TEXAS HEALTH AND HUMAN SERVICES COMMISSION

OFFICE OF INSPECTOR GENERAL

ROLLING AUDIT PLAN

February 2019

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 2018 19

AUDIT REPORTS ISSUED IN FISCAL YEAR 2019 23

INTRODUCTION

The Role of OIG

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 Office of Inspector General's (OIG) 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."

The OIG'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).

OIG Principles

Vision

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

Values

Accountability. Integrity. Collaboration. Excellence

Mission

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

AUDIT AUTHORITY

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

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

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

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

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[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 OIG adopted RAT/STATS, statistical software available from the United States Department of Health and Human Services Office of Inspector General and policies and procedures consistent with the mathematical processes for sampling and overpayment estimation described in the Centers for Medicaid and Medicare Services Program Integrity Manual.

AUDIT UNIVERSE

The audit universe represents an inventory of all potential areas that can be audited, which are commonly referred to as auditable units. The OIG Audit Division defines its audit universe as the departments, programs, functions, and processes within the Health and Human Services (HHS) System and DFPS, including services delivered through managed care, and services delivered through providers and contractors. Services delivered through managed care, and services delivered through providers and contractors, primarily applies to the HHS System, but may also apply to DFPS.

<u>Health and Human Services System</u>

Administrative Services

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

Departments

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

<u>Department of Family and Protective Services</u>

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

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

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

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

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

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

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

TYPES OF AUDITS

The OIG Audit Division conducts risk-based performance, provider, contractor, 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 OIG Audit Division makes recommendations to mitigate performance gaps and risks that could prevent HHS System and DFPS programs from achieving their goals and objectives. These audits may make recommendations that funds be put to better use.

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

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

- Information Technology Audits - Assess compliance with applicable information technology requirements and examine the effectiveness of general and application controls for systems that support HHS System and DFPS programs or are used by contractors or business partners who process and store information on behalf of HHS and DFPS programs. These audits may make recommendations for information technology control improvements and to mitigate security vulnerabilities.

AUDITS IN PROGRESS

Performance Audits

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

Objective

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

Scope

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

Contractor Audits

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

An audit of one health plan is being performed.

Objective

Determine whether delivery of pharmacy benefits by the MCO and its subcontracted Pharmacy Benefit Manager was effective and in compliance with the HHSC Uniform Managed Care Contract and the Uniform Managed Care Manual, and applicable state rules and statutes.

Scope

The scope of the audit covers the period of September 1, 2015 through November 30, 2017.

Medical Transportation Program Vendor Performance

Audits of four vendors are being performed.

Objective

Determine whether (a) contract funds were used as intended and (b) contractor performance was in accordance with contract requirements, and where performance deficiencies were identified by HHSC or the Managed Transportation Organization, corrective actions taken were implemented timely and were effective.

Scope

The scope of the audit covers the period of September 1, 2016 through August 31, 2017.

Dental Maintenance Organization Comprehensive Review

Audits of two dental health plans are being performed.

Objective

Evaluate the effectiveness of Dental Maintenance Organization performance in complying with contract requirements, achieving key contract outcomes, and reporting contractual performance to HHSC.

Scope

The scope of the audit includes policies, practices, and activities related to (a) claims processing and (b) financial and performance reporting for the period of September 1, 2016 through February 28, 2018.

Services Under STAR+PLUS Waiver

An audit of one health plan is being performed.

Objective

Determine whether MCO STAR+PLUS Waiver members (a) were timely assessed, (b) were assessed at least one institutional level need as required by the waiver program, and (c) received the services planned in a timely manner.

Scope

The scope of the audit covers the period of September 1, 2016 through August 31, 2017.

Financial Impact of Long-Term Care Nursing Facility Therapy Practices on Resource Utilization Group Payments

Objective

Determine the financial impact of long-term care nursing facilities practice of clustering the scheduling of resident therapy sessions during evaluation look-back periods to obtain higher therapy level resource utilization group payments.

Scope

The scope of the audit covers the period of September 1, 2016, through August 31, 2017.

STAR Kids and STAR Health Managed Care Programs

Audits of two health plans are being performed.

Objective

Determine the extent to which selected MCOs (a) are providing services to the Medically Dependent Children Program (MDCP) population and (b) processes support the provision of services for the MDCP population.

Scope

The scope of the audit covers the period of November 1, 2016 through July 31, 2018.

MCO Service Coordination

Audits of three health plans are being performed.

Objective

Evaluate selected MCOs' compliance with regulatory and contractual requirements for service coordination activities provided to Level One STAR+PLUS members.

Scope

The scope of the audit includes service coordination activities for the period of September 1, 2016 through August 31, 2018.

DFPS Child-Specific Contract Payments

Objective

Determine if DFPS appropriately administered child-specific contracts by ensuring (a) contracts were signed by both parties, (b) payments were made for confirmed, completed services, and (c) contract payments were not made for services covered by STAR Health.

Scope

The scope of the audit covers child-specific contracts issued by DFPS for the period of September 1, 2016 through May 31, 2018.

Selected Local Intellectual and Developmental Disability Authority Contracts

Preliminary Objective

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

MCO Clean Claims From Nursing Facility Providers

Preliminary Objective

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

Selected DFPS Contracts

Preliminary Objective

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

Provider Audits

Selected Vendor Drug Program Pharmacy Providers

Audits of two 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

The scope of the audit includes paid claims for the period from May 1, 2013 through August 31, 2015, or September 1, 2013 through August 31, 2016.

Selected Durable Medical Equipment Providers

An audit of fee-for-service claims for one provider is being performed.

Objective

Determine whether support exists for Medicaid Durable Medical Equipment and supplies (DME) fee-for-service claims billed, represented by accurate and complete documentation of (a) authorizations for DME and supplies, and (b) DME certification and receipt forms or other documentation supporting delivery.

Scope

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

Information Technology Audits

Selected IT Security Controls and Business Continuity and Disaster Recovery Processes

Audits of two health plans are being performed.

Objective

- Assess the design and effectiveness of selected security controls over HHS System confidential information stored and processed.
- Evaluate the effectiveness of business continuity and disaster recovery plans and related activities.

AUDIT PLAN

The HHS System has over 42,000 employees responsible for managing approximately $41.78 billion each year[7], and DFPS has over 12,000 employees responsible for managing approximately $2.05 billion each year.[8] Collectively, the HHS System and DFPS have over 200 programs providing needed services to millions of Texans. These programs are subject to federal and state regulations, statutes and rules, and agency and program policies. The programs, and the administrative and technical support that enables them to function, are subject to funding constraints, policy changes, and changing priorities. As a result, risks associated with functions within the HHS System and DFPS are constantly changing.

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

The audit projects the OIG plans to initiate follow.

[7] $41.78 billion represents the sum of the fiscal year 2019 appropriations reported in the General Appropriations Act for the 2018-19 Biennium (January 2018) for the Department of State Health Services and the Health and Human Services Commission, which is approximately $36.42 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, 2017, which is approximately $5.36 billion.

[8] $2.05 billion represents the sum of the fiscal year 2019 appropriations reported in the General Appropriations Act for the 2018-19 Biennium (January 2018) for the Department of Family and Protective Services.

Audits OIG Plans to Initiate

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

Prevention of Fraud, Waste, and Abuse

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

  Preliminary Objective

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

- Performance of Contractors Supporting TIERS

  Preliminary Objective

  Evaluate contractor performance for compliance with key contract requirements.

- Licensing of Home and Community Support Services Agencies

  Preliminary Objective

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

Program Integrity in Medicaid Managed Care

- IT Security Controls and Business Continuity and Disaster Recovery Processes

  Preliminary Objective

  - Assess the design and effectiveness of selected security controls over HHS System confidential information stored and processed.
  - Evaluate the effectiveness of business continuity and disaster recovery plans and related activities.

- 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.

- Utilization and Access to Care

  Preliminary Objective

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

- Fee-for-Service 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.

- Expedited Credentialing of Providers

  Preliminary Objective

  Evaluate selected MCOs' processes for expedited credentialing of providers for compliance with federal and state regulations and contractual requirements.

- MCO Clean Claims for Nursing Facility Providers

    Preliminary Objective

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

- Cost Allocation of MCO Shared Services

    Preliminary Objective

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

Non-Medicaid Programs and Contracts

- Selected Local Intellectual and Developmental Disability Authority Contracts
- Selected DFPS Contracts
- Other Selected Non-Medicaid Contracts

    Preliminary Objective

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

Providers

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

    Preliminary Objective

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

AUDIT REPORTS ISSUED IN FISCAL YEAR 2018

The OIG issued the following audit reports between September 1, 2017 and August 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.
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.
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. • 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.
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
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.
Homelife and Community Services, Inc.: A Texas Medicaid Home and Community-Based Services Program Provider	November 30, 2017	• Audit results found 623 of 24,212 claims tested did not have sufficient supporting documentation, which resulted in an overpayment of $71,645. • 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.
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.
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.
Southside Pharmacy: A Texas Vendor Drug Program Provider	February 28, 2018	• Southside Pharmacy did not bill the Vendor Drug Program properly, or comply with contractual or TAC requirements, for 15 of 133 claims tested. • Audit results identified 21 exceptions related to these 15 claims. The dollar value of the exceptions totaled $8,817.40, which after extrapolating, represented an overpayment of $81,513.
Security Controls Over Confidential HHS System Information: MAXIMUS Enrollment Broker	February 23, 2018	• MAXIMUS did not (a) adequately manage access to systems that store and transmit confidential HHS System information, (b) configure password parameters to meet applicable standards, (c) timely remediate identified vulnerabilities, or (d) maintain and execute system maintenance processes.
Medicaid and CHIP MCO Special Investigative Units: Driscoll Health Plan	April 3, 2018	• Driscoll did not conduct investigations within required timelines and did not fully recover identified overpayment amounts. • Driscoll overstated annual recoveries and underreported the number of investigations it performed in monthly reports to the OIG.

Audit	Report Issue Date	Key Findings
R Medical Outreach and Associates: A Durable Medical Equipment Provider	April 27, 2018	• Audit results found R Medical did not bill Medicaid in accordance with state rules and guidelines for 15,147 of 15,341 claims tested. • The 15,147 claims were not supported by current Title XIX forms, or associated Title XIX forms were improperly completed, which resulted in an overpayment of $1,210,376.17.
Cook Children's Home Health: A Texas Vendor Drug Program Provider	April 30, 2018	• Audit results found no exceptions for the claims tested and that Cook Children's complied with applicable Texas Medicaid requirements.
Assessment and Evaluation Practices at Mission Nursing and Rehabilitation Center	May 11, 2018	• Audit results found that for all 30 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 other weeks outside the look-back period, which indicated a pattern of clustering. This practice resulted in Mission being reimbursed at a higher RUG level than would have been provided had clustering not occurred. Total RUG reimbursements resulting from clustering were $692,952.
Specialty Therapeutic Care, L.P.: A Texas Vendor Drug Program Provider	May 31, 2018	• Specialty Therapeutic did not bill the Vendor Drug Program properly, or comply with contractual or TAC requirements, for 6 of 211 claims tested. All six claims were billed with incorrect prescriber identification numbers and resulted in an overpayment of $92,615.08.
Pharmacy Inventory Controls: Richard's Pharmacy	June 27, 2018	• Audit results found no exceptions for the claims tested and that Richard's Pharmacy complied with applicable Texas Medicaid requirements.
Himmel Home Health, LLC: A Texas Medicaid Speech Therapy Provider	July 23, 2018	• Audit results found no exceptions for the claims tested and that Himmel complied with applicable Texas Medicaid requirements.
Premier Care Pharmacy Services: A Texas Vendor Drug Program Provider	July 31, 2018	• Premier Care Pharmacy did not bill the Vendor Drug Program properly, or comply with contractual or TAC requirements, for 9 of 86 claims tested. • Dispensing fees associated with these nine claims totaled $658.61, which after extrapolating, represented an overpayment of $10,497.

Audit	Report Issue Date	Key Findings
Amber Pharmacy: A Texas Vendor Drug Program Provider	July 31, 2018	• Amber Pharmacy did not bill the Vendor Drug Program properly, or comply with contractual or TAC requirements, for 11 of 213 claims tested. • The dollar value of the exceptions totaled $5,809.89, which after extrapolating, represented an overpayment of $59,231.
Security Controls over Confidential HHS System Information: Community First Health Plans	August 2, 2018	• Community First did not (a) adequately manage user access to systems storing confidential HHS System information, (b) have documented server configuration settings that met required security standards, (c) conduct disaster recovery training, or (d) have an effective incident response plan. • HHSC IT Applications reviewed and approved system security plans for Community First's pharmacy benefit manager, Navitus. However, system security plans submitted by Community First were not reviewed.

Ten contracted audits conducted on behalf of the OIG Audit Division were completed of the following providers:

- Tropical Texas Behavioral Health
- St. Louis Medical Supply, Inc.
- CTW Home Health, Inc. dba Circle of Care
- Jordan Health Services
- Therapy 2000, Inc.
- Epic Pediatric Therapy LP
- Epic Health Services Inc.
- Shield Denver Health Care Center, Inc.
- URS Medical I, L.P.
- Travis Medical Sales Corp.

Nine audits conducted by the CMS Unified Program Integrity Contractor were completed of the following providers:

- Texoma Community Center
- OakBend Medical Center
- CHCA Clear Lake, L.P.
- CHCA Bayshore, L.P.
- Atlanta Hospital Authority
- Memorial Hermann Hospital Systems (8735)
- Memorial Hermann Hospital Systems (3782)
- Memorial Hermann Hospital Systems (3787)
- Medical Case Management and Social Services

AUDIT REPORTS ISSUED IN FISCAL YEAR 2019

The OIG issued the following audit reports between September 1, 2018 and February 28, 2019.

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

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

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

- Christus Health Ark-La-Tex
- Christus Health Southeast Texas 9707
- Christus Health Southeast Texas 7888