processes for Analyzing and Preventing Eligibility Determination Errors

Objective

Evaluate activities designed to analyze and mitigate eligibility determination errors for SNAP, TANF, Medicaid, and CHIP, including practices for:

- Identifying the root causes of incorrect eligibility determinations resulting from agency errors.
- Developing and implementing corrective actions to prevent or reduce the recurrence of future errors.

Selected MCOs' Delivery of Pharmacy Benefit Services Through a Pharmacy Benefit Manager

Informational Report

An informational report will be developed and released during project planning. The informational report may include some or all of the following:

- Background information on Pharmacy Benefit Managers (PBM), PBM business models, and PBM relationships with MCOs and other entities.
- Regulations governing PBMs in the State of Texas.
- Compilation and analysis of non-audited information submitted by PBMs and MCOs, and non-audited information obtained from other federal and state sources.

Preliminary Objective

- Determine whether selected MCOs' delivery of pharmacy benefits through a PBM are in compliance with the HHSC Uniform Managed Care Contract and the Uniform Managed Care Manual.
- Determine whether selected MCOs' contracts with a PBM support HHS program objectives and allow for objective evaluation of PBM performance by the MCO.

STAR+PLUS Enrollment

Preliminary Objective

- Evaluate processes and controls related to enrollment in STAR+PLUS and to evaluate the effect on client populations.
- Review trends in utilization and costs associated with the STAR+PLUS program before and after expansion of the program in nursing facilities in March 2015.

Provider Audits

Assessment and Evaluation Practices at Long Term Care Nursing Facilities

An audit of one nursing facility is being performed.

Objective

Determine whether therapy services are provided consistent with physician orders and in accordance with resident assessments and evaluations.

Scope

The assessment, evaluation, and billing for therapy practices for March 2015 through July 2016.

Selected MCO Speech Therapy Providers

An audit of one provider is being performed.

Objective

Evaluate whether speech therapy providers:

- Comply with and follow Texas Medicaid Provider Procedure Manual for authorization and reauthorization requirements for services
- Follow criteria established for determining the discontinuation of therapy services, in terms of duration and total number of visits
- Comply with Texas Medicaid provider enrollment guidance and applicable licensure and certification requirements

Scope

For the period September 2014 through August 2016, audit fieldwork will consist of reviewing:

- Speech therapy administrative and medical records for the period
- Policy, practices, and procedures as indicated in the MCO provider manual that address Speech Therapy
- Data integrity of applicable information technology systems
- Selected treatment and procedural records
- Appropriate licensing records

Selected Vendor Drug Program Pharmacy Providers

Audits of five pharmacies are being performed.

Objective

Determine whether the vendor accurately billed the Texas Medicaid Vendor Drug Program and complied with contractual requirements, as well as the Texas Administrative Code rules.

Scope

For the period of September 2011 through August 2014:

- Review selected invoices for drug purchases
- Review a statistical sample of paid claims

Selected Durable Medical Equipment Providers

Preliminary Objective

Determine whether selected durable medical equipment (DME) providers billed and were paid for services and supplies in accordance with state and federal regulations and guidelines.

Hospital Cost Reports

Preliminary Objective

Determine whether selected cost centers of the hospital cost report are correct and accurate according to applicable Centers for Medicare and Medicaid Services (CMS) and state regulations.

Selected Air Ambulance Providers

Preliminary Objective

Determine whether paid fee-for-service claims for air ambulance services of Texas Medicaid enrollees' were billed in accordance with state laws, regulations, and the Texas Medicaid Provider Procedures Manual.

Residential Services

An audit of one residential services contractor is being performed.

Preliminary Objective

Determine whether state funds were used as intended to provide services in accordance with contract requirements.

Information Technology Audits

IT Security Assessment

Two IT security assessment audits are being performed.

Preliminary Objective

Assess the effectiveness of logical and physical security controls over confidential information stored and processed.

AUDIT PLAN

The HHS System currently has over 54,000 employees responsible for managing approximately \$44.2 billion each year, and includes over 200 programs providing needed services to millions of Texans.⁸ These programs are subject to federal and state regulations, statutes and rules, and HHS 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 are constantly changing.

In an effort to be responsive to continuously changing risks and an evolving environment, the IG Audit Plan contains two components. The first component focuses on the short term, and is used in conjunction with a schedule of current audit projects and available staff to guide the utilization of audit resources within the upcoming six-month period of time. The audit projects listed in the section called “Audits IG Plans to Initiate During the Next Six Months,” while still subject to change when needed to address near-term changes in the audit environment and to accommodate executive management requests for audit services, is intended to represent the roadmap the IG Audit Division plans to follow for the next several months. Audit projects will be planned and initiated based on current priorities and availability of audit staff members needed to form audit teams.

The second component, called “Potential Audit Topics - Fiscal Years 2017 Through 2018,” covers the balance of the two year period. This section, which includes potential audit topics that represent possibilities for future audit consideration, is updated with each new version of the rolling audit plan, which will occur in three month intervals. Some potential topics will fall off the list, and others will be added, reflecting changing risks and priorities.

The two components of the IG Rolling Audit Plan follow.

⁸ \$44.2 billion represents the sum of the fiscal year 2016 HHS Agency Operating Budgets, 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, 2015, which is approximately \$5.3 billion.

Audits IG Plans to Initiate During the Next Six Months

Proposed audit projects are listed below. While IG anticipates it will initiate the audits listed below during the next six months, changing risks and priorities could result in some of the planned audits not being initiated, or in other audits, not listed below, being initiated.

Performance Audits⁹

- Performance of Third Party Recovery Contractor Managed by Claims Administrator

Preliminary Objective:

Determine whether third party recovery contractor performance was in compliance with contract requirements.

- Medical Transportation Program Vendor Performance

Preliminary Objective:

Determine whether (a) contract funds were used as intended, (b) contractor performance was in accordance with contract requirements, and (c) the MTO service delivery methodology, as designed, is cost effective and achieving its intended purpose.

- Fee-for-Service (FFS) 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.

- MCO Special Investigative Units

Preliminary Objective:

Evaluate the effectiveness of MCO Special Investigative Unit (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.

⁹ Due to resource constraints, the IG Audit Division may only initiate the first six performance audit topics during the next six months.

- Electronic Visit Verification (EVV) Contractor Performance

Preliminary Objective:

Determine whether (a) contract funds were used as intended, (b) contractor performance was in accordance with contract requirements, and (c) the process, as designed, is achieving its intended purpose.

- Dental Maintenance Organization Comprehensive Review

Preliminary Objective:

Evaluate the effectiveness of dental maintenance organization's (DMO) performance in complying with contract requirements and achieving key contract outcomes.

- FFS Payments for Services Covered by MCOs

Preliminary Objective:

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

Provider Audits

The preliminary objective for provider audits is typically:

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

- Potential Duplicate Payments for Services Covered by STAR Health Procured Under DFPS Child-Specific Contracts
- Therapy Services at Selected Long Term Care Nursing Facilities (partnered audit with DHHS OIG)
- Selected Vendor Drug Program Pharmacy Providers
- Selected Durable Medical Equipment (DME) Providers
- Selected MCO Speech Therapy Providers
- Selected Home Health, Personal Care Services, and Home and Community-Based Services Providers

- Assessment and Evaluation Practices at Selected Long Term Care Nursing Facilities
- Selected Air Ambulance Providers
- Hospital Cost Reports

Information Technology Audits

- IT Security at Selected Contractors and Business Partners, and for HHS agency systems and applications

Preliminary Objective:

Assess the design and effectiveness of selected logical and physical controls intended to address the security of confidential information at rest, in transit, and during processing.

Potential Audit Topics - Fiscal Years 2017 Through 2018

The potential audits listed below are organized by program, process, or business area. The IG Audit Division will update this list, based on changing risks and priorities, each time it issues a new rolling audit plan. When IG plans to initiate a proposed audit listed in this section within the following six months, it will remove the proposed audit from this section and list it in the previous section, called “Audits IG Plans to Initiate During the Next Six Months.”

Medicaid

Managed Care

- Accuracy and Usability of MCO Scorecards
- Expedited Credentialing by MCOs
- MCO Adjustment of Encounters After Collecting Overpayments from Providers
- Cost Allocation of MCO Shared Services
- Physician Administered Drug Rebate Processes in MCOs
- MCO Behavioral Health Initiatives Funded With Medicaid Dollars
- MCO Support for Quality Payments
- MCO Prior Authorizations
- Retrospective Utilization Management
- Validity of Information Reported in MCO Deliverables
- Quality and Completeness of MCO Encounter Data
- Duplicate Payments to MCOs
- MCO Third Party Recovery Performance
- External Quality Review Organization Contractor Performance
- Follow-up on MCO Corrective Action Plans

Medicaid Claims Administrator

- Prior Authorization Processes
- Effectiveness and Monitoring of Medicaid Claims Administrator Key Performance Indicators

Pharmacy

- Drug Destruction Practices at Selected Long Term Care Providers
- Selected Vendor Drug Program Pharmacy Providers
- Pharmacy Cost Methodologies (Informational Report)
- 340b Program in Federally-Qualified Health Centers (FQHCs)

STAR+PLUS

- DME in STAR+PLUS
- Recovery of Assets From Long Term Care Residents in Medicaid

STAR Kids

- STAR Kids Implementation

Hospital

- Hospital Audit (Topic to be Determined)
- Selected Delivery System Reform Incentive Payments (DSRIP)
- Emergency Medical Services

CHIP

- CHIP Complaint Process

Eligibility

- Duplicate Eligibility in TIERS
- TIERS Access Controls

- TIERS Processes and Workflows
- Application and Database Security Assessment for TIERS
- Effectiveness of TIERS Manual Workarounds

SNAP

- Out of State SNAP Expenditures
- Able-Bodied Working Adults Without Dependents
- Application and Database Security Assessment for Electronic Benefit Transfer (EBT)
- Effectiveness of Edits Checks and Other Controls Related to Issuance and Activation of EBT Cards
- EBT Contract Procurement
- SNAP Eligibility Interfaces

TANF

- Accuracy of TANF Eligibility and Payments
- TANF Eligibility Interfaces

Foster Care

- Intake Processes - “V” (Victim) Coding on Medical Records
- Foster Care Psychotropic Medication Utilization and Monitoring

Miscellaneous

- Medically Dependent Children Program (MDCP) Enrollment
- School and Health Related Services (SHARS)
- Selected MHMR Contracts and Related Providers
- Grants Management Processes at the Department of State Health Services
- Selected Consumer Directed Services Providers

- Selected Early Childhood Intervention Services Providers
- Selected Family Violence Program Services Providers
- Selected Client Services Providers
- Prescription Waste in Nursing Facilities
- HHS System Collections
- Behavioral Health Services

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AUDIT REPORTS ISSUED IN FISCAL YEAR 2017

IG issued the following audit reports between September 1, 2016 and February 28, 2017.

Audit	Report Issue Date	Key Findings
Audit of Medicaid and CHIP MCO Special Investigative Units: Christus Health Plan SIU	November 22, 2016	<ul style="list-style-type: none"> • Christus did not have an active SIU function from March 2015 through July 2016. • Christus did not initiate or conduct investigations of referrals of suspected fraud, waste, or abuse in accordance with regulations.
Audit of Contractors Selected as Noncompetitive Procurements Over \$10 Million: Newborn Screening Program Contract Between Department of State Health Services and PerkinElmer Health Sciences, Inc.	November 22, 2012	<ul style="list-style-type: none"> • PerkinElmer complied with key contract requirements related to performance and the use of contract funds. • Although DSHS acted in accordance with state contracting rules and guidelines by posting a sole source procurement for the 2015 contract, this process potentially discouraged other vendors from submitting a proposal.
Audit of a Clinical Research Study to Treat Traumatic Brain Injury and Post-Traumatic Stress Disorder in Veterans: Brain Synergy Institute Contractor Performance and Billing, and HHSC Contract Procurement and Monitoring	November 22, 2016	<ul style="list-style-type: none"> • The audit identified \$278,441 in overpayments to Brain Synergy Institute (BSI) for failing to follow the requirements of the contract as amended and for treating the same participants multiple times. • The BSI contract was inadequately drafted, included a poorly designed research protocol, and did not include key provisions such as a participant eligibility requirement.
Audit of Acute Care Utilization Management in Managed Care Organizations: Superior HealthPlan, Inc.	November 30, 2016	<ul style="list-style-type: none"> • Superior did not have data input controls and edit checks in place to help ensure prior authorization request received dates and prior authorization determination dates were accurate. • Superior did not have a process in place to ensure that all out-of-state contractors who made medical necessity determinations received all required Texas-specific training.
Audit of Contractors Selected as Noncompetitive Procurements Over \$10 Million: Local Authority Contract between Department of Aging and Disability Services and Alamo Area Council of Governments	November 30, 2016	<ul style="list-style-type: none"> • The audit identified weaknesses in Alamo Area Council of Governments' equipment accountability and inventory processes.

Audit	Report Issue Date	Key Findings
Audit of Acute Care Utilization Management in Managed Care Organizations: FirstCare Health Plans	February 21, 2017	<ul style="list-style-type: none"> • FirstCare's electronic prior authorization data was not reliable for measuring timeliness because FirstCare did not have data input controls and edit checks in place to help ensure prior authorization dates were accurate. • FirstCare did not consistently process appeal acknowledgement letters and resolution letters timely.
Audit of Contractors Selected as Noncompetitive Procurements Over \$10 Million: Early Childhood Intervention Program Contract between Texas Department of Assistive and Rehabilitative Services and Easter Seals Rehabilitation Center	February 21, 2017	<ul style="list-style-type: none"> • Easter Seals did not use the federally required E-verify system to verify its employees' eligibility to work in the United States. • Easter Seals did not perform fingerprint-based criminal background checks on prospective employees.
Audit of Acute Care Utilization Management in Managed Care Organizations: Community Health Choice, Inc.	February 28, 2017	<ul style="list-style-type: none"> • Community Health Choice's electronic prior authorization data was not reliable for measuring timeliness because Community Health Choice did not have data input controls and edit checks in place to help ensure prior authorization dates were accurate. • Community Health Choice did not retain all necessary documentation to show that it consistently processed appeal acknowledgement letters and resolution letters timely.
Medicaid and CHIP MCO Special Investigative Units: Initiatives Underway to Improve Collaboration and Performance Capstone	February 28, 2017	<ul style="list-style-type: none"> • MCOs have increased, or indicated they plan to increase, their SIU financial commitment in fiscal years 2016 and 2017 by \$5.3 million, primarily by increasing SIU staff and increasing data analytics capabilities.
Deep East Texas Council of Governments: While HHS Contract Funds Were Used as Intended, Financial and IT Controls Should be Improved	February 28, 2017	<ul style="list-style-type: none"> • Deep East Texas Council of Governments did not comply with contract provisions that require it to limit access to confidential and financial information. • Roles and responsibilities are not properly segregated among the Finance and Accounting staff.

Audit	Report Issue Date	Key Findings
Audit of DADS Claims Management System: Information Technology Interface Processing Controls	February 28, 2017	<ul style="list-style-type: none"> • HHSC IT manually released job schedules, rather than allowing processing of bath files to be automatically released through the DADS Provider Payment System, a practice which could result in unnecessary delays or errors in processing. • There are controls weaknesses in the DADS Long-Term Care Provider System and in the Texas and Medicaid Healthcare Partnership (TMHP) system that could allow improper provider payments.
Audit of Recovery of Overpayments Identified in Federal Audits	February 28, 2017	<ul style="list-style-type: none"> • The audit did not identify any reportable issues.
Texas Medicaid Speech Therapy: Informational Report on Payment Trends and Service Delivery	February 28, 2017	<ul style="list-style-type: none"> • The report provides information about Medicaid acute speech therapy in Texas, based on the IG Audit Division's compilation and analysis of non-audited information obtained from HHS System agencies.