TEXAS HEALTH AND HUMAN SERVICES COMMISSION

OFFICE OF INSPECTOR GENERAL

MISSION ROAD DEVELOPMENTAL CENTER

A Texas Medicaid Home and Community-Based Services Program Provider

November 30, 2018
OIG Report No. AUD-19-004

HHSC OIG
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WHY THE OIG CONDUCTED THIS AUDIT

The Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) Audit Division conducted an audit of Mission Road Developmental Center (Mission Road), a Home and Community-based Services (HCS) provider.

HCS is the largest Texas Medicaid Long-Term Services and Supports (LTSS) program with expenditures of $947 million in state fiscal year 2015.

The HCS program provides more than 20 individualized services and supports to persons with intellectual disabilities who are living with their family, in their own home, or in other community settings such as small group homes.

Mission Road provides HCS services in San Antonio, Texas. It processed 63,824 Medicaid claims through HCS during the audit period, June 1, 2015, through May 31, 2016, for which it received reimbursements of more than $5.2 million.

WHAT THE OIG RECOMMENDS

Mission Road should ensure that providers who deliver services (a) appropriately sign Service Delivery Logs and (b) fully and accurately document billable services on Service Delivery Logs. Mission Road should reimburse HHSC $2,081.50 for claims that did not have sufficient supporting documentation.

For more information, contact:
OIG.AuditDivision@hhsc.state.tx.us

WHAT THE OIG FOUND

Mission Road did not comply with the HCS provider agreement or with state rules and guidelines for documentation associated with 14 of 398 claims associated with 60 Service Delivery Logs tested.

Specifically, Mission Road did not always ensure providers signed Service Delivery Logs, and did not always document services provided to clients on Service Delivery Logs. Of the 60 Service Delivery Logs tested, 8 were missing signatures, impacting 13 claims for which HHSC paid Mission Road $1,938.31, and one included a documentation error, impacting one claim for which HHSC paid Mission Road $143.19.

Other audit results indicated that Mission Road:

- Maintained authorizations for billed services, represented by Individual Plans of Care that contained required signatures.
- Had application controls in place to ensure that information was entered into the Client Assignment and Registration System (CARE) by authorized individuals, and that services entered were limited to authorized (a) clients and their associated providers, (b) services approved by the local authorities, (c) number of hours and days, and (d) dollar amounts.
- Had sufficient information technology application controls in place to ensure the accuracy and reliability of the data for purposes of this report.

The 14 errors resulted in $2,081.50 in unsupported Medicaid reimbursements.

The audit was conducted to determine whether (a) documentation to support fee-for-service claims for residential support services and supervised living submitted by and paid to Mission Road existed and were completed in accordance with the HCS provider agreement and with state rules and guidelines and (b) authorizations for other billed HCS services existed and were signed in accordance with the HCS provider agreement and with state rules and guidelines.

Mission Road acknowledged the OIG Audit Division's findings in management responses that are included in the body of the report after each applicable recommendation. Mission Road indicated it has implemented corrective actions to address the process changes recommended in the report.

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INTRODUCTION

The Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) Audit Division conducted an audit of Mission Road Developmental Center (Mission Road), a Home and Community-based Services (HCS) provider.

Objectives and Scope

The objectives of this audit were to determine whether (a) documentation to support fee-for-service claims for residential support services and supervised living[1] submitted by and paid to Mission Road existed and were completed in accordance with the HCS provider agreement and with state rules and guidelines and (b) authorizations for other billed HCS services existed and were signed in accordance with the HCS provider agreement and with state rules and guidelines.

The audit scope included paid claims for the period from June 1, 2015, through May 31, 2016, and a review of relevant activities, internal controls, and information technology (IT) general and application controls through the end of fieldwork in November 2017.

Background

The HCS program provides individualized services and supports to persons with intellectual disabilities who are living with their family, in their own home, or in other community settings such as small group homes. There are more than 20 services available to clients through the HCS program, with service determinations made by teams comprised of local intellectual and developmental disability authority service coordinators, the client (and/or designee), and provider representatives.

HCS is the largest Texas Medicaid Long-Term Services and Supports (LTSS) program with expenditures of $947 million in state fiscal year 2015 (September 1, 2014, through August 31, 2015).[2]

Mission Road has been an HCS provider since 1997, serving clients in San Antonio, Texas. Mission Road offers residential assistance services through (a) 12 community homes, each of which provides residential support services and supervised living to 4 individuals, and (b) host home/companion care services,

[1] "Residential support services" and "supervised living" are almost identical residential assistance services offered only in group homes; residential support services requires that provider staff remain awake overnight, whereas supervised living does not. Examples of these residential assistance services include assisting with meal preparation, housekeeping, ambulation and mobility, and supervising safety and security.

[2] Texas Medicaid and CHIP in Perspective, 11th ed., HHSC (Feb. 2017).

where individuals can live in their own home, a family home, or a host home setting. Other HCS services offered by Mission Road, in descending order of paid claims dollars, are (a) day habilitation, (b) dental treatment, (c) nursing, (d) behavioral support services, (e) adaptive aids, (f) minor home modifications, (g) therapy services, (h) transportation, and (i) supported employment.

Mission Road enters Medicaid claims into the Health and Human Services (HHS) System application called the Client Assignment and Registration System (CARE). CARE adjudicates the claims using a process designed to determine whether claims should be paid or not, and what amount will be paid.

During the audit period, Mission Road received $5,264,809.81 in Medicaid payments for the following:

- 14,650 residential support service claims, for which it received reimbursements of $2,187,359.32.
- 938 supervised living claims, for which it received reimbursements of $126,159.59.
- 48,236 other HCS services claims, including host home/companion care services, for which it received reimbursements of $2,951,290.90.

The focus of this audit was the testing of (a) Service Delivery Logs associated with a sample of weeks in which there were paid claims for residential support services or supervised living for a unique client and (b) Individual Plans of Care for a sample of clients who used day habilitation services, but for whom there were no paid claims for residential support services or supervised living. The OIG Audit Division also tested selected IT controls.

The OIG Audit Division conducted the audit in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Unless otherwise described, any year referenced is the state fiscal year, which covers the period from September 1 through August 31.

The OIG Audit Division presented preliminary audit results, issues, and recommendations to Mission Road in a draft report dated April 4, 2017. Mission Road provided responses to the audit findings that indicated it has taken actions to address recommended process changes.

AUDIT RESULTS

The OIG Audit Division tested 75 Individual Plans of Care for 20 sampled day habilitation services clients to determine whether authorizations used to support claims submitted by and paid to Mission Road existed and contained required signatures. The Individual Plans of Care were available and included all signatures required in support of claims for day habilitation services, host home/companion care services, and other HCS services authorized by the tested Individual Plans of Care.

Audit results indicated application controls were in place to ensure that only authorized individuals entered information into CARE, and that services entered were limited to authorized:

- Clients and their associated providers
- Services approved by the local authorities
- Numbers of hours and days
- Dollar amounts

The OIG Audit Division assessed the reliability of Mission Road's data by reviewing system application controls, and interviewing Mission Road personnel. The OIG Audit Division determined that the data was sufficiently reliable for the purpose of this audit.

The OIG Audit Division reviewed Service Delivery Logs maintained by Mission Road to support paid claims for residential support services and supervised living, and identified issues relating to paid claims support, which are discussed in the sections that follow.

CLAIMS SUPPORT

Form 4119, Residential Support Services and Supervised Living Service Delivery Log (Service Delivery Log), is used by Mission Road to document claims for residential assistance services and represents support for a billed claim. The Service Delivery Log supports up to seven days of billed claims and is used as a source of data from which to enter billing information into CARE.

The OIG Audit Division tested 60 Service Delivery Logs that corresponded to a sample of weeks in which there were paid claims for residential support services or supervised living for a unique client. The 60 Service Delivery Logs represented documentation intended to support 398 paid claims from a total of 15,588 paid claims for residential support services or supervised living for the period of June 1, 2015, through May 31, 2016. The OIG Audit Division performed test work

to determine whether claims submitted by and paid to Mission Road were adequately supported by documentation.

Audit results indicated some Service Delivery Logs were either not signed or did not include a list of services. Results are detailed in the findings that follow.

Finding 1: Support for Billed Services Did Not Include Required Provider Signatures

Service Delivery Logs did not always contain required signatures. Of the 60 Service Delivery Logs tested, 8 were missing signatures to support 13 of the 398 claims associated with the tested Service Delivery Logs, for which HHSC paid Mission Road $1,938.31. HCS Program Billing Guidelines state that claims must be supported by written documentation and that the Service Delivery Log must be written and signed by the provider who delivered the service.[3]

Signatures were missing from the Service Delivery Logs supporting the 13 claims because Mission Road did not follow requirements that Service Delivery Logs must be signed. As a result, HHSC paid for claims that did not meet program documentation requirements.

HHSC may recoup any payment made to a program provider for a service if the service is not documented in accordance with the HCS Program Billing Guidelines,[4] or if the claim for the service does not meet the requirements of the HCS Program Billing Guidelines.[5] Claim details related to this finding are listed in Appendix C.

Recommendation 1

Mission Road should ensure that Service Delivery Logs are appropriately signed by the provider who delivered the services before using a Service Delivery Log as support for an HCS claim billed to Medicaid.

Mission Road should reimburse HHSC $1,938.31 for 13 HCS claims paid on services that were not supported by signed Service Delivery Logs.

[3] Home and Community-based Services Program Billing Guidelines, §§ 3210 (July 23, 2012), 3810.2 (Oct. 30, 2015), and 3820.1 (Mar. 21, 2014).

[4] 40 Tex. Admin. Code § 9.170(4)(E) (Nov. 15, 2015, and Mar. 20, 2016) and § 9.170(4)(F) (Sept. 1, 2014).

[5] 40 Tex. Admin. Code § 9.170(4)(F) (Nov. 15, 2015, and Mar. 20, 2016) and § 9.170(4)(G) (Sept. 1, 2014).

Management Response

Actions Taken

The Mission Road HCS Program is now using an electronic data collection system, TaskMaster Pro, which provides an electronic signature for all documentation submitted within the system to include Service Delivery Logs. The system automatically generates a signature upon initial login.

Responsible Manager

Group Home Supervisors, Program Coordinator, Director of Operations

Implementation Date

July 30, 2018

Finding 2: Billed Services Were Not Documented on a Service Delivery Log

Mission Road did not always document the services provided to clients on Service Delivery Logs, as required. Of the 60 Service Delivery Logs tested, one included a documentation error, impacting one claim for which HHSC paid Mission Road $143.19.

HCS Program Billing Guidelines state that claims must be supported by a Service Delivery Log, which must include a "description or list of activities performed by the service provider … that evidences the performance of one or more billable activities."[6] In addition, the HCS provider agreement requires Mission Road to certify that information submitted regarding claims will be true, accurate, and complete, and that such information can be verified by source documents.[7]

Support for the claim was missing because Mission Road did not follow requirements that billed services must be documented. As a result, HHSC paid for a claim that did not meet program documentation requirements.

HHSC may recoup any payment made to a program provider for a service if the service is not documented in accordance with the HCS Program Billing Guidelines,[8] or if the claim for the service does not meet the requirements of the

[6] Home and Community-based Services Program Billing Guidelines §§ 3810.2 (Oct. 30, 2015) and 3820.1 (Mar. 21, 2014).

[7] Medicaid Provider Agreement for the Provision of HCS Program Services #001007446 § II.H (Sept. 1, 2003).

[8] 40 Tex. Admin. Code § 9.170(4)(F) (Sept. 1, 2014) and § 9.170(4)(E) (Nov. 15, 2015, and Mar. 20, 2016).

HCS Program Billing Guidelines.[9] Claim details related to this finding are listed in Appendix C.

Recommendation 2

Mission Road should ensure that billed services are fully and accurately documented on Service Delivery Logs.

Mission Road should reimburse HHSC $143.19 for one HCS claim paid on services that were not supported by a complete Service Delivery Log.

Management Response

Actions Taken

Mission Road HCS program developed training that includes how to thoroughly document Service Delivery Logs for Residential Support Services. Training explains who, when and what to document during a shift.

All DCS working in the HCS program will be trained.

Responsible Manager

Group Home Supervisors, Program Coordinator, Director of Operations

Implementation Date

October 15, 2018

[9] 40 Tex. Admin. Code § 9.170(4)(G) (Sept. 1, 2014) and § 9.170(4)(F) (Nov. 15, 2015, and Mar. 20, 2016).

CONCLUSION

The OIG Audit Division evaluated support for Medicaid fee-for-service HCS claims submitted by Mission Road to determine whether:

- Service Delivery Logs for residential support services and supervised living detailed the services provided and were properly signed.
- Individual Plans of Care for day habilitation services, host home/companion care services, and other HCS services contained required signatures.

The OIG Audit Division also evaluated IT application controls to determine whether data used for audit testing was reliable. The OIG Audit Division conducted site visits in October 2017.

Mission Road did not comply with the HCS provider agreement or with state rules and guidelines for documentation for 14 of 398 claims associated with 60 Service Delivery Logs tested. The 14 claims represented $2,081.50 in unsupported Medicaid reimbursements.

The OIG Audit Division concluded:

- Mission Road's authorizations for services, represented by Individual Plans of Care, existed and contained required signatures.
- Mission Road had application controls in place to ensure that information was entered into CARE by authorized individuals, and that services entered were limited to authorized (a) clients and their associated providers, (b) services approved by the local authorities, (c) number of hours and days, and (d) dollar amounts.
- Mission Road had sufficient IT application controls in place to ensure the accuracy and reliability of the data for purposes of this report.
- Mission Road did not always ensure Service Delivery Logs were signed.
- Mission Road did not always document services delivered to clients on Service Delivery Logs.

The OIG Audit Division offered recommendations to Mission Road, which Mission Road indicated have been implemented to ensure Service Delivery Logs are appropriately signed and include all delivered services.

The OIG Audit Division thanks management and staff at Mission Road for their cooperation and assistance during this audit.

Appendix A: Objectives, Scope, Methodology, Criteria, and Auditing Standards

Objectives

The objectives of this audit were to determine whether (a) documentation to support fee-for-service claims for residential support services and supervised living submitted by and paid to Mission Road existed and were completed in accordance with the HCS provider agreement and with state rules and guidelines and (b) authorizations for other billed HCS services existed and were signed in accordance with the HCS provider agreement and with state rules and guidelines.

Scope

The audit scope included paid claims for the period from June 1, 2015, through May 31, 2016, and a review of relevant activities, internal controls, and IT general and application controls through the end of fieldwork in November 2017.

Methodology

To accomplish its objectives, the OIG Audit Division collected information for this audit through discussions and interviews with Mission Road management and staff and by reviewing:

- Mission Road's organizational chart
- Mission Road's policies and procedures
- Service Delivery Logs
- Individual Plans of Care
- IT general and application controls

The OIG Audit Division issued an engagement letter on October 30, 2017, to Mission Road providing information about the audit, and conducted fieldwork at the Mission Road facility in San Antonio, Texas, October 30 through November 2, 2017. Auditors did not remove original records from the Mission Road premises. During fieldwork, auditors requested additional documents, which Mission Road provided. While on site, the OIG Audit Division interviewed responsible personnel, evaluated internal controls, and reviewed relevant documents related to sampled claims.

The OIG Audit Division obtained a sample of 60 Service Delivery Logs associated with 398 residential support services and supervised living paid claims. It performed test work to determine whether each Service Delivery Log provided required support for the corresponding claims. The OIG Audit Division considered

all claims associated with a Service Delivery Log that was not complete or lacked required signatures to be questioned costs.

The OIG Audit Division also obtained a sample of 20 clients who used day habilitation services, and identified 75 Individual Plans of Care associated with the 20 selected clients. It performed test work to determine whether each Individual Plan of Care was properly signed. The OIG Audit Division considered all claims associated with an Individual Plan of Care (claims for day habilitation services, host home/companion care services, or any of the other HCS services) that lacked required signatures to be questioned costs.

Criteria

The OIG Audit Division used the following criteria to evaluate the information provided:

- 40 Tex. Admin. Code § 9.170(4) (2014 through 2016)
- Medicaid Provider Agreement for the Provision of HCS Program Services #001007446 § II.H (2003)
- Home and Community-based Services Program Billing Guidelines §§ 3210 (2012), 3810.2 (2015), 3820.1 (2014), and 4560.9 (2014)
- Home and Community-based Services Handbook, §§ 6230, 6431.2, and 6523 (2011) and § 6324 (2014)

Auditing Standards

Generally Accepted Government Auditing Standards

The OIG Audit Division conducted this audit in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the issues and conclusions based on our audit objectives. The OIG Audit Division believes the evidence obtained provides a reasonable basis for our issues and conclusions based on our audit objectives.

ISACA

The OIG Audit Division performs work in accordance with the IT Standards, Guidelines, and Tools and Techniques for Audit and Assurance and Control Professionals published by ISACA.

Appendix B: Sampling Methodology

After an initial assessment of risk and contractor performance outcomes, the OIG Audit Division performed testing of Service Delivery Logs associated with paid claims for residential support services and supervised living, and testing of Individual Plans of Care for day habilitation services, which in some instances also included authorization for host home/companion care services and other HCS services, for the period of June 1, 2015, through May 31, 2016. The data for testing came from the Claims Management System at Texas Medicaid and Healthcare Partnership, which includes data from the CARE system.

Claims and Service Delivery Logs for Residential Support Services and Supervised Living

The OIG Data and Technology Division defined and validated the residential support services and supervised living population to include all fee-for-service paid claims between June 1, 2015, and May 31, 2016, inclusively. This population consisted of 15,588 paid claims for 50 clients. The total paid amount for the 15,588 claims associated with this population was $2,313,518.91.

The sampling unit is a unique ID that consists of client ID and week of service. All 2,297 sampling units associated with Mission Road clients from June 1, 2015, through May 31, 2016, comprise the sampling frame. The sampling frame was extracted from the Vision 21 data warehouse on October 23, 2017.

Due to a large variation in the dollar amounts associated with each sampling unit, a statistician used stratified sampling to create a representative sample of the population. The statistician divided the sampling units into two strata to ensure high variation between strata and low variation within stratum. Next, RAT-STATS, the primary statistical tool used by the Office of Inspector General for the United States Department of Health and Human Services, calculated a minimum sample size of 3 for Stratum 1, and a minimum sample size of 4 for Stratum 2, with a 95 percent confidence interval and an assumed 10 percent precision.

The audit team used a sample size of 30 for each stratum, resulting in a sample of 60 units. The statistician used a random number generator to select the random sample. Each sampling unit corresponded to one Service Delivery Log, each of which was associated with one or more paid claims. The total paid amount for the 398 claims associated with the sample was $57,872.53.

Individual Plans of Care for Day Habilitation, Host Home/Companion Care, and Other HCS Services

The audit team used judgmental sampling[10] applied against the population of day habilitation services clients to select the audit sample for testing of Individual Plans of Care. The sampling unit for testing of Individual Plans of Care was at the client level.

The OIG Data and Technology Division defined and validated an initial population that included all Medicaid clients that received day habilitation services associated with fee-for-service paid claims between June 1, 2015, and May 31, 2016, inclusively. This population consisted of 106 clients.

Because clients who received day habilitation services may have also received residential support services or supervised living, which were included in a separate audit test, auditors excluded clients enrolled in either of these services from the list of clients receiving day habilitation services. This resulted in the initial population of 106 clients being reduced by 45 (42 residential support services clients and 3 supervised living clients) to a final population of 61 clients.

The audit team used a stop-and-go sampling approach for testing. The audit team would test an initial sample of 20 clients, and if the error rate exceeded 10 percent, the audit team would test an additional 10 clients; otherwise, no additional testing would occur. The audit team used a random number generator to select the initial 20-client sample, the 10 additional client sample, and 5 alternates to accommodate the occurrence of duplicates.

An Individual Plan of Care typically covers a one-year period; however, an individual may have multiple revisions of service occur during the course of the year, with each occurrence resulting in a new Individual Plan of Care generated to reflect the agreed-upon revision.

The 20 clients selected in the sample had differing numbers of Individual Plans of Care, ranging from 2 to 8 per client. Table 1 indicates the number of clients with each number of Individual Plans of Care, and multiplies the number of clients by the number of corresponding Individuals Plans of Care, resulting in the total number of 75 Individual Plans of Care tested during the audit.

[10] "Judgmental sampling" is a non-probability sampling method in which the auditor selects the sample based on certain characteristics, such as dollar amount, timeframe, or type of transaction.

Table 1: Individual Plan of Care Sample Data

Individual Plans of Care Per Client	Corresponding Number of Clients in the Sample	Total Number of Individual Plans of Care Tested
2	6	12
3	5	15
4	4	16
5	1	5
6	2	12
7	1	7
8	1	8
Total	20	75

Source: OIG Audit Division

The Individual Plans of Care tested represented authorizations for the following services:

- Day habilitation
- Dental treatment
- Nursing
- Behavioral support
- Adaptive aids
- Host home/companion care
- Supported employment

The Individual Plans of Care tested did not list any of the following services:

- Audiology services
- Cognitive rehabilitation therapy
- Dietary services
- Employment assistance
- Minor home modifications
- Occupational therapy services
- Physical therapy services
- Residential support
- Respite
- Social work services
- Speech and language pathology services
- Supervised living
- Supported home living
- Transportation

Appendix C: Recoupable Paid Claims

The table below provides details about the claims filed and paid in error for the following findings discussed in the report.

Finding 1. Support for Billed Services Did Not Include Required Provider Signatures
Finding 2. Billed Services Were Not Documented on a Service Delivery Log

Client Sample Identifier	Service Date	Finding Number	Claim Amount
3	4/3/2016	1	$ 133.72
16	1/22/2016	2	143.19
16	1/23/2016	1	143.19
19	11/29/2015	1	155.52
22	5/31/2016	1	155.52
30	10/5/2015	1	155.52
30	10/7/2015	1	155.52
30	10/8/2015	1	155.52
30	10/9/2015	1	155.52
30	5/21/2016	1	155.52
31	1/25/2016	1	143.19
31	1/26/2016	1	143.19
31	1/28/2016	1	143.19
31	3/12/2016	1	143.19
Total			$2,081.50

Source: OIG Audit Division

Appendix D: Report Team and Distribution

Report Team

The OIG staff members who contributed to this audit report include:

- Joel A. Brophy, CIA, CFE, CRMA, CICA, Audit Director
- Dan Hernandez, CFE, MBA, Audit Manager
- Lorraine Chavana, Audit Project Manager
- Melissa Larson, CISA, CIA, CFE, HCISPP, IT Audit Project Manager
- Jim Hicks, IT CISA, Senior Auditor
- Telvina Cole, CFE, CICA, Senior Auditor
- Larry Gambone, Senior Auditor
- Keven Holst, Senior Auditor
- Lorraine Wayland, CFE, Staff Auditor
- Mo Brantley, Senior Audit Operations Analyst

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- Stephanie Muth, State Medicaid Director, Medicaid and CHIP Services
- Nikolaos Vekris, Director, Contract Administration and Provider Monitoring

Mission Road Developmental Center

- Toby Summers, President and Chief Executive Officer
- David Davis, Vice President and Chief Financial Officer
- Lora Butler, Executive Director

Appendix E: OIG Mission and Contact Information

The mission of the OIG is to prevent, detect, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of OIG's mission and statutory responsibility includes:

- Sylvia Hernandez Kauffman, Inspector General
- Anita D'Souza, Chief of Staff and Chief Counsel
- Olga Rodriguez, Chief Strategy Officer
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Brian Klozik, Deputy IG for Medicaid Program Integrity
- Lizet Hinojosa, Deputy IG for Benefits Program Integrity
- David Griffith, Deputy IG for Audit
- Quinton Arnold, Deputy IG for Inspections and Investigations
- Alan Scantlen, Deputy IG for Data and Technology
- Judy Hoffman-Knobloch, Assistant Deputy IG for Medical Services

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