Annual Audit and Inspections Plan

September 2022

Inspector General

Texas Health and Human Services

TABLE OF CONTENTS

INTRODUCTION 3

AUDIT AND INSPECTIONS AUTHORITY 5

AUDIT AND INSPECTIONS UNIVERSE 6

RISK ASSESSMENT 10

TYPES OF AUDITS AND INSPECTIONS 12

CARRY-OVER AUDITS IN PROGRESS 13

CARRY-OVER INSPECTIONS IN PROGRESS 16

FISCAL YEAR 2023 AUDIT PLAN 17

FISCAL YEAR 2023 INSPECTIONS PLAN 23

FISCAL YEAR 2022 AUDIT AND INSPECTIONS REPORTS ISSUED 25

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
- Family Health Services
- Community 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

- Adult Protective Services
- Child Protective Services
- Child Protective Investigations
- Prevention and Community Well-Being
- 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)
- Managed Vision Care (MVC)
- Pharmacy Benefit Managers (PBM)
- Third Party Administrators (TPA)

Managed Care Programs

- Children's Health Insurance Program (CHIP)
- Children's Medicaid Dental Services
- CHIP Dental
- Medical Transportation Program
- 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
- COVID-19 Section 6004 and 6008 Expenditures
- Critical Access Hospital Services
- Dental Services
- Diagnostic Screening and Preventative Services
- Emergency Hospital 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
- Laboratory and Radiological Services
- Medical Equipment
- Medical Transportation
- Mental Health Facility Services
- Non-Emergency Medical Transportation
- Nurse Midwife
- Nurse Practitioner Services
- Nursing Facility Services
- Occupational Therapy
- Other Care Services
- Other Practitioners' Services
- Outpatient Hospital Services
- Personal Care Services
- Physical Therapy
- Physician and Surgical Services
- Prescribed Drugs
- Preventative Services
- Primary Care and Case Management
- 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
- 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 Community Well-Being
- 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 continuous risk assessment activities to identify potential audit topics for inclusion in its Annual 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
- Ongoing data analysis to identity potential trends that may indicate potential fraud, waste, or abuse or other systemic issues
- 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
- 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
- Other ongoing risk assessment activities

After compiling the list of potential audit and inspections topics, the OIG Audit and Inspections Division considers several factors to select audits for its Annual 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.

The OIG Audit and Inspections division also 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, 2022.

HHS System Audits

Department of State Health Services Contract Oversight

Preliminary Objective

To determine if DSHS performed certain contract oversight and management functions related to its STD/HIV Prevention Services Program contracts in order to ensure that services were administered in accordance with applicable requirements.

Contractor Audits

Selected Health and Human Services Commission Contracts

Preliminary Objectives

To determine if a selected contractor providing services to the Women, Infants, and Children Program delivered those services in accordance with selected requirements.

To determine if a selected contractor providing services to the Family Violence Program delivered those services in accordance with selected requirements.

Selected Department of Family and Protective Services Contract

Preliminary Objective

To determine if a selected foster care provider has processes and controls in place to ensure it provides foster care services in accordance with selected contract terms and minimum standards.

MCO Oversight of Durable Medical Equipment (DME)

Preliminary Objectives

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

Pharmacy Benefits Manager (PBM) Spread Pricing

Preliminary Objective

To determine if the selected MCO had processes and controls in place to ensure payments to and reimbursements for managed care pharmacy services were (a) based on actual amounts paid to the pharmacies, (b) were accurately reported on Financial Statistical Reports, and (c) complied with the Uniform Managed Care Contract and other applicable requirements related to reimbursement methods and spread pricing.

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.

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.

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.

Provider Audits

Telemedicine

Preliminary Objective

To determine if telemedicine services provided during the COVID-19 waiver period were (a) billed accurately and (b) followed applicable requirements.

Vendor Drug Program (VDP) Providers in Managed Care

Preliminary Objective

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

Information Technology Audits

IT Security Controls and Business Continuity and Disaster Recovery Processes

Preliminary Objective

To determine if (a) confidential HHS System information in the custody of a selected MCO was protected as required (b) plans were developed and tested, and the MCO's workforce was trained to support availability and continuity of business operations and services to members in the event of IT outages or disasters.

CARRY-OVER INSPECTIONS IN PROGRESS

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.

Mental Health Private Psychiatric Funds

Preliminary Objective

To determine if 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.

Wound Care Billing

Preliminary Objective

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

Nursing Facility Emergency Preparedness Plans

Preliminary Objective

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

MCO Oversight of Ambulance Claims

Preliminary Objective

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

FISCAL YEAR 2023 AUDIT PLAN

The HHS System has over 41,000 employees responsible for managing approximately $51.6 billion each year,[7] and DFPS has over 12,000 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 2023 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

Day Care Regulation

Preliminary Objective

To determine if HHSC licensed and renewed childcare operations in accordance with selected rules, statutes, and requirements.

[7] $51.6 billion represents the sum of the fiscal year 2023 appropriations reported in House Bill 1, General Appropriations Act for 2022–23 Biennium (May 2021) for DSHS and HHSC, which is approximately $40.2 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 $11.4 billion.

[8] $2.29 billion represents the sum of the fiscal year 2023 appropriations reported in House Bill 1, General Appropriations Act for 2022–23 Biennium (May 2021) for DFPS.

Clinical Management for Behavioral Health Services (CMBHS) System

Preliminary Objective

To determine if HHSC had processes and controls in place to ensure that substance abuse and mental health services providers utilized the CMBHS Data System in accordance with selected rules, statutes, and requirements.

Comprehensive Rehabilitation Services

Preliminary Objective

To determine if HHSC had processes and controls in place to ensure that its Comprehensive Rehabilitation Services Program was administered in accordance with selected rules, statutes, and requirements.

Contractor Audits

Selected Agency and Program Contracts

- Department of Family and Protective Services
- Department of State Health Services
- Health and Human Commission, including:
    - Program and Services
    - Medicaid and CHIP Services
    - Policy and Regulatory

Preliminary Objective

To determine if selected contractors complied with certain contract terms.

Consumer Directed Services

Preliminary Objective

To determine if selected contractors had processes and controls in place to ensure that Consumer Directed Services were provided in accordance with selected rules, statutes, and requirements.

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

MCO Financial Reporting

Preliminary Objective

To determine if the selected MCO (a) reported expenses on its Financial Statistical Report submitted to HHSC in accordance with contract requirements and laws and (b) related internal controls over the preparation of its Financial Statistical Report were designed and operating effectively.

Pharmacy Benefits Manager (PBM) Spread Pricing

Preliminary Objective

To determine if the selected MCO had processes and controls in place to ensure payments to and reimbursements for managed care pharmacy services were (a) based on actual amounts paid to the pharmacies, (b) were accurately reported on Financial Statistical Reports, and (c) complied with the Uniform Managed Care Contract and other applicable requirements related to reimbursement methods and spread pricing.

STAR+PLUS HCBS Waiver Upgrade

Preliminary Objective

To determine if 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.

MCO Reporting of Provider Refunds

Preliminary Objective

To determine if the selected MCO (a) reported refunds, overpayments, and other funds received from providers and (b) maintained documentation to support those amounts.

Outlier Claims

Preliminary Objective

To determine if selected MCOs participating in the STAR+PLUS Program implemented processes and controls to ensure they accurately and timely adjudicated qualified nursing facility provider clean claims.

MCO Subcontracted Networks

Preliminary Objective

To determine if the selected MCO had processes and controls in place to ensure its contractors and subcontractors provided services in accordance with selected rules, statutes, and requirements.

Provider Audits

Emergency Ambulance Services

Preliminary Objective

To determine if 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 if 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 if 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.

Telemedicine

Preliminary Objective

To determine if telemedicine services provided during the COVID-19 waiver period were (a) billed accurately and (b) followed applicable requirements.

Long-Term Care Discharges

Preliminary Objective

To determine if the selected nursing facility discharged residents in accordance with selected standards, rules, and contractual requirements.

Centers for Independent Living

Preliminary Objective

To determine if the selected Center for Independent Living provided services in compliance with selected standards, rules, and contractual requirements.

Prescribed Pediatric Extended Care Centers

Preliminary Objective

To determine if the selected prescribed pediatric extended care center provided services in accordance with selected rules, statutes, and requirements.

Local Mental Health Authority Reporting

Preliminary Objective

To determine if the selected local mental health authority complied with selected reporting requirements.

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.

MCO Application Controls

Preliminary Objective

To determine if the selected MCO implemented general or application controls over stored and processed HHSC information to ensure that confidential data in its possession was secure.

Other Audits

Follow-Up on Selected Recommendations

Preliminary Objectives

To determine the implementation status of selected prior OIG audit recommendations.

Nursing Facility Transfers to Emergency Rooms

Preliminary Objective

To determine if selected nursing facilities (a) have written transfer agreements with hospitals and (b) have processes to ensure compliance with requirements governing resident transfer documentation.

Nursing Facility Abuse, Neglect, and Exploitation Reporting

Preliminary Objective

To determine if selected nursing facilities had processes and controls in place to ensure it complied with requirements for reporting abuse, neglect, and exploitation.

Trust Funds in Nursing Facilities

Preliminary Objective

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

MCO Provider Claims Appeals

Preliminary Objective

To determine if the selected MCOs system for tracking and resolving provider appeals is (a) established in compliance with statues and contractual agreements and (b) functioning as intended.

MCO Case-by-Case Reporting

Preliminary Objective

To determine if the selected MCO reported case by case services in accordance with applicable requirements.

Opioid Rx

Preliminary Objective

To determine if the pharmacy had processes and controls in place to ensure it dispensed opioids or other controlled substances in accordance with selected rules, statutes, and requirements.

Follow-Up on Selected Recommendations

Preliminary Objectives

To determine the implementation status of selected prior OIG inspections recommendations.

FISCAL YEAR 2022 AUDIT AND INSPECTIONS REPORTS ISSUED

The OIG issued the following audit reports between September 1, 2021, and August 31, 2022.

Audit	Report Issue Date	Key Findings
Audit Report on Cenikor Foundation: Region 6 Substance Use Disorder Treatment Provider	September 29, 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 on Managed Care Claims Submitted by Cook Children's Home Health and Paid by Cook Children's Plan: A Texas Medicaid Durable Medical Equipment and Supplies Provider	September 30, 2021	Cook Children's Home Health had processes and controls in place to ensure most required documentation was complete and met DME requirements; however: • Cook Children's Home Health did not consistently comply with requirements for documentation and deliveries for DME and supplies claims and was paid for duplicate claims of DME and supplies.
Audit Report Health and Safety of Medicaid Beneficiaries in the HHSC Home and Community-Based Services Program: EduCare Community Living Corporation – Texas	October 15, 2021	• EduCare did not ensure that its homes consistently complied with HHSC's health and safety requirements, including those for eliminating hazards from interior and exterior areas, storage of medications, and maintaining medication administration records.
Audit Report on El Paso City-County Nutrition Program: A Texas Home-Delivered Meals Program Provider	October 28, 2021	• El Paso County did not always make required contracts to waiver participants. • El Paso County did not always initiate home-delivered meal services to new participants timely. • El Paso County did not always comply with requirements for unsuccessful delivery attempts.
Audit Report on The Visiting Nurse Association (VNA) of Texas: A Texas Home-Delivered Meals Program Provider	November 16, 2021	• VNA did not always initiate home-delivered meal services to new participants timely. • VNA did not always comply with requirements for unsuccessful delivery attempts.
Audit Report on Selected Memory Care Facilities: Village Green Alzheimer's Care Home – Cypress	February 28, 2022	• Village Green – Cypress advertised as an Alzheimer's care facility without the required certification. • Village Green – Cypress staff did not fully comply with COVID-19 emergency rules. • Village Green – Cypress did not review and update its emergency preparedness response plan.

Audit	Report Issue Date	Key Findings
Audit Report on The Center for Comprehensive Mental Health: A Texas Medicaid Provider	April 19, 2022	• The Center did not always bill the appropriate CPT codes for evaluation and management services and psychotherapy services. • The Center did not notify patients about its privacy practices.
Audit Report on Community First Health Plans, Inc. Special Investigative Unit: A Texas Medicaid Managed Care Organization	April 28, 2022	• Community First did not consistently comply with certain state and contractual requirements related to (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on special investigative unite activities, results, and recoveries to HHSC.
Audit Report on Deaf Blind with Multiple Disabilities Program: Mission Road Developmental Center	April 28, 2022	• Mission Road facilities were clean and in good repair, but one facility was not entirely free of hazards. • Mission Road did not ensure carbon monoxide detectors were installed in all required spaces.
Audit Report on Medcare Clinics PLLC: A Texas Medicaid and CHIP Provider	April 29, 2022	• Medcare did not always bill the appropriate CPT codes for evaluation and management services and psychotherapy services.
Audit Report on Selected Memory Care Facilities: Le Rêve Rehabilitation and Memory Care	May 10, 2022	• Le Rêve did not provide a written disclosure notice to required individuals. • Le Rêve did not ensure all direct resident care staff were properly trained.
Audit Report on Deaf Blind with Multiple Disabilities Program: Lighthouse for the Blind of Houston	May 19, 2022	Lighthouse operated and provided residential Deaf Blind with Multiple Disabilities program services at its assisted living facilities in compliance with almost all applicable requirements, laws, rules, and guidelines tested; however: • Lighthouse did not ensure carbon monoxide detectors were installed in resident bedrooms.
Audit Report on Selected Memory Care Facilities: Silverado Barton Springs Memory Care Community	June 3, 2022	Silverado complied with most health and safety regulations tested; however: • Silverado did not perform annual employee misconduct registry checks. • Silverado did not comply with all selected Texas Administrative Code requirements.
Audit Report on the Sexually Transmitted Disease/Human Immunodeficiency Virus (STD/HIV) Prevention Services Grant Program: San Antonio Metropolitan Health District	July 15, 2022	• Metro Health did not always meet STD and HIV program objectives. • Metro Health did not always meet grant agreements and financial requirements. • Metro Health did not comply with some security and confidentiality requirements.

Audit	Report Issue Date	Key Findings
Audit Report on Security Controls Over Confidential HHS Information: Community Health Choice	July 22, 2022	Community Health Choice did not: • Consistently ensure that network and claims management accounts and applications were disable when user access was no longer required. • Enforce requirements for locking accounts when unsuccessful log on attempts occurred • Enforce all authentication requirements as required by HHS IS-Controls.
Audit Report on Selected Memory Care Facilities: Matagorda House Healthcare Center	July 22, 2022	• Matagorda House did not comply with all staffing requirements for Alzheimer's-Certified Facilities. • Matagorda House did not maintain the facility to ensure the health and safety of residents. • Matagorda House did not secure resident overflow medications and medications to be destroyed. • Matagorda House did not distribute required Alzheimer's disclosure statements.
Audit Report on the Sexually Transmitted Disease/Human Immunodeficiency Virus (STD/HIV) Prevention Services Grant Program: Dallas County Health and Human Services	August 2, 2022	• Dallas County HHS did not always meet STD and HIV program objectives. • Dallas County HHS did not always meet grant agreement financial requirements. • Dallas County HHS did not always maintain required confidentiality agreements.
Audit Report on the Sexually Transmitted Disease/Human Immunodeficiency Virus (STD/HIV) Prevention Services Grant Program: City of Houston Health Department	August 11, 2022	• City of Houston Health Department did not always meet STD and HIV Program objectives. • City of Houston Health Department did not always meet grant agreement financial requirements. • City of Houston Health Department did not comply with some security and confidentiality requirements.
An Audit Report on Home and Community Support Services Agencies Oversight of Attendants: Elara Caring	August 12, 2022	• Elara Caring consistently developed and performed individual service plans. • Elara Caring did not consistently perform required visit maintenance. • Elara Caring provided adequate oversight of sampled attendants but did not consistently perform background checks timely.
An Audit Report on Home and Community Support Services Agencies Oversight of Attendants: Girling Community Care	August 12, 2022	• Girling consistently developed and performed individual service plans. • Girling did not consistently perform required visit maintenance. • Girling did not always provide adequate oversight of sampled attendants.

Audit	Report Issue Date	Key Findings
An Audit Report on Administrative Expenses Reported by Molina Healthcare of Texas, Inc. on its Financial Statistical Report	August 16, 2022	• Molina used an incorrect weighted average allocation methodology. • Molina allocated expenses across line items in the Administrative FSR, Part 2, rather than carrying forward the actual classification of the expenses. • Molina allocated direct administrative expenses across incorrect lines of business. • Molina incorrectly reported certain indirect administrative expenses and direct administrative expenses on its FSR.
An Audit Report on Emergency Ambulance Services at American Medical Response: A Texas Medicaid Ambulance Provider	August 18, 2022	• AMR billed incorrect mileage for two claims. • AMR submitted claims with incorrect patient data.
An Audit Report on Managed Care Pharmacy Claims Paid to ReCept Pharmacy #1: A Managed Care Network Provider Contracted Under Aetna Better Health of Texas, Inc.	August 22, 2022	• ReCept consistently followed requirements for pharmacy claims submission with two exceptions. • ReCept did not always meet dispensing label requirements.
An Audit Report on Administrative and Medical Expenses Reported on Financial and Statistical Reports: UnitedHealthcare Community Plan of Texas, L.L.C. and UnitedHealthcare Insurance Company, Inc.	August 24, 2022	• UnitedHealthcare did not meet all contract requirements when reporting affiliate outsourced service expenses at fair market value on the Combined FSR. • UnitedHealthcare incorrectly reported behavioral health claims expenses on the STAR+PLUS Medical FSR-Travis.

Audit	Report Issue Date	Key Findings
An Audit Report on Inpatient Psychiatric Hospitals: Cypress Creek Hospital	August 25, 2022	Cypress Creek followed inpatient facility requirements; however: • Physicians did not always evaluate voluntarily admitted patients who requested discharge and initial psychiatric evaluations were not always completed or completed timely. • Physicians did not always sign medication orders or sign medication order timely and medication consents were not always obtained, completed, or completed timely. • Admission orders were not always completed or completed timely and court orders were not always retained as required. • Acknowledgement of patient rights were not always completed or completed timely, interdisciplinary treatment plants were not always completed as required, and consent forms did not always contain the required information. • It sometimes billed for days before the patient was admitted to the facility.
An Audit Report on Inpatient Psychiatric Hospitals: West Oaks Hospital	August 26, 2022	West Oaks followed most inpatient facility requirements; however: • Physicians did not always follow state requirements regarding voluntarily admitted patients who requested discharge and initial psychiatric evaluation were not always completed or completed timely. • Medication consent forms and admission orders were not always obtained, completed, or completed timely and court order were not always retained as required. • Consents for voluntary admission, acknowledgement of patient rights, interdisciplinary treatment plans, and consents for electroconvulsive therapy were not completed or completed timely and did not always contain the required information. • Posters for reporting abuse and neglect were not prominently displayed and did not have required information.

The OIG Audit and Inspections Division contracted with external audit services entities who completed audits of the following providers between September 1, 2021, and August 31, 2022:

Audit	Report Issue Date
Healthy City Pharmacy	July 25, 2022
Acorn Pharmacy	August 19, 2022
Amber Pharmacy	August 19, 2022
Texas Home Modification Services	August 26, 2022
Southside Pharmacy 9	August 29, 2022
Y Medical Associates	August 29, 2022
Aeroflow	August 30, 2022
One Source Medical Group	August 31, 2022
Heart of Texas Region MHMR	August 31, 2022
Sunwest Behavioral Associates	August 31, 2022

The OIG issued the following inspections reports between September 1, 2021, and August 31, 2022.

Inspection	Report Issue Date	Key Findings
Nursing Facility Staffing Hours Verification: The Villa at Mountain View	February 17, 2022	• Villa at Mountain View submitted accurate and complete licensed nursing hours to CMS for all payroll records reviewed.
Clinical Laboratory Improvement Amendments Certification Series 1: Community Health Choice, FirstCare HealthPlans, Scott & White Health Plan, and Texas Children's Health Plan	July 11, 2022	MCOs did not have consistent processes for: • Obtaining and maintaining current provider CLIA certificates. • Denying claims from laboratories with expired CLIA certificates. • Denying claims from providers that billed for procedures not covered by their CLIA certificate.
Clinical Laboratory Improvement Amendments Certification Series 2: Aetna Better Health of Texas, Community First Health Plans, Driscoll Health Plan, and Parkland Community Health Plan	July 11, 2022	MCOs did not have consistent processes for: • Obtaining and maintaining current provider CLIA certificates. • Denying claims from laboratories with expired CLIA certificates. • Denying claims from providers that billed for procedures not covered by their CLIA certificate.

Inspection	Report Issue Date	Key Findings
Clinical Laboratory Improvement Amendments Certification Series 3: Amerigroup, Blue Cross and Blue Shield of Texas, Dell Children's Health Plan, Molina Healthcare of Texas, and United Healthcare Community Plan	July 12, 2022	MCOs did not have consistent processes for: • Obtaining and maintaining current provider CLIA certificates. • Denying claims from laboratories with expired CLIA certificates. • Denying claims from providers that billed for procedures not covered by their CLIA certificate.
Clinical Laboratory Improvement Amendments Certification Series 4: Cook Children's Health Plan, El Paso Health, and Superior Health Plan	July 12, 2022	MCOs did not have consistent processes for: • Obtaining and maintaining current provider CLIA certificates. • Denying claims from laboratories with expired CLIA certificates. • Denying claims from providers that billed for procedures not covered by their CLIA certificate.
Nursing Facility Staffing Hours Verification: Winchester Lodge Healthcare Center	August 9, 2022	• Winchester did not have documented processes for correctly reporting direct care hours to CMS. • Winchester did not consistently maintain complete payroll records.
Nursing Facility Staffing Hours Verification: Westchase Health and Rehabilitation Center	August 9, 2022	• Westchase did not have documented processes for correctly reporting direct care hours to CMS. • Westchase did not consistently maintain payroll records. • Westchase did not maintain daily nurse staffing data.
Nursing Facility Staffing Hours Verification: Mira Vista Court	August 16, 2022	• Mira Vista Court did not deduct the allotted time for meal breaks as required by CMS.
Clinical Laboratory Improvement Amendments: Texas Medicaid and Healthcare Partnership (TMHP)	August 19, 2022	• TMHP's claims payer system does not use CLIA laboratory certification codes in its claims adjudication process.
Nursing Facility Staffing Hours Verification: Mystic Park Placeholder	August 25, 2022	• Mystic Park did not consistently document initial emergency preparedness plan training completions within the required time frame. • Mystic Park did not have policies and procedures that identified alternate energy sources to maintain power needs for key systems during an emergency. • Mystic Park did not maintain a copy of its current emergency preparedness plan at each personnel supervisor workstation as required. • Mystic Park's communication plan did not include some required contact information.