Rolling Audit and Inspections Plan

September 2021

Inspector General

Texas Health and Human Services

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INTRODUCTION

Role of the OIG

In 2003, the 78th Texas Legislature created the Office of Inspector General (OIG) to strengthen the Health and Human Services Commission's (HHSC) capacity to combat fraud, waste, and abuse in publicly funded state-run Health and Human Services (HHS) programs.

The OIG's mission, as prescribed by statute, is the "prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services in the state, including services through any state-administered health or human services program that is wholly or partly federally funded, or services provided by the Department of Family and Protective Services (DFPS) 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 Generally Accepted Government Auditing Standards, "Yellow Book" standard);
- Investigations (conducted pursuant to generally accepted investigative policies);
- Inspections (conducted under the federal "Blue Book" standard); and
- Reviews (conducted under the Principles and Standards for Offices of Inspector General developed by the Association of Inspectors General, also known as the Green Book).

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

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.

AUDIT AND INSPECTIONS AUTHORITY

Texas Government Code Section 531.102 created the OIG in 2003 and gives the OIG the responsibility to audit and inspect 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 DFPS.[1]

The OIG's authority to conduct audits and inspections is derived from several statutes and rules, including:

Section 531.102(h)(4) permits the OIG to audit and inspect 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 and inspections, possible fraud, waste, and abuse by managed care organizations.[4] Section 531.102(s) also establishes the OIG's authority to utilize a peer-reviewed sampling and extrapolation process when auditing provider records.[5]

[1] Tex. Gov. Code § 531.102(a) (Sept. 1, 2017).

[2] Tex. Gov. Code § 531.102(h)(4) (Sept. 1, 2015).

[3] Tex. Gov. Code § 531.1025(a) (Sept. 1, 2015).

[4] Tex. Gov. Code § 531.113(d-1) (Sept. 1, 2015).

[5] Tex. Gov. Code § 531.102(s) (Sept. 1, 2015); See also 1 Tex. Admin. Code § 371.35 (May 15, 2016) wherein 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 Medicare Program Integrity Manual.

AUDIT AND INSPECTIONS UNIVERSE

The audit and inspections universe represents an inventory of all potential areas that can be audited and inspected by the OIG. The OIG Audit and Inspections Division defines its audit and inspections universe as the departments, programs, functions, and processes within the HHS System and DFPS, including services delivered through providers and contractors. Those potential areas include:

Health and Human Services System

Administrative Services

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

Departments

- Health and Specialty Care System
- Regulatory Services
- Access and Eligibility Services
- Health, Developmental and Independence Services
- Intellectual and Developmental Disabilities and Behavioral Health Services
- Medicaid and CHIP Services

Department of State Health Services (DSHS)

- Community Health Improvement
- Consumer Protection
- Laboratory and Infectious Disease Services
- Program Operations
- Regional and Local Health Operations

Department of Family and Protective Services

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

Medicaid Managed Care

Managed Care Entities, Subcontractors, and Providers

- Managed Care Organizations (MCO)
- Dental Maintenance Organizations (DMO)
- Medical Transportation Organizations (MTO)
- Behavioral Health Organizations (BHO)
- Pharmacy Benefit Managers (PBM)
- Third Party Administrators (TPA)

Managed Care Programs

- Children's Health Insurance Program (CHIP)
- Children's Medicaid Dental Services
- CHIP Dental
- Texas Dual Eligible Integrated Care Project (Medicare-Medicaid Plans)
- State of Texas Access Reform (STAR)
- STAR+PLUS
- STAR Kids
- STAR Health

Services Delivered Through Providers and Contractors

The audit and inspections universe includes the services delivered through providers and contractors that support the HHS System programs and managed care sections listed above. These services are categorized into two groups: (a) Medicaid and CHIP services and (b) other services.

Medicaid and CHIP Services

The list of Medicaid and CHIP services was compiled by reviewing the Medicaid and CHIP expenditures included in the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) 64 reports and CMS 21 reports.

- Behavioral Health Services
- Case Management (Primary Care and Targeted)
- Clinic Services
- Critical Access Hospital Services
- Dental Services
- Diagnostic Screening and Preventative Services
- Emergency Hospital Services
- Emergency Services for Undocumented Aliens
- Family Planning
- Federally Qualified Health Center Services
- Freestanding Birth Center Services
- Health Home for Enrollees with Chronic Conditions
- Health Services Initiatives
- Home and Community-Based Services
- Home Health Services
- Hospice
- Inpatient Hospital Services
- Inpatient Mental Health Facility Services
- Intermediate Care Facility Services (Private and Public)

- Laboratory and Radiological Services
- Medical Equipment
- Medical Transportation
- Non-Emergency Medical Transportation
- Nurse Midwife
- Nurse Practitioner Services
- Nursing Facility Services
- Occupational Therapy
- Other Care Services
- Other Practitioners' Services
- Outpatient Hospital Services
- Outpatient Mental Health Facility Services
- Personal Care Services
- Physical Therapy
- Physician and Surgical Services
- Prescribed Drugs
- Private Duty Nursing
- Programs of All-Inclusive Care for the Elderly
- Prosthetic Devices, Dentures, and Eyeglasses
- Rehabilitative Services (Non-School-Based)
- Rural Health Clinic Screening Services
- School-Based Services
- Screening Services Component of Early and Periodic Screening, Diagnosis, and Treatment Services
- Services for Speech, Hearing, and Language
- Sterilizations
- Therapy Services
- Tobacco Cessation for Pregnant Women
- Translation and Interpretation
- Vision Services

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:

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

We identify potential audit and inspections 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, including:
  - Texas State Auditor's Office (SAO)
  - U.S. Department of Agriculture Office of Inspector General (USDA OIG)
  - U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS)
  - U.S. Department of Health and Human Services Office of Inspector General (HHS OIG)
  - U.S. Government Accountability Office (GAO)
- Conducting interviews with HHS System and DFPS management and staff, and external stakeholders
- Coordinating with the OIG Investigations and Reviews Division
- Reviewing the results of external reviews conducted on managed care organizations
- Analyzing data of services delivered through providers and contractors
- Monitoring relevant Texas House and Senate legislative committee hearings
- Requesting referrals from within the OIG, the HHS System, DFPS, and the public[6]
- Considering impacts of emergency events or extenuating circumstances, such as the COVID-19 pandemic

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

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

[6] Members of the public are encouraged to report suspected fraud, waste, or abuse by recipients or providers in Texas HHS programs by calling the OIG toll-free Integrity Line at 1-800-436-6184 or submitting a referral online via ReportTexasFraud.com.

TYPES OF AUDITS AND INSPECTIONS

The OIG Audit and Inspections Division conducts risk-based performance audits related to (a) services delivered through medical providers and contractors and (b) programs, functions, processes, and systems within the HHS System and DFPS, to help identify and reduce fraud, waste, and abuse. While variations occur for which audit type is performed, those audit types are generally defined as follows:

- HHS System and DFPS Audits—Review the effectiveness and efficiency of HHS System and DFPS program performance and operations.

- Provider Audits—Assess medical service provider compliance with criteria contained in statute, rules, guidance, or contracts, and determine whether funds were used as intended.

- Contractor Audits—Evaluate contractor performance for compliance with contract requirements and determine whether funds were used as intended.

- 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.

- Inspections—Conducts inspections of HHS programs, systems, and functions, including inspections of contractors, vendors, and providers.

Audits and inspections may result in recommendations to improve the provision and delivery of health and human services in the state. Recommendations may include options for how funds may be utilized in a more efficient and effective manner or for information technology control improvements to mitigate security vulnerabilities. They may also identify questioned or unsupported costs and include recoveries, liquidated damages, and penalties or other sanctions.

CARRY-OVER AUDITS IN PROGRESS

The following audit projects were in progress as of August 31, 2021.

Contractor Audits

Selected HHS Substance Abuse Contract

Objective

To evaluate whether the selected contractor's residential withdrawal management and intensive residential treatment services (a) were provided in accordance with selected regulations and contractual requirements; and (b) supported the payment received.

Enrollment Broker (MAXIMUS)

Preliminary Objective

To determine if MAXIMUS, Inc., Texas' Medicaid enrollment broker services contractor, met applicable requirements related to communications with members who have been determined eligible for Medicaid and CHIP services.

Home-Delivered Meals Program

Objective

To determine if the selected providers complied with program billing requirements and applicable statutes, rules, and contract requirements.

Home Health Agency Oversight of Personal Attendant Services

Preliminary Objective

To determine if the selected home and community support services agency (HCSSA) conducted oversight activities of personal attendants to ensure service claims, supervisory visits, and electronic verification visits were adequately supported and that personal attendants were qualified to deliver those services.

MCO Financial Reporting

Preliminary Objective

To determine if the selected MCO accurately reported selected expenses to HHSC in its Financial Statistical Report.

MCO Special Investigative Units (SIU)

Preliminary Objective

To evaluate the effectiveness of the selected MCO SIU performance in (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to HHSC.

Department of State Health Services Selected Contracts

Preliminary Objective

To determine if the selected providers had processes and controls in place to ensure it administered STD/HIV Prevention Services Grant funds in accordance with selected requirements.

Provider Audits

Home and Community-Based Services (HCS) Health and Safety

Objective

To determine whether the selected provider of HHSC's HCS program furnished Medicaid beneficiaries residing in three- and four-person homes with safe and healthy living environments, as defined by the HHSC Waiver Survey and Certification Residential Survey Checklist and the COVID-19 emergency rules for the HCS program.

Durable Medical Equipment (DME) Providers in Managed Care

Objective

To determine whether documentation to support the authorization and delivery of DME and supplies associated with Medicaid claims submitted by and paid to a selected MCO (a) existed and (b) were completed in accordance with applicable contractual requirements, state laws, rules, and guidelines.

CARRY-OVER INSPECTIONS IN PROGRESS

Clinical Laboratory Improvement Amendments

Preliminary Objective

To determine if MCOs had processes to ensure that payments to clinical laboratories complied with established standards and were made only to certified laboratories.

Oversight of Nursing Facility Staffing Levels

Preliminary Objectives

- Analyze self-reported nursing facility staffing data submitted to CMS.
- Determine if the staffing levels at selected nursing facilities complied with state and federal requirements.

FISCAL YEAR 2022 AUDIT PLAN

The HHS System has over 41,000 employees responsible for managing approximately $46.9 billion each year,[7] and DFPS has over 13,000 employees responsible for managing approximately $2.3 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 (a) federal and state regulations, statutes, and rules and (b) 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 shifting priorities. As a result, risks associated with functions within the HHS System and DFPS are constantly evolving.

In an effort to respond to continuously changing risks and an evolving service delivery environment, and to accommodate requests for audit services, the OIG Audit and Inspections Division will periodically update the audit projects listed in the section "Fiscal Year 2022 Audit Plan." Audit projects will be planned and initiated based on current priorities and availability of audit staff members needed to form audit teams.

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.

HHS System Audits

Texas Integrated Eligibility Redesign System (TIERS)

Preliminary Objective

To determine whether selected automated and process controls within TIERS were operating effectively.

Inpatient Psychiatric Hospitalization

Preliminary Objective

To determine if admission and commitment practices for STAR+PLUS members receiving services at inpatient psychiatric hospitals were conducted in accordance with federal and state regulations, rules, and guidelines.

[7] $46.97 billion represents the sum of the fiscal year 2022 appropriations reported in House Bill 1, General Appropriations Act for 2022–23 Biennium (May 2021) for DSHS and HHSC, which is approximately $40.4 billion, in addition to the amount reported for SNAP benefits in the State of Texas Schedule of Expenditures of Federal Awards for the year ended August 31, 2020, which is approximately $6.68 billion.

[8] $2.29 billion represents the sum of the fiscal year 2022 appropriations reported in House Bill 1, General Appropriations Act for 2022–23 Biennium (May 2021) for DFPS.

Home and Community-Based Services (HCS) Oversight

Preliminary Objective

To determine if HHSC conducted effective oversight of the HCS waiver program to promote the health and safety of individuals in residential settings.

Contractor Audits

Selected Agency and Program Contracts

- Department of Family and Protective Services
- Department of State Health Services
- Health, Developmental, and Independence Services
- Intellectual and Developmental Disability and Behavioral Health Services

Preliminary Objective

To determine whether selected contractors complied with certain contract terms.

MCO Special Investigative Units (SIU)

Preliminary Objective

To determine if the selected MCO complied with state and contractual requirements related to (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to HHSC.

Substance Use Disorder (SUD) Treatment Facility

Preliminary Objective

To determine whether selected SUD treatment facility services (a) were provided in accordance with contractual requirements and (b) supported the payment received.

MCO Oversight of Durable Medical Equipment (DME)

Preliminary Objectives

To determine whether the selected MCO conducted oversight activities to ensure its DME claims were reimbursed in accordance with applicable contractual requirements, state laws, rules, and guidelines.

MCO Utilization Management

Preliminary Objective

To assess the utilization of services by selected managed care populations.

MCO Financial Reporting

Preliminary Objective

To determine if the selected MCO accurately reported selected expenses to HHSC in its Financial Statistical Report.

Pharmacy Benefits Manager (PBM) Spread Pricing

Preliminary Objective

To determine whether the selected MCO had controls in place to ensure payments to its subcontracted PBM were based on actual amounts paid to pharmacies for dispensing and ingredient costs, including any discounts, refunds, or other return payments, were accurately reported to the state, and complied with other related requirements.

STAR+PLUS HCBS Waiver Upgrade

Preliminary Objective

To determine whether the selected MCO (a) upgraded members to the STAR+PLUS waiver program in accordance with applicable contractual requirements, laws, rules, and guidelines and (b) maintained adequate support for those upgrades.

Medicaid Vendor Security

Preliminary Objective

To determine whether the selected Medicaid vendor complied with cybersecurity requirements, rules, and guidelines.

Provider Audits

Emergency Ambulance Services

Preliminary Objective

To determine whether emergency ambulance and air ambulance services provided and billed in the managed care and fee-for-service environments were conducted in accordance with applicable statutes, rules, and procedures.

Vendor Drug Program (VDP) Providers in Managed Care

Preliminary Objective

To determine whether the selected pharmacy (a) properly billed for paid claims associated with enrolled Medicaid members and (b) complied with applicable contractual, state, and federal requirements.

Durable Medical Equipment (DME) Providers in Managed Care

Preliminary Objective

To determine whether documentation to support the authorization and delivery of DME and supplies associated with Medicaid claims submitted by and paid to a selected MCO (a) existed and (b) was completed in accordance with applicable contractual requirements, state laws, rules, and guidelines.

Memory Care Centers

Preliminary Objective

To determine whether the selected memory care facility provided services and operated in compliance with applicable contractual requirements, laws, rules, and guidelines.

Deaf Blind with Multiple Disabilities (DBMD)

Preliminary Objective

To determine whether the selected DBMD residential support services home provided services and operated in compliance with applicable contractual requirements, laws, rules, and guidelines.

Information Technology Audits

IT Security Controls and Business Continuity and Disaster Recovery Processes

Preliminary Objectives

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

Telecommunications

Preliminary Objective

To determine if certain telemedicine visits during the COVID-19 waiver period were billed accurately and in compliance with rules and guidance provided by HHS.

Nursing Facility Emergency Preparedness Plans

Preliminary Objective

To determine whether the selected nursing facilities complied with certain requirements related to emergency preparedness.

Mental Health Private Psychiatric Funds

Preliminary Objective

To determine whether the selected local mental health authority performed contract management and oversight for mental health and private psychiatric funds to ensure contractors provided services in compliance with regulatory standards.

Provider Designation to Billing Comparison

Preliminary Objective

To determine if sufficient documentation was maintained to support provider designations and if those designations were accurate based on requirements and reimbursement actions.

Medicaid Payments for Deceased Clients

Preliminary Objective

To understand whether Access and Eligibility Services had implemented processes to ensure that Medicaid capitation payments were not made to MCOs for deceased clients.

MCO Oversight of Ambulance Claims

Preliminary Objective

To determine whether selected MCOs have processes and controls to ensure ambulance claims payments complied with applicable requirements.

Trust Funds in Nursing Facilities

Preliminary Objective

To determine whether selected nursing facilities complied with certain requirements related to residents' personal funds accounts.

Wound Care Billing

Preliminary Objective

To determine whether selected providers billed Medicaid for wound care supplies in accordance with applicable requirements.

FISCAL YEAR 2021 AUDIT AND INSPECTIONS REPORTS ISSUED

The OIG issued the following audit reports between September 1, 2020, and August 31, 2021.

Audit	Report Issue Date	Key Findings
Audit of Homeward Bound, Inc.: Substance Use Disorder Treatment Provider	November 13, 2020	• Homeward Bound did not ensure detoxification clients always received individual counseling sessions each day or meet monthly coinfection group counseling requirements. • Homeward Bound did not always perform discharge summaries and discharge and referral follow-ups according to requirements.
Audit Report on Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments: Superior HealthPlan, Inc.	November 20, 2020	• Superior HealthPlan did not process all nursing facility utilization review RUG rate adjustments. • Superior HealthPlan did not process other retroactive claims adjustments timely.
Fee-for-Service Claims Submitted by Maverick Medical Supply: A Texas Medicaid Durable Medical Equipment and Supplies Provider	November 30, 2020	• Maverick did not always meet authorization requirements for DME and supplies. • Maverick did not always maintain the appropriate proof of delivery documentation for Medicaid fee-for-service claims.
Audit Report on Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments: Molina Healthcare of Texas	December 9, 2020	• Molina did not process all nursing facility utilization review RUG rate adjustments. • Molina did not process other retroactive claims adjustments timely.
Summary of Results: Pharmacy Benefits Manager Navitus Health Solutions, LLC: Audits of Community First Health Plans, Parkland Community Health Plan, and Community Health Choice	January 8, 2021	• Navitus did not consistently comply with requirements related to design and performance of non-preferred and clinical prior authorizations. • Navitus did not always process prior authorizations and reject claims correctly.
Security Controls Over Confidential Information: Parkland Community Health Plan, Inc.	January 20, 2021	• Parkland did not comply with all information technology controls over confidential HHS Information.
Audit Report on Reporting and Compliance of Affiliate Third-Party Administrator Services: MCNA Insurance Company	February 25, 2021	• The OIG did not identify any significant reportable issues.

Audit	Report Issue Date	Key Findings
Audit of Cenikor Foundation: Region 7 Substance Use Disorder Treatment Provider	February 26, 2021	• Cenikor did not consistently provide evidence that it delivered required monitoring and counseling services. • Cenikor did not provide evidence to support that it consistently met program and contractual requirements. • Cenikor did not consistently admit clients into the proper service type. • Cenikor did not always ensure direct care and clinical staff met qualification, training and education, and supervision requirements.
Audit of STAR Kids Screening and Assessment Instrument New Enrollment Timeliness: Texas Medicaid and Healthcare Partnership	April 29, 2021	• The OIG did not identify any significant reportable issues.
Audit Report on Driscoll Health Plan: A Texas Medicaid and CHIP Managed Care Organization	May 27, 2021	• Driscoll reported unallowable, unsupported, and misclassified expenses and did not have effective controls.
Summary of Results: Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments	May 28, 2021	• MCOs did not process retroactive claims adjustments timely. • MCOs did not process all nursing facility utilization review RUG rate adjustments.
Audit Report on Managed Care Organization Reimbursements to Pharmacy Benefit Managers: Superior HealthPlan, Inc. and Superior HealthPlan Network	May 28, 2021	• Superior did not accurately or completely report payments that affect its reported cost of prescriptions.
Audit Report on Co-Treatment Therapy Billing: MindWorks Rehabilitation Center	June 22, 2021	• The OIG did not identify any significant reportable issues.
Audit report of Woman, Infants, and Children's Nutrition Program (WIC): City of Laredo	July 23, 2021	• The OIG did not identify any significant reportable issues.
Audit Report on Acadian Ambulance Services: A Texas Medicaid Ambulance Provider	July 28, 2021	• Acadian incorrectly reported and was paid for non-medically necessary transports. • Acadian could not provide support for the service level billed. • Acadian submitted a claim with incorrect patient data.
Audit Report on Fee-for-Service Claim Payments for Pregnant Women with Medicaid Managed Care Eligibility	July 30, 2021	• Fee-for-Service claims were paid for individuals eligible for managed care.
Audit Report on Security Controls Over Confidential HHS Information: Scott and White Health Plan	July 30, 2021	• Scott and White did not comply with all information technology controls over confidential HHS Information.
Audit Report on Healthy Texas Women and Family Planning Program Contract Compliance: The Heidi Group	July 30, 2021	• The Heidi Group submitted and was reimbursed for duplicate, unsupported, and unallowable costs. • The Heidi Group did not have a supported or consistent allocation methodology.

Audit	Report Issue Date	Key Findings
Audit Report on Data Processing and Integrity of Medicaid Eligibility Determinations	July 30, 2021	• Controls within TIERS did not always ensure Medicaid eligibility records were closed for applicable deceased individuals. • Automated controls were not adequate to reasonably ensure information used to determine Medicaid eligibility was accurate and complete.
Audit Report on Cenikor Foundation: Region 4 Substance Use Disorder Treatment Provider	August 13, 2021	• Cenikor did not consistently provide evidence that it delivered required monitoring and counseling services. • Cenikor did not provide evidence to support that it consistently met program and contractual requirements. • Cenikor did not properly bill HHSC for client transition days.
Audit Report on Benchmark Family Services, Inc.: A Former Texas Department of Family Protective Services Contractor	August 13, 2021	• Benchmark did not complete services plans as required. • Benchmark did not monitor foster homes adequately.
Audit Report on Managed Care Pharmacy Claims Paid to Rx Plus Pharmacy of Live Oak: A Managed Care Network Providers Contracted Under Superior HealthPlan, Inc.	August 13, 2021	• Rx Plus consistently followed requirements for prescription dosage directions and issuance dates with two exceptions.
Audit Report on Aetna Better Health of Texas, Inc. Special Investigative Unit: A Texas Medicaid Managed Care Organization	August 18, 2021	• Preliminary investigation timeline requirements were not always met or sufficiently documented. • Extensive investigations were not completed within required timelines.
Audit Report on NorthgateArinso, Inc.: A Texas Health and Human Services Commission Contractor	August 20, 2021	• NorthgateArinso did not have sufficient controls to ensure reported costs on the Retrospective Cost Settlement statements were reasonably stated and adequately supported.
Audit Report on Health and Safety of Medicaid Beneficiaries in the HHSC Home and Community-Based Services Program: Kenmar Residential HCS Services, Inc.	August 23, 2021	• Kenmar did not ensure consistent compliance with medication requirements. • Kenmar did not ensure that staff consistently complied with infection control requirements.
Audit Report on Health and Safety of Medicaid Beneficiaries in the HHSC Home and Community-Based Services Program: Community Options, Inc.	August 26, 2021	• Community Options did not maintain the interior areas and outside areas of some homes. • Community Options staff did not consistently comply with medication administration and documentation requirements. • Community Options did not consistently comply with emergency evacuation plan and fire safety requirements.
Audit Report on Cenikor Foundation: Region 11 Substance Use Disorder Treatment Provider	August 26, 2021	• Cenikor did not consistently provide evidence that it delivered required monitoring and counseling services. • Cenikor did not provide evidence to support that it consistently met program and contractual requirements. • Certain Cenikor billing practices resulted in overpayments.

Audit	Report Issue Date	Key Findings
Audit Report on Co-Treatment Therapy Billing: Rebound Sports and Physical Therapy	August 26, 2021	• Rebound did not follow all billing requirements by submitting claims for more than one therapist performing concurrent treatment without including the required modifier.

The CMS Unified Program Integrity Contractor completed audits of the following providers between September 1, 2020, and August 31, 2021.

Audit	Report Issue Date
Scott and White Hospital: College Station	September 29, 2020
St. Luke's Patients Medical Center	December 16, 2020
Harlingen Medical Center Limited Partnership	December 22, 2020
Accuread Quality Mobile X-ray	April 21, 2021
Dusara Corporation	June 30, 2021

The OIG Audit and Inspections Division contracted with Myers and Stauffer LC, which completed audits of the following providers between September 1, 2020, and August 31, 2021.

Audit	Report Issue Date
Junior's Pharmacy	February 3, 2021
Santa Cruz Adult Day Care	July 14, 2021
Angleton Health Mart Pharmacy	August 23, 2021
Avita Pharmacy	August 27, 2021
Vida Clinic	August 30, 2021

The OIG issued the following inspections reports between September 1, 2020, and August 31, 2021.

Inspection	Report Issue Date	Key Findings
Processes for Hiring and Training Direct Support Professionals: Austin State Supported Living Center	November 9, 2020	• HHSC-HR did not always comply with due diligence check requirements. • Austin SSLC did not always document compliance with training requirements.
Child and Adolescent Needs and Strengths (CANS 2.0) Assessment: CANS 2.0 Assessments in Community-Based Care	December 18, 2020	• CANS 2.0 assessments and Medicaid services were not always documented or not always provided timely.
Processes for Hiring Direct Support Professionals at State Supported Living Centers: Texas Health and Human Services Commission Human Resources	February 25, 2021	• HHSC-HR did not always comply with Texas Administrative Code requirements for due diligence checks. • HHSC-HR did not consistently document due diligence checks in accordance with policies and procedures.
Inspection of Telemonitoring Services: Prior Authorizations	April 29, 2021	• The OIG did not identify any significant reportable issues.

Inspection	Report Issue Date	Key Findings
Documentation of Reductions to Authorized Levels of Care: Local Mental Health Authorities in Texas	July 28, 2021	• Member files did not always contain required information.
The National Correct Coding Initiative in Texas Medicaid: Informational Report on Use of NCCI Edits by Managed Care Organizations	August 12, 2021	• This report includes compilation and analysis of information obtained by OIG Inspections from responses to two separate surveys. No findings were included in this report.
Supplemental Nutrition Assistance Program: Second Level Review Process	August 25, 2021	• HHSC AES policies and procedures provide limited guidance for the second level review process, which could cause inconsistent reviews and may weaken the effectiveness of the second level review process as a control.
Mental Health Targeted Case Management and Mental Rehabilitative Services in Managed Care	August 30, 2021	• Member files did not consistently contain required treatment plans, documentation to identify why eligible members did not receive core services, or document that core services were discussed with the member.
Delivery Supplemental Payments: Medicaid CHIP Services – Financial Reporting and Audit Coordination	August 31, 2021	• FRAC is not performing retrospective reviews of delivery supplemental payment claims. • Not all pertinent diagnosis codes are included in the automated diagnosis code check when validating delivery supplemental payment claims.