Texas Health and Human Services Commission
Office of the Inspector General
and Texas Home Modification Services, LLC

Performance Audit Report

Medicaid and CHIP Programs:
September 2019 to August 2021 (SFY 2020 and 2021)

DK PARTNERS

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August 24, 2022

Texas Health and Human Services Commission
Office of the Inspector General
11501 Burnet Road, Building 902
Austin, Texas 78758

We have conducted our performance audit over Texas Home Modification Services, LLC ("THMS" or the "Provider"), for State Fiscal Years (SFYs) 2020 (September 1, 2019 through August 31, 2020) and 2021 (September 1, 2020 through August 31, 2021).

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

This report includes the performance audit objectives, scope, methodology, findings, conclusions, and recommendations, as well as the related responses from THMS.

This performance audit report is intended solely for the purpose of addressing the scope and objective set forth below and is not suitable for any other purpose.

Objective

To determine whether delivery of Durable Medical Equipment (DME) and submissions of Medicaid and CHIP managed care claims by THMS were in accordance with applicable Federal and State Medicaid laws, regulations, rules, policies, and contractual requirements.

Scope

The performance audit scope was dictated by the Office of the Inspector General (OIG) of the Texas Health and Human Services Commission (HHSC) and focused primarily on determining THMS's compliance with applicable Federal and State Medicaid laws, regulations, rules, policies, and contractual requirements related to delivery of DME and submissions of Medicaid and CHIP managed care claims.

The audit scope was limited to DME encounters occurring during SFYs 2020 and 2021 and the associated DME claims.

Methodology

We established multiple risk factors and reviewed all DME providers with encounters during SFYs 2020 and 2021 for the existence of those multiple risk factors. Based on such analysis, we identified nine providers who appeared to present higher risk relative to our audit objectives and we submitted those nine providers to OIG for consideration. OIG selected three of the nine providers for detailed testing, including THMS. See report section "Methodology" on page 3 for a detailed walk through of our risk assessment process.

Findings

A finding results from a significant variance or non-compliance with criteria, including applicable Federal and State Medicaid laws, regulations, rules, policies, and contractual requirements. We identified no findings in our sample of 40 claims.

Conclusions

We identified no findings in our sample of 40 claims.

Recommendations

We do not have any recommendations based on this performance audit.

Sincerely,

DK PARTNERS, PC

Austin, Texas
August 24, 2022

cc: Texas Home Modification Services, LLC

Methodology

Methodology:

We received files from OIG of DME encounters during SFY 2020 and 2021 and the associated DME claims. The initial population included 1,040 providers and $1,063,280,309 in encounters. We first reduced the population to only providers with $1 million or more in encounters for the time period, which left a population of 143 possible providers. We also received a file of top providers for the time period that included the total paid for DME encounters and what was labeled as "total risk"; total risk was explained as dollars paid to the DME provider for members who had not had a physician encounter in the six months preceding the DME encounter. We found that on average total risk dollars paid accounted for 21% of total dollars paid to DME providers. We created a ratio for comparing total risk among providers by calculating risk amounts paid/total paid for each provider, and then used that ratio to divide all providers into three categories and used this as a field in our risk assessment:

- Risk to total dollars of 25% or less;
- Risk to total dollars of 25% to 35%;
- Risk to total dollars of 35% or more.

We next considered the impact of COVID on DME providers and determined that a large increase in claims after March of 2020 could be a red flag for non-compliant behavior due to potential provider expectations of less monitoring and oversight. We reviewed the DME encounter data and compared total encounters from the period of 9/1/19 to 2/29/20 to the total encounters for the three following six-month periods of 3/1/20 to 8/31/20, 9/1/20 to 2/28/21, and 3/1/21 to 8/31/21.

Based on the three periods above, we found average growth from before COVID to during COVID to be 9%, and divided all providers into the following three categories based on growth and used this as a field in our risk assessment:

- Growth of 15% or less;
- Growth of 16% to 50%;
- Growth of 51% or more.

We were also provided with a file of complaints to OIG about DME providers. We divided all providers in our encounters file into the following three groups from this file and used this as a field in our risk assessment:

- No complaints;
- One complaint;
- Two or more complaints.

We analyzed the 143 possible providers using the three criteria mentioned above and focused on providers with risk to total encounters of 25% and higher, or COVID growth of 51% or more, as well as one provider who did not fit in either category but had complaints to OIG we believed should be considered in more detail for our test work. This resulted in a population of 42 providers for additional analysis.

See table on the following page for an illustration of the results of our analysis and refinement of our population of 143 providers down to 42.

	COVID growth of 15% or less	COVID growth of 16% to 50%	COVID growth of 51% or more	Total Providers
Risk to total dollars of 35% or more				
Two or more complaints to OIG	1			1
One complaint to OIG	1			1
No complaints	1	1		2
Risk to total dollars of 25% to 35%				
Two or more complaints to OIG	1	1		2
One complaint to OIG	2	1		3
No complaints	9	3	1	13
Risk to total dollars of 25% or less				
Two or more complaints to OIG	9	1	2	12
One complaint to OIG	18	4	5	27
No complaints	54	16	12	82
Total Providers	**96**	**27**	**20**	**143**

41	Testing population
1	One provider judgementally added from this group
101	Not included for further testing

We researched the 42 providers for additional risk factors such as:

- Lack of an obvious website or other sales platform;
- Complaints of fraudulent behavior;
- Other red flags.

We then added this information to our assessment and risk weighted the 42 providers to come up with a reduced population of nine DME providers that we sent to OIG for review. OIG selected three providers for additional test work, including THMS.

Once a provider was selected, we performed multiple analytical procedures over the provider. Details of our procedures and the results can be seen in report section “Procedures and Summarized Results of Audit” beginning on page 5. Analytical procedures varied for each provider, based on both information acquired from our risk assessment process and the results of the analytical procedures as they were performed. Analytical procedures were customized to each provider based on our professional judgement.

From our conclusions on our analytical procedures, we picked a sample of 40 members for detailed testing. Our sample size was based on OMB Circular A-133 Audits of States, Local Governments, and Non-Profit Organizations. We made judgmental, risk-based samples and felt the control testing sample size was appropriate to our audit objective.

We performed detailed testing on DME claims associated with our sample of 40 members. Details of our procedures can be seen in report section “Procedures and Summarized Results of Audit” beginning on page 5.

Procedures and Summarized Results of Audi

Analytical Procedures

The following analytical procedures were performed over the DME encounters during the period of our scope for THMS, and/or the claims associated with those DME encounters.

Analytical Procedure 1:

Identify the procedure codes with the highest average paid amount and the ten most common detail procedure code descriptions.

Summarized Results:

Two procedure codes represented over 99% of the total encounters for the provider; we sampled from these two procedure codes.

Analytical Procedure 2:

Perform a trend analysis on the count of procedure codes by month.

Summarized Results:

No significant results found.

Analytical Procedure 3:

Review for members who have died and scan for DME charges more than 30 days after death.

Summarized Results:

No members with DME related activity more than 30 days after death found.

Analytical Procedure 4:

Review for the members with the most dollars paid for encounters to identify trends or unusual activity.

Summarized Results:

No significant results found.

Analytical Procedure 5:

Review encounters to identify members with the highest number of claims.

Summarized Results:

We selected samples from the members with the highest number of claims.

Analytical Procedure 6:

Apply Benford's law to paid claims and review for unusual activity or outliers.

Summarized Results:

We selected samples from the results of this analysis.

Analytical Procedure 7:

Scan for the most common amounts paid for unusual trends or outliers.

Summarized Results:

We selected samples from the results of this analysis.

Detailed Testing Procedures

The following procedures were performed over the 40 claims selected for detail testing.

Procedure 1:

Agreed member information and work performed in claim data to supporting documentation provided.

Summarized Results:

No exceptions noted.

Procedure 2:

Confirm the work performed was completed within the time period granted per the MCO(s) Authorization form.

Summarized Results:

No exceptions noted.

Procedure 3:

Verify claims paid to Provider were paid in accordance with rates and terms in the underlying contract between the Provider and MCO(s).

Summarized Results:

No exceptions noted.

Procedure 4:

Obtain an understanding of and assess the MCO's internal controls to the extent necessary to address the audit objectives.

Summarized Results:

We determined that the components of internal control most significant to our audit objectives were information and communication, monitoring, and control activities. In addition, we believe that the information systems control considerations are significant to the audit objectives.

Based on Provider communication and support received related to our gaining an understanding of THMS internal controls, we determined that the testing internal controls appeared unlikely to provide superior audit evidence with regard to the achievement of our audit objectives. Specifically, we determined that the majority of internal controls either operated at high, rather than transactional level, or were likely not designed and operating sufficiently effective to place reliance on. Given that information, instead of testing internal controls we opted to test specific claims for the provider.