**TEXAS HEALTH AND HUMAN SERVICES COMMISSION**

# INSPECTOR GENERAL

# TWO-YEAR ROLLING AUDIT PLAN

*Fiscal Years 2018 - 2019*

**January 2018**

# TABLE OF CONTENTS

INTRODUCTION ..... 3

AUDIT AUTHORITY ..... 4

AUDIT UNIVERSE ..... 5

RISK ASSESSMENT ..... 8

TYPES OF AUDITS ..... 9

AUDITS IN PROGRESS ..... 10

AUDIT PLAN ..... 15

AUDIT REPORTS ISSUED IN FISCAL YEAR 2017 ..... 23

AUDIT REPORTS ISSUED IN FISCAL YEAR 2018 ..... 27

# 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, or services provided by the Department of Family and Protective Services 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

Be the best state-level IG in the country.

### Values

Professionalism, Productivity, Perseverance.

### Mission

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

# AUDIT AUTHORITY

Texas Government Code Section 531.102 created 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 or services provided by the Department of Family and Protective Services (DFPS).[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, 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 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 and DFPS, including services delivered through managed care, and services delivered through providers and contractors. Services delivered through managed care, and services delivered through providers and contractors, primarily applies to the HHS System, but may also apply to DFPS.

Health and Human Services System

*Administrative Services*

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

*Programs*

- Medical and Social Services
- Regulatory Services
- State Facilities
- Department of State Health Services
    - Laboratory and Infectious Disease Services
    - Community Health Improvement
    - Regional and Local Health Operations
    - Consumer Protection
    - Program Operations

Department of Family and Protective Services

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

Medical and Dental 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)
- Children's Medicaid Dental Services
- CHIP Dental
- 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 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
- 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 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
  - 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 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, DFPS, and the public[6]

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

[6] 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 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.

- Performance Audits - Review the effectiveness and efficiency of HHS System and DFPS program performance and operations. The IG 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 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 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.

# AUDITS IN PROGRESS

## Performance Audits

### Selected STAR+PLUS Enrollees in Nursing Facility Risk Groups

Objective

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

Scope

Includes STAR+PLUS enrollees from March 2015 through December 2016, including activities and systems related to nursing facility risk group placement and capitation payments. Audit fieldwork will consist of:

- Interviewing staff in Program Enrollment and Support, Access and Eligibility Services, and other relevant business areas to validate processes, policies, and procedures.
- Evaluating and testing the design and effectiveness of certain key controls including the submission and processing of Resident Transaction Notices.
- Analyzing data from relevant systems that provide information related to the risk group placement and capitation payments.

### Selected Residential Child-Care Contracts

An audit of one residential child-care contractor is being performed.

Objective

Determine whether the contractor is performing in accordance with contract requirements for the following:

- State funds were used as intended for children placed with foster parents based on the documented service level and need per child.
- Oversight of foster parents was conducted.
- Children's service plans were implemented and updated.

Scope

The scope of the audit will cover the period of January 2015 through December 2015.

**Medicaid and CHIP Managed Care Organization Special Investigative Units**

An audit of one health plan is being performed.

Objective

Determine 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

For the period of September 2015 through February 2017, audit fieldwork will consist of reviewing:

- Processes and activities that support the MCO SIU's approved fraud plans, including activities performed by subcontractors.
- Policy and practices supporting the reporting of the MCO's SIU activities and results to HHSC.

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

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.

Scope

The scope of the audit will cover the period of September 2014 through August 2016.

**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 managed transportation organization service delivery methodology, as designed, is cost effective and achieving its intended purpose.

## Provider Audits

### Selected Vendor Drug Program Pharmacy Providers

Audits of six pharmacies are being performed.

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

For the period of March 2012 through February 2015, audit fieldwork will consist of reviewing:

- Selected invoices for drug purchases.
- A statistical sample of paid claims.

### Assessment and Evaluation Practices at Long Term Care Nursing Facilities

An audit of one nursing facility is being performed.

Objective

Determine whether therapy services were provided consistent with physician orders, in accordance with resident assessments and evaluations, and in compliance with applicable federal and state requirements.

Scope

The nursing facility’s practices for assessing, evaluating, delivering, and billing therapy services during the period of March 2015 through March 2017.

### Selected Air Ambulance Providers

An audit of one provider is being performed.

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.

Scope

Fee-for-service paid claims for the period of September 2015 through August 2016.

**Selected Durable Medical Equipment Providers**

Audits of two providers are being performed.

Objective

Determine whether paid fee-for-service claims were billed in accordance with state laws, regulations, and the Texas Medicaid Provider Procedures Manual appropriately, including determining whether:

- Title XIX Forms or Plans of Care are properly completed.
- DME certification and Receipt Forms (Delivery Slips) exist and support paid claims for incontinence supplies.

Scope

For the period of September 2015 through August 2016, audit fieldwork will consist of reviewing:

- Selected Medicaid beneficiaries' Title XIX forms and Plan of Care.
- Documentation in support of paid claims for incontinent supplies.

**Selected Home and Community-Based Services Providers**

Audits of two providers are being performed.

Objective

Determine whether fee-for-service claims submitted by and paid to the provider were billed and documented in accordance with state laws, regulations, contracts, and agency guidelines.

Scope

Fee-for-service paid claims for the period of June 2015 through May 2016.

### Pharmacy Inventory Reconciliations

Preliminary Objective

To perform an inventory of a sample of anti-psychotic drugs to determine whether the pharmacy:

- Incorrectly billed Medicaid for the sample selected.
- Maintained sufficient drug inventory to fulfill Medicaid claims during the audit scope period.

### Selected MCO Speech Therapy Providers

An audit of one provider is being performed.

Preliminary Objective

Evaluate whether the speech therapy provider complied with the following Texas Medicaid requirements:

- Prior authorization and re-authorization requirements.
- Criteria for determining when discontinuation of therapy is appropriate, in terms of duration and total number of visits.
- Applicable licensure and certification requirements for the speech therapists.

## Information Technology Audits

### IT Security Assessment

Three IT security assessment audits are being performed.

Objective

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

# AUDIT PLAN

The HHS System has over 42,000 employees responsible for managing approximately $42.2 billion each year[7], and DFPS has over 12,000 employees responsible for managing approximately $2.0 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, 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 2018 Through 2019," 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 periodically throughout the fiscal year. 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.

[7] $42.2 billion represents the sum of the fiscal year 2018 appropriations reported in the 85th Legislature, Senate Bill 1 (General Appropriations Act), for Department of State Health Services and the Health and Human Services Commission, which is approximately $36.9 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, 2016, which is approximately $5.3 billion.

[8] $2.0 billion represents the sum of the fiscal year 2018 appropriations reported in the 85th Legislature, Senate Bill 1 (General Appropriations Act), for the Department of Family and Protective Services

## 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**

- 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.

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

  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.

- Dental Maintenance Organization (DMO) Comprehensive Review

  Preliminary Objective

  Evaluate the effectiveness of DMO's 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 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.

- Recovery of Assets From Long Term Care Residents in Medicaid

  Preliminary Objective

  Evaluate the accuracy of eligibility determinations for long term care residents and whether assets are transferred or disclosed in accordance with federal and state requirements.

- Selected Residential Child-Care Contracts

  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.

- 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.

**Provider Audits**

*Inventory*

- Vendor Drug Program Pharmacy Providers

  Preliminary Objective
  Determine whether pharmacies were billing for prescriptions that were never provided.

- Durable Medical Equipment

  Preliminary Objective

  Determine whether durable medical equipment providers were billing for equipment or supplies that were never provided.

*Hospice*

- Selected Vendor Drug Program Pharmacy Providers for Hospice Recipients

  Preliminary Objective

  Determine whether pharmaceuticals paid for by the Texas Medicaid Vendor Drug Program for Medicaid hospice patients included drugs and biologicals related to the palliation and management of the terminal illness and related conditions, and should have been provided and paid for by the hospice organization.

*STAR+PLUS*

Preliminary Objective

Determine whether services provided under HCBS STAR+PLUS Waiver are provided in compliance with the HHSC Uniform Managed Care Contract, the STAR+PLUS Expansion Contract; and the STAR+PLUS Medicaid Rural Service Area Contract.

*STAR Kids*

Preliminary Objective

- Determine whether selected MCOs' delivery of services are provided as identified in the MCO member's ISP, the associated assessments and in compliance with the HHSC STAR Kids Managed Care Contract.
- Evaluate the effectiveness of selected MCOs' service coordination and whether members are, and to what extent, receiving care coordination services as required by the HHSC STAR Kids Managed Care Contract.

*STAR Health*

Preliminary Objective

- Determine whether selected MCOs' delivery of services are provided as identified in the MCO member's Healthcare Service Plan (HSP), the associated assessments and in compliance with the HHSC STAR Health Managed Care Contract.
- Evaluate the effectiveness of selected MCOs' service coordination and whether members are, and to what extent, receiving care coordination services as required by the HHSC STAR Health Managed Care Contract.
- Determine whether court-ordered services are provided as identified in the MCO member's court-ordered commitment and the HHSC STAR Health Managed Care Contract.

*All Other Providers*

- Selected Behavioral Health Service Providers
- Potential Duplicate Payments for Services Covered by STAR Health Procured Under DFPS Child-Specific Contracts
- Therapy Services at Selected Long Term Care Nursing Facilities
- Selected Vendor Drug Program Pharmacy Providers
- Selected Durable Medical Equipment Providers
- Selected MCO Speech Therapy Providers
- Selected Personal Care Services, Personal Assistance Services, Habilitation Services, and In-Home Respite 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 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.

- Selected MCO Business Continuity and Disaster Recovery Processes

  Preliminary Objective

  Determine whether MCO business continuity and disaster recovery processes are appropriately prioritized, documented, designed and tested to help ensure (a) continuity of operations for selected mission essential functions, and (b) recovery of selected information systems and infrastructure related to selected mission essential functions, in accordance with recovery prioritizations, in the event of a disaster.

## Potential Audit Topics - Fiscal Years 2018 Through 2019

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 and CHIP

- Accuracy and Usability of MCO Report Cards
- Expedited Credentialing by MCOs
- MCO Adjustment of Encounters After Collecting Overpayments from Providers
- 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
- MCO Third Party Recovery Performance
- External Quality Review Organization Contractor Performance
- Follow-up on MCO Corrective Action Plans
- Quality and Completeness of MCO Encounter Data
- Medicaid Claims Administrator Prior Authorization Processes
- Effectiveness and Monitoring of Medicaid Claims Administrator Key Performance Indicators
- 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)
- DME in STAR+PLUS
- Selected Delivery System Reform Incentive Payments (DSRIP)
- Emergency Medical Services
- Medicaid and CHIP Complaint Process
- Prescription Waste in Nursing Facilities
- Cost Allocation of MCO Shared Services

**Eligibility**

- Duplicate Eligibility in TIERS
- TIERS Access Controls
- TIERS Processes and Workflows
- Application and Database Security Assessment for TIERS
- Effectiveness of TIERS Manual Workarounds
- Performance of Contractors Supporting TIERS

**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

**DFPS**

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

**Miscellaneous**

- School Health and 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
- Electronic Visit Verification (EVV) Contractor Performance

# AUDIT REPORTS ISSUED IN FISCAL YEAR 2017

IG issued the following audit reports between September 1, 2016 and August 31, 2017.

| Audit | Report Issue Date | Key Findings |
|---|---|---|
| Audit of Medicaid and CHIP MCO Special Investigative Units: Christus Health Plan SIU | November 22, 2016 | • Christus did not have an active SIU function from March 2015 through July 2016.<br>• 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, 2016 | • PerkinElmer complied with key contract requirements related to performance and the use of contract funds.<br>• 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 | • 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.<br>• 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 | • 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.<br>• 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 | • 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 | • FirstCare's electronic prior authorization data was not reliable for measuring timeliness because it did not have data input controls and edit checks in place to help ensure prior authorization dates were accurate.<br>• 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 | • Easter Seals did not use the federally required E-verify system to verify its employees' eligibility to work in the United States.<br>• 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 | • Community Health Choice's electronic prior authorization data was not reliable for measuring timeliness because it did not have data input controls and edit checks in place to help ensure prior authorization dates were accurate.<br>• 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 | • 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 | • Deep East Texas Council of Governments did not comply with contract provisions that require it to limit access to confidential and financial information.<br>• 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 | • HHSC IT manually released job schedules, rather than allowing processing of bath files to e automatically released through the DADS Provider Payment System, a practice which could result in unnecessary delays or errors in processing.<br>• 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 | • The audit did not identify any reportable issues. |
| Texas Medicaid Speech Therapy: Informational Report on Payment Trends and Service Delivery | February 28, 2017 | • This 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. |
| Audit of Acute Care Utilization Management in Managed Care Organizations: Amerigroup Texas, Inc. | May 30, 2017 | • Amerigroups's electronic prior authorization data was not reliable for measuring timeliness because it did not have data input controls and edit checks in place to help ensure prior authorization dates were accurate.<br>• Amerigroup did not have a process in place to ensure that personnel who are responsible for prospective medical necessity determinations completed the required training. |
| Audit of the University of Texas Medical Branch at Galveston Cost Report: Fiscal Year 2014 | May 30, 2017 | • Capitalization and depreciation amounts reported on UTMB's fiscal year 2014 UTMB cost report were accurate, allowable, and adequately supported according to CMS and state requirements.<br>• UTMB was in compliance with applicable standards related to the IT system security standards. |
| Dental Service Organizations Informational Report | May 31, 2017 | • This report provides information about Dental Service Organizations (a) practice structures, (b) operations in Texas, (c) alleged influence on Medicaid and CHIP participation, (d) state payments, and (e) oversight efforts and investigations. |
| Audit of Houston Medicine Chest, LLC: A Texas Vendor Drug Program Provider | August 3, 2017 | • Houston Medicine Chest did not comply with contractual obligations relating to records retention.<br>• Audit results found medication was dispensed without valid documentation or identification of the prescriber, and refilled prescriptions were not properly authorized. |

| Audit | Report Issue Date | Key Findings |
|---|---|---|
| Audit of MedCare Pediatric Group, LP: A Medicaid Speech Therapy Provider | August 11, 2017 | • Audit results found 7 of 1,554 speech therapy claims tested were filed and paid incorrectly.<br>• MedCare was not in compliance with information security laws, rules, and regulations required by its Ancillary Services Provider Agreement with Superior. |
| Summary of Results from Audits of Acute Care Utilization Management in Managed Care Organizations: Informational Report | August 15, 2017 | • MCOs face challenges in complying with different prior authorization processing requirements.<br>• MCOs assess and monitor personnel performance, but do not always ensure Texas-specific training is completed.<br>• The Medicaid and CHIP Services Department and audited MCOs are taking actions to address the findings identified in the audit reports. |
| Audit of Security Controls Over Confidential HHS Information System: FirstCare Health Plans | August 22, 2017 | • Security plans submitted by FirstCare were reviewed and approved by HHSC IT, but were incomplete and did not comply with the UMCC.<br>• User access to information systems that contained confidential HHS System information was not effectively managed. |
| Audit of US Bioservices Corporation: A Texas Vendor Drug Program Provider | August 29, 2017 | • Audit results found no exceptions for the claims tested and that the claims (a) were properly billed and (b) complied with applicable contractual and TAC requirements. |
| Audit of HEB Pharmacy #084: A Texas Vendor Drug Program Provider | August 31, 2017 | • HEB did not bill the Vendor Drug Program properly, or comply with other contractual requirements, for 57 of 290 claims tested. |
| Audit of Baylor Scott & White Medical Center – Lake Pointe Cost Report: Fiscal Year 2014 | August 31, 2017 | • Capitalization and moveable equipment amounts reported on Lake Pointe's cost report were not accurate or adequately supported. As a result, the IG Audit Division will submit an adjustment to the reported expense in the amount of $321,396 to the Texas Medicaid and Healthcare Partnership (TMHP), the Texas Medicaid fiscal intermediary. |
| Audit of Maxor National Pharmacy Service LLC: A Texas Vendor Drug Program Provider | August 31, 2017 | • Audit results identified $2,575 in overpayments for a prescription that was paid with an incorrect prescription issuance date. |

# AUDIT REPORTS ISSUED IN FISCAL YEAR 2018

IG issued the following audit reports between September 1, 2017 and January 31, 2018.

| Audit | Report Issue Date | Key Findings |
|---|---|---|
| Assessment and Evaluation Practices at Sunny Springs Nursing and Rehabilitation | October 25, 2017 | • Audit results found that for 28 of 48 resident files tested, the number of therapy days and minutes provided during the look-back period were greater than therapy days and minutes scheduled for any week outside the look-back period, which indicated a pattern of clustering. This practice resulted in Sunny Springs being reimbursed at a higher Resource Utilization Group (RUG) level than would have been provided had clustering not occurred. Total RUG reimbursements resulting from clustering were $225,824. |
| Audit of Providence Memorial Hospital Cost Report: Fiscal Year 2014 | October 31, 2017 | • Depreciation amounts reported in the Providence cost report were not in compliance with all CMS and state requirements for four of ten assets tested. As a result, the IG Audit Division will submit an adjustment to increase the reported expense in the amount of $6,031.43 to TMHP, the Texas Medicaid fiscal intermediary. |
| Audit of HHSC Processes for Analyzing and Preventing Eligibility Determination Errors | November 13, 2017 | • HHSC Access and Eligibility Services processes for developing corrective action plans and evaluating the effectiveness of those plans need improvement. Corrective action plans did not always fully address identified errors and were not always designed to reduce or prevent errors in future time periods.<br>• There were no procedures or processes in place for reviewing errors across regions and determining when corrective actions at a multi-regional or statewide level should be development. |
| Audit of Halo-Flight A Texas Medicaid Air Ambulance Provider | November 15, 2017 | • Audit results found no exceptions for the claims tested and that Halo-Flight complied with applicable Texas Medicaid requirements. |
| Pharmacy Benefit Managers In Texas - Informational Report on the Role of PBMs in Delivering Medicaid and CHIP Pharmacy Benefits to Managed Care Members | November 17, 2017 | • This report provides information about the functions and components necessary to delivery pharmacy services to Medicaid and CHIP managed care members in Texas. |

| Audit | Report Issue Date | Key Findings |
|---|---|---|
| Audit of Wee-Care Pediatric Home Health, LLC: A Texas Medicaid Speech Therapy Provider | November 20, 2017 | • Audit results found no exceptions for the claims tested and that Wee-Care complied with applicable Texas Medicaid requirements. |
| Audit of Homelife and Community Services, Inc.: A Texas Medicaid Home and Community-Based Services Program Provider | November 30, 2017 | • Audit results found $71,645 in overpayments for 623 of 24,212 claims that did not have sufficient supporting documentation.<br>• Homelife did not have written policies and procedures and did not have an adequate process in place for management review or oversight of the billing process |
| Audit of Children's Hope Residential Services, Inc.: Residential Child-Care Contracts with the Texas Department of Family and Protective Services | November 30, 2017 | • Children's Hope did not (a) ensure child-to-caregiver ratios were sufficient to meet requirements, (b) review and update service plans according to required intervals, (c) pay foster parents accurate amounts for children's service level, and (d) have a strong internal control environment. |
| Audit of Gaddy Enterprises, Inc.: A Texas Medicaid Durable Medical Equipment Provider | December 20, 2017 | • Audit results found no exceptions for the claims tested and that Gaddy Enterprises complied with applicable Texas Medicaid requirements. |