INSPECTOR GENERAL
TEXAS HEALTH AND HUMAN SERVICES COMMISSION

TWO-YEAR ROLLING AUDIT PLAN

Fiscal Years 2017 – 2018

December 2016
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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.
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)
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.
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 System

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
- NorthSTAR

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

7 NorthSTAR program ends December 31, 2016.
- 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 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 public

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

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8 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
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.
Performance Audits

Medicaid and CHIP Managed Care Organization Special Investigative Units - SIU Resources, Activities, and Infrastructure

Objective

Determine the effectiveness of managed care organization (MCO) special investigative units (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.

Scope

MCO SIUs for the period of September 2013 through August 2016, to include:

- Processes and activities that support SIU fraud plans at Medicaid and CHIP MCOs and subcontractors.
- Policies and practices supporting the reporting of SIU activities and results to HHSC.
- Information technology systems that support SIU processes, and related data.

Performance of Contractors Selected as Sole Source Procurements over $10 Million

An audit of one HHS agency contractor is being performed.

Objective

Determine whether (a) funds are used as intended and (b) contractors are performing in accordance with contract requirements.

Scope

The most recent 12 to 18 months, to include:

- Contractor and subcontractor processes and activities that ensure contract requirements are met and funds are used as intended.
- Policy and practices supporting contract deliverables and performance measures.
- Information technology systems that support the reporting process, and related data.
Utilization Management in Managed Care Organizations

Audits of three health plans are being performed.

Objective

Evaluate the effectiveness of acute care utilization management practices at selected MCOs 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.

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.

Texas Association of Local Governments Financial Review

Objective

- Review contractor's adherence to requirements for contracts with HHS System agencies.
- Determine whether State funds were used as intended according to contractual requirements and recover State funds, if applicable.
Scope

For the period of September 2014 through March 2016, to include:

- Conducting site visits to contractor's locations to observe and evaluate activities relate to the audit objectives.
- Reviewing 100 percent of financial transactions for the contracts within scope to verify validity, completeness, and accuracy.

Processes for Identifying and Preventing Eligibility Determination Errors

Preliminary Objective

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

- Preventing or minimizing errors resulting in incorrect eligibility determinations.
- Identifying and resolving incorrect eligibility determinations caused by agency error.

Provider Audits

Selected Vendor Drug Program Pharmacy Providers

An audit of one pharmacy is being performed.

Preliminary 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.

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.
**Selected MCO Speech Therapy Providers**

An audit of one provider is being performed.

**Preliminary Objective**

Determine whether speech therapy providers:

- Comply with Texas Medicaid provider enrollment guidance and applicable licensure and certification requirements.
- Follow criteria established for determining when discontinuation of therapy is appropriate, in terms of:
  - Duration
  - Total number of visits

**Information Technology Audits**

**Claims Management System IT Interfaces**

**Objective**

Evaluate the adequacy of IT interface processing controls designed to:

- Ensure data transmitted and processed is valid, complete, and accurate.
- Protect data from unauthorized access, modification, and deletion.

**Scope**

- Claims submitted for payment in March 2016 and June 2016.
- Processes and controls over Medicaid provider claim payment data processed and transmitted to and from relevant automated systems.
- Monitoring and oversight of contractor activities relevant to the audit objective.

**IT Security Assessment**

An audit of one application is being performed.

**Preliminary Objective**

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

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9 $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 Audits

- STAR+PLUS Enrollment
- Managed Care Pharmacy Benefit Manager Compliance
- Performance of Third Party Recovery Contractor Managed by Claims Administrator
- Dental Service Organizations (Informational Report)
- Dental Management Organizational Comprehensive Review
- HHS System Collections

Provider Audits

- Selected Vendor Drug Program Pharmacy Providers
- Selected Durable Medical Equipment (DME) Providers
- Hospital Cost Reports
- 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 Women’s Health Program Providers
- Selected Delivery System Reform Incentive Payments (DSRIP)
- 340b Program in Federally-Qualified Health Centers (FQHCs)
Information Technology Audits

- IT Security at Selected Contractors and Business Partners, and for HHS agency systems and applications
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
- Follow-up on MCO Corrective Action Plans
- Duplicate Payments to MCOs
- MCO Third Party Recovery Performance
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)

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)

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

• Electronic Visit Verification (EVV) Contractor Performance

• Potential Duplicate Payments for Services Covered by STAR Health Procured Under DFPS Child-Specific Contracts

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IG issued the following audit reports between September 1, 2016 and November 30, 2016.

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<th>Report Issue Date</th>
<th>Key Findings</th>
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| Acute Care Utilization Management in Managed Care Organizations (MCO) - Superior HealthPlan, Inc. | November 30, 2016 | • Prior authorization request determinations did not consistently meet timeliness requirements  
• Electronic prior authorization data was not reliable for measuring timeliness |
| Noncompetitive Contractor Procurements Over $10 Million - Alamo Area Council of Governments (AACOG) | November 30, 2016 | • Improve AACOG’s equipment accountability and inventory processes                                                                          |
| Medicaid and CHIP MCO Special Investigative Units (SIU) - Christus Health Plan | November 22, 2016 | • Scope of SIU investigation activities was limited  
• SIU activities necessary to detect fraud, waste, and abuse were not performed |
| Noncompetitive Contractor Procurements Over $10 Million - PerkinElmer Health Sciences, Inc. | November 22, 2012 | • DSHS should post an open market solicitation at the end of the current contract term to determine whether PerkinElmer remains the best value offer for the state |
| Clinical Research Study to Treat Traumatic Brain Injury and Post-Traumatic Stress Disorder in Veterans Brain Synergy Institute (BSI) | November 22, 2016 | • The audit identified $278,441 in overpayments to BSI for failing to follow the requirements of the contract as amended and for treating the same participants multiple times  
• BSI was not properly vetted and monitored to ensure that it complied with the contract |