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# Key Points of Report

## **An Audit Report on the Department of Health's Medicaid Contract With National Heritage Insurance Company**

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July 2000

### **Overall Conclusion**

The Department of Health (Department) has not held National Heritage Insurance Company (NHIC) accountable for processing Medicaid claims accurately, for enrolling providers properly, or for completing a new Medicaid Management Information System on time. NHIC processed over \$3.5 billion in Medicaid expenditures during fiscal year 1999.

### **Key Facts and Findings**

- The Department has not had adequate controls to detect and correct problems with the claims payment process. For example, invalid provider identification information on paid claims resulted in approximately \$35 million in improper payments over the life of the contract.
- The Department has been slow to address problems with the provider enrollment process problems it has known about since June 1998. In May 2000, 205 active dental providers were without a valid license status.
- The Department's contract for Compass 21, the new claims processing system, did not base payments to NHIC on the completion of processes or activities. The Department has paid NHIC \$69 million, the full balance of the contract. However, Compass 21 will not be implemented until December 2001 25 months after the original target date.

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## **Office of the State Auditor**

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*This audit was conducted in accordance with Government Code, Section 321.0133*

# Executive Summary

The Department of Health (Department) has not held National Heritage Insurance Company (NHIC) accountable for processing Medicaid claims accurately, for enrolling providers properly, or for completing a new Medicaid Management Information System on time. NHIC processed over \$3.5 billion in Medicaid expenditures during fiscal year 1999.

The State Auditor's Office and the Sunset Commission reported in 1998 and 1999 that the Department was not adequately monitoring its contract with NHIC. Simultaneously, other entities external to the Department identified issues that the Department has been slow to address. For example:

- In May 1999, the Health and Human Services Commission (Commission) identified invalid billing and performing provider numbers on paid claims that resulted in approximately \$35 million in improper payments. In May 2000, a process was implemented to reprocess and recover the improper payments.
- In 1999, the Commission identified over 400 dental providers who had received duplicate payments exceeding \$270,000. As of June 1, 2000, neither the Department nor NHIC had determined the cause of the duplicate payments. In response to an inquiry by the State Auditor's Office, NHIC identified possible weaknesses in prepayment controls.
- In June 1998, the media reported that an ineligible dental provider was participating in Medicaid. However, the Department did not begin to evaluate the situation until late 1999, and then it determined that there was a problem with the provider enrollment process. As of May 2000, 205 active dental providers did not have a valid license status due to the problem.

The Department has primarily relied upon an annual audit by the Department's Internal Auditor to monitor NHIC. While the audits produce useful information, they have not been completed in a timely manner. For example, 18 months after the end of fiscal year 1998, the Department's Internal Auditor reported that NHIC had failed to recoup \$22 million of inappropriate payments made to Medicaid providers.

Other concerns have been identified related to the development of the new \$69 million claims processing system called Compass 21. The Department's contract for Compass 21 did not base payments to NHIC on the completion of processes or activities. The Department has paid the full balance of the contract. However, Compass 21 will not be implemented until December 2001—25 months after the original target date.

The Department needs to critically evaluate contractor performance on an ongoing basis and ensure that appropriate, timely action is taken to address questions and concerns. The Department should promptly address problems with prepayment controls and the provider enrollment process. Additionally, the Department should be proactive in the consideration and use of remedies to ensure NHIC performs as expected.

## Summary of Objective and Scope

The objective of this audit was to evaluate the adequacy of the Department's contract monitoring of NHIC and to evaluate controls in the Medicaid Management Information System at NHIC. The scope of the audit included the duties and responsibilities of the Department's Health Care Financing Division.

# Executive Summary, concluded

## **Summary of Management's Response**

*The Texas Department of Health (TDH), and specifically the Deputyship for Health Care Financing (HCF), concurs with the State Auditor's Office (SAO) that TDH needs to improve its monitoring of the National Heritage Insurance Company's (NHIC) performance in prepayment controls, the provider enrollment process and Compass 21 development. HCF staff has already taken steps to address the recommendations made.*

*In response to SAO's comment that some of the claims processing issues were identified by entities external to the Department, TDH notes that it considers the functions of monitoring and identifying claims processing issues associated with NHIC's claims*

*administrator responsibilities to be a shared responsibility of both TDH and the Health and Human Services Commission (HHSC). The Surveillance and Utilization Review System (SURS) and internal auditing functions within TDH support this effort. The Medicaid Fraud and Abuse Detection System (MFADS) and the Compliance Monitoring and Referral Section within the Office of Investigations and Enforcement, HHSC, also assist in this monitoring and identification effort by notifying TDH of potential claims processing issues. The notification by HHSC to TDH occurs through Office of Investigations and Enforcement Action Request (OARS) memorandums which result in TDH issuing directives to NHIC to research and resolve the potential claims issues.*

Section 1:

## The Department Should Improve Its Monitoring of Prepayment Controls to Prevent Improper Payments

The Department of Health (Department) has not had adequate controls to detect and correct problems with the claims payment process. During 1999, the Health and Human Services Commission (Commission) identified improper payments that highlight problems with certain prepayment controls. The Department is only now resolving these problems. This is not a new issue. In September 1995, the State Auditor's Office reported that prepayment controls did not prevent overpayments for Medicaid laboratory services. The State Auditor's Office recommended then that the Department monitor the effectiveness of the contractor's prepayment controls. While the Department addressed controls specific to laboratory payments, it did not address prepayment controls for other types of claims.

Over 800 computer audits and edits are in NHIC's claims processing system to ensure proper payment. While this report identifies breakdowns in some prepayment controls, other testing showed that a sample of 24 audits and edits are functioning properly.

Section 1-A:

### Invalid Provider Identification Information on Paid Claims Resulted in Approximately \$35 Million in Improper Payments

In May 1999, the Commission identified invalid billing and performing provider numbers on paid claims. In May 2000, a year later, National Heritage Insurance Company (NHIC) provided a report to the Department that showed approximately \$35 million in claims that had been paid improperly over the life of the contract due to invalid provider identification information.

The Commission identified these instances either through the Medicaid Fraud and Abuse Detection System or its Compliance Monitoring and Referral Division, which is to be commended. However, these systems are used to review payments after they have been made; they are not intended to evaluate the effectiveness of prepayment controls.

While a process has been implemented to reprocess and recover the improper payments, corrections still need to be made to the automated claims processing system. Management anticipated that its new system, Compass 21, would address the system problems, but Compass 21 will be delayed at least 18 months from the revised implementation date of May 1, 2000. (See Section 3.) Without corrections to the current system or the implementation of other controls, improper payments will continue.

#### Recommendation:

The Department should continue to work with NHIC to expedite the reprocessing of claims that have been paid improperly and recoup payments where appropriate. The Department should require NHIC to make appropriate changes to the current

Medicaid Management Information System or implement other controls to ensure that all claims have correct provider identification before payment is made. The Department should also ensure that the proper edits are included in Compass 21.

Management's Response:

*The Department concurs with the recommendation. At the direction of TDH and the Health and Human Services Commission (HHSC), National Heritage Insurance Company (NHIC) is continuing to research and identify the total amount of claims and dollars that may have been inappropriately processed or paid. Initial indications are that a significant amount of the initial \$35M in claims may have been appropriately processed, however, the specific amount of claims and dollars involved has not been finalized. Upon finalization of the research by NHIC, TDH will direct NHIC to begin recoveries or adjustments of any past inappropriate claims payments for providers. Although the targeted completion date for this process will be dependent on the amount of claims and dollars identified, TDH is anticipating completing the process no later than three months from the identification of the referenced provider claims. A corrective action plan has been developed that is intended to prevent future occurrences of inappropriate claims processing by modifying both the current Medicaid Management Information System (current claims processing system) and the future Compass 21 (C21) system. TDH is anticipating that the changes to the MMIS systems edits to prevent inappropriate claims processing will occur within three months. To ensure the identification and recovery of any inappropriate claims payments pending the implementation of the proposed system changes, NHIC will initiate ad hoc reports that will identify any future inappropriate claims payments and will initiate appropriate recoveries or adjustments for the identified claims.*

Section 1-B:

**The Cause of Duplicate Payments to Over 400 Dental Providers Was Not Detected or Researched by the Department**

In 1999, the Commission identified over 400 dental providers who had received duplicate payments exceeding \$270,000 in 1996 and 1997. As of June 1, 2000, neither the Department nor NHIC had taken action to determine the cause of the duplicate payments. In response to an inquiry by the State Auditor's Office, NHIC initially stated that a clerical error had caused the duplicate payments. However, further research by NHIC revealed possible weaknesses in prepayment controls. Without a clear understanding of the cause of the duplicate payments, the Department risks continued overpayments.

The Commission requested that NHIC begin recouping the overpayments, and NHIC communicated that it was in the process of recouping the money.

Recommendation:

The Department should require NHIC to fully research the duplicate payments to dental providers and determine their cause. The Department should also determine if other duplicate payments were made since 1997. Then, the Department should ensure that NHIC takes corrective action to prevent similar overpayments.

Management's Response:

*The Department concurs with the recommendation. TDH will direct National Heritage Insurance Company (NHIC) to research and identify any inappropriate duplicate payments for dental providers since 1997 within 60 days. Upon identification of any duplicate payments, NHIC will implement appropriate recovery or adjustments for the identified claims within 30 days of identification. TDH will ensure that NHIC identifies the causes of the inappropriate duplicate payments and develops and implements appropriate processing and quality control activities to prevent any future duplicate payments. These activities will be implemented within 60 days of the determination of the causes of the duplicate payments.*

*Pending the implementation of an automated method for testing system edits and audits in Compass 21 (C21), TDH will direct NHIC to develop and implement a manual process for ensuring that a sample of edits and audits are tested on a monthly basis and the results of testing is reported to TDH. The manual process will be developed and implemented within 90 days.*

Section 1-C:

**Internal Audit Identified Approximately \$22 Million of Inappropriate Payments 18 Months After the End of Fiscal Year 1998**

Eighteen months after the end of fiscal year 1998, the Department's Internal Auditor reported that NHIC had failed to recoup \$22 million of inappropriate payments made to Medicaid providers. These payments date back to 1982. According to the Internal Auditor, these providers billed under provider numbers different from the ones under which the inappropriate payments were made. NHIC continued to pay these providers without recouping the amounts owed to the State.

Agency management and the State Auditor's Office agree with the finding. NHIC initially disagreed with the finding and maintained that there was no inappropriate payment detail to be provided, and therefore, no basis for a corrective action plan. However, NHIC reversed its position after release of the report in February 2000 and documented a corrective action plan as of May 12, 2000.

Two joint task forces, a Process Task Force and a Recovery Task Force, were implemented in May 2000 to address the problem. Additionally, NHIC reported that it has already recovered over half of the \$22 million. According to NHIC, the balance of receivables is \$9.8 million as of the end of March 2000. Yet, NHIC states in its

audited financial statements, “It is not possible to estimate the amount that will remain outstanding after this effort is completed; however, because certain of these liabilities date back several years, this amount could be significant.”

The Department’s Internal Auditor should be commended for detecting and reporting this problem. However, the results were reported 18 months after the end of the fiscal year. This delay prevents the Department from identifying errors and taking prompt corrective action. The Department’s Internal Auditor has conducted annual compliance audits since fiscal year 1994, but the audits have not been timely.

Recommendation:

The Department should continue to ensure proper action by NHIC through the two joint task forces implemented in May 2000—the Process Task Force and the Recovery Task Force. The Department should ensure the recovery of inappropriate payments made to Medicaid providers.

The Department’s Internal Auditor should conduct its compliance audits of NHIC nearer to the close of the fiscal year being audited.

Management’s Response:

*The contract between TDH and NHIC requires NHIC to recoup inappropriate payments made to Medicaid providers. Inappropriate payments include payments that were correct based on initially submitted information that was later found to be in error.*

*The Department Internal Auditor determined that NHIC failed to recoup \$22.0 million in inappropriate payments issued from FY 1982-1998. NHIC has reported that approximately \$12.2 million of the total has been recouped since the end of the audit period. The remaining \$9.8 million balance includes about 30,000 claims.*

*The Department agrees with the recommendation that inappropriate payments to Medicaid providers should be recovered. Developing policies and processes that will ensure timely recoupments in the future and that will guide the recovery of inappropriate payments made in the past are the charges for the two task forces mentioned by the SAO.*

*The task forces were established in accordance with the corrective action plan requested by TDH from NHIC. The task forces are chaired by TDH staff and are composed of representatives from TDH and NHIC. Members have been meeting weekly since May and are expected to complete their work by the end of the summer. A joint TDH-NHIC Executive Oversight Committee meets with the task force chairs each month to provide guidance and to monitor progress. In addition, TDH staff provides a status report to the Board of Health at their monthly meetings.*

*As the SAO indicates in the executive summary, this is a very large contract. Internal Audit conducts thorough, comprehensive testing of transactions, financial balances, compliance issues, and systems controls. As the SAO indicates, the report for fiscal year 1998 contained significant monetary findings that were disputed by the contractor until after the report was released. While we do not agree that the audits have been delayed or untimely, we will continue to complete the audits as quickly as possible, without compromising the scope, thoroughness, or quality of the audits.*

*The annual audit is, by definition, performed retrospectively. At the request of Health Care Finance, Internal Audit has agreed to provide technical assistance in the areas of accounting, receivables recoupment, and day-to-day monitoring.*

Section 2:

## **The Department Should Improve the Provider Enrollment Process**

The Department has been slow to address problems with the provider enrollment process—problems it has known about since June 1998. Furthermore, the weakness in the provider enrollment process has apparently existed for the life of the contract (since 1977) without detection.

In June 1998, the media reported that an ineligible dental provider was participating in Medicaid. In July 1999, the media reported another ineligible dental provider. After the second media report, the Department requested that NHIC develop a corrective action plan and research the extent of the problem. In May 2000, NHIC provided a report to the Department that showed 205 active dental providers without a valid license status. According to the Department, as of May 24, 2000, all but 45 providers had been cleared or removed from enrollment, and the remaining 45 providers were on vendor hold.

Since August 1999, several points of disagreement have arisen between the Department and NHIC, including responsibility for the cost to fix the problem. While the Department believes NHIC has failed to comply with its contractual obligations related to the validation of license status, NHIC does not agree. The contract between the Department and NHIC requires NHIC to enroll eligible providers in the Texas Medicaid Program and to comply with all applicable statutes and regulations. According to NHIC, the enrollment process has simply been a collection of information with very limited validation that the Department has accepted.

At the same time, other problems were detected with the provider enrollment process:

- On July 23, 1999, the Department reported that four times during the previous six weeks, clients had received services from enrolled providers who were not appropriately licensed in the discipline under which they were enrolled.
- In November 1999, the Commission identified a discrepancy between license numbers on the Board of Dental Examiners file and the NHIC provider file for 17 dental providers.

- In December 1999, the Commission identified an individual who was inappropriately enrolled as a licensed professional counselor based on a temporary license.
- In January 2000, the Department reported to NHIC discrepancies with license data for eight physicians.

Recommendation:

The Department needs to scrutinize every element of the provider enrollment process to ensure that an effective process is in place. The Department needs to resolve points of disagreement with NHIC and implement appropriate measures to properly enroll eligible providers of all disciplines. The Department should ensure that NHIC takes appropriate action to properly remove ineligible providers and to identify ineligible providers before they are enrolled.

Management's Response:

*The Department concurs with the recommendation. In a November 17, 1999 memorandum to NHIC, the Department clarified both policies associated with the enrollment of providers as well as its expectations for the enrollment process. NHIC was directed to implement verification activities to ensure that currently enrolled dental providers and applicants meet the appropriate licensure, certification, and/or registration requirements. In order to ensure that TDH maintains compliance with federal requirements for recipient accessibility to services, as well as legal mandates, both NHIC and TDH conducted further verification activities with those providers whose initial review indicated noncompliance. To date, enrollment information for four groups and 25 individual providers indicate noncompliance with licensure requirements. Notification of disenrollment actions for the affected providers will occur during July 2000. In addition to annually verifying the proper licensure, registration, and certification of current providers, NHIC was directed to initiate a standardized quality review process for all applicants for participation in the Medicaid Program. The quality review process includes a monthly random sample of newly enrolled providers to ensure proper enrollment and reporting of the results of this activity to TDH. The reporting includes reasons for the inappropriate enrollment, as well as corrective action for those enrollments. NHIC was also directed to update the provider enrollment application, new provider enrollment packets, the Medicaid Provider Procedures Manual, the bi-monthly Medicaid Bulletin with sections intended to reinforce these requirements to providers. New applicants whose license is scheduled to expire within 30 days of enrollment will have their application pended until such time they submit an updated license. Those applicants whose license will expire in 60 days will be allowed to enroll, however, they will be monitored to ensure an updated license is obtained prior to the expiration of the current license.*

*TDH met with NHIC executive staff on June 14, 2000, to further discuss the resolution of disagreements associated with provider enrollment activities. Staff from both TDH and NHIC will continue to discuss modifications to the current enrollment process*

*that will ensure the prevention and identification of inappropriate enrollments in the future. Emphasis will be placed on quality review processes and the increased use of systems interfaces to support this effort. It is anticipated that the identification of these processes and their impact on current operations will be completed by January 2001.*

Section 3:

## **The Department Should Closely Monitor NHIC's Development of Compass 21 to Avoid Further Delays**

The Department's contract for Compass 21, the new claims processing system, did not base payments to NHIC on the completion of processes or activities. The Department has paid NHIC \$69 million, the full balance of the contract. Additionally, NHIC is seeking \$7 million more for agreed upon changes in scope. However, Compass 21 will not be implemented until December 2001—25 months after the original target date. Compass 21's initial implementation date was November 1, 1999. The first revised implementation date was May 1, 2000.

The Department requested proposals in 1997 for a new contract to include the development of a new Medicaid Management Information System (MMIS), and NHIC was the only bidder. The Department noted in October 1997 that there was low risk of implementation problems with NHIC. Yet, a Department evaluation team raised numerous concerns about NHIC's proposal for a new MMIS. The evaluation team noted that the proposal was "very general" and did not adequately address many aspects of the Request for Proposals. Questions were submitted to NHIC in order to clarify or elaborate, but several responses to key questions were vague or inconclusive. Comments were made that if NHIC was unable to comply with certain requirements, an option would be to carve out certain functions such as provider enrollment or third party reimbursement and contract separately. According to management, negotiations between the Department and NHIC resulted in many technical improvements to the original proposal.

The State has contracted with NHIC for Medicaid claims administration since 1977. Effective September 1, 1993, the Texas Legislature transferred the administration of the contract to the Department of Health from the Department of Human Services. The Department of Health and NHIC then extended the contract to August 31, 1998.

An independent contractor, hired by the Department to provide independent verification and validation services for the Compass 21 project, concluded in May 2000 that NHIC gave inadequate attention to project management tools and techniques early in the project. Department management cited the "technological challenge" of introducing such a complicated system as the main reason for the delay.

In its response to the independent verification and validation, NHIC stated, "external scope changes and technical issues necessitated the shift of the Phase Two delivery date from November 1, 1999, to May 1, 2000." NHIC further stated that the process of conducting performance testing and optimization would require another shift in the delivery date to ensure that Compass 21 would fully support the program requirements and Department needs. NHIC acknowledged the need to improve its

project management activities and discussed changes and improvements that it has implemented since late 1999.

The delay in implementation means that the Department and NHIC will not receive the functionality of a new client/server-based Medicaid Management Information System in a timely manner. Compass 21 is supposed to provide functionality not available in the current system. As noted by the Commission, "Compass 21 will allow the State to more effectively support both traditional and managed care systems."

According to Department management, the existing system will continue to process claims, and the delay should not cost the State additional money unless the original scope changes. However, maintenance to the existing system will be necessary, especially since Compass 21 was expected to solve some of the problems identified in Section 1 of this report.

There will be a significant cost to NHIC, a wholly owned subsidiary of Electronic Data Systems Corporation. According to NHIC's audited financial statements for the year ended December 31, 1999, "management of the Company [NHIC] determined that implementation of the new system would be significantly delayed and, as a result, the Company is expected to incur substantial future costs in order to complete development and testing of the new system." Based on costs incurred to date (\$69 million ÷ 24 months), we estimate a cost to NHIC of approximately \$2.875 million per month during the delay. A delay of 18 months from May 1, 2000, amounts to over \$50 million (18 x \$2.875 million), which could have an adverse impact on NHIC's financial position. According to the December 31, 1999, financial statement, NHIC's Cash and Cash Equivalents totaled \$14.957 million at the end of fiscal year 1998 and \$13.178 million at the end of fiscal year 1999.

Additionally, the Department informed NHIC of its intent to assess NHIC daily penalties, beginning May 2, 2000. The contract allows the assessment of liquidated damages of \$2,000 per day for the first 15 days of the assessment period and \$5,000 per day thereafter until the system meets the contractual requirements.

Recommendation:

The Department should ensure that NHIC strictly adheres to project management standards during the development and implementation of Compass 21. The Department should ensure that NHIC addresses all recommendations made from the independent verification and validation. The Department should critically evaluate NHIC performance on an ongoing basis and in a timely manner. The Department should also consider the use of all available remedies to ensure NHIC performs as expected. In case NHIC does not perform as expected, the Department should identify options for a new claims processing system. For example, the Department should review comments and concerns made by the Department evaluation team to consider carving out certain functions and contracting separately for those functions.

Additionally, the Department should strongly consider suggestions made by the Private Sector Technical Advisory Group. At the Health Care Financing Administration's (HCFA) request, a Private Sector Technical Advisory Group (PS-TAG), representing a wide range of vendors serving the system needs of the Medicaid program, meets periodically to discuss the issues of the day. With HCFA's encouragement and support, the PS-TAG published a paper on October 15, 1997, entitled "Steps Needed to Improve State Medicaid Information Systems: The Private Sector View of Challenges and Opportunities for the 21st Century." The purpose of the paper was to generate discussion among states, HCFA, and the private sector group about common MMIS problems and possible solutions. Moreover, it presents suggestions for improving the MMIS procurement and contracting process to attract more competition.

Management's Response:

*The Department concurs with the recommendation. The Department has issued an RFO to contract with an Independent Verification and Validation (IV & V) Team to assist the Department in the active monitoring of project, work plan, deliverables and due dates. The IV & V and the Department will jointly review and monitor project management standards, and will continue to develop, publish and review appropriate progress performance metrics.*

*Regular meetings are held to identify and address all findings identified by the IV & V Team mentioned in the SAO report. An Issues Log is maintained to track the life cycle of issues initiated and completed. These meetings consist of: weekly meetings of Department and IV & V Staff to identify and evaluate the impact of any issues to the current schedule; weekly meetings of Department, IV & V and NHIC staff to discuss and resolve issues identified, and review the project plan and progress; and weekly meetings of Department and NHIC Executive Staff to review the status of the project and to resolve any outstanding issues. TDH staff also provides a status report to the Board of Health at their monthly meetings.*

*The Department continues to strengthen its oversight responsibility in the management, monitoring and measurement of performance of NHIC by implementing the following activities: establishment of review dates for critical project (Claims Engine and Financial) components; actively monitoring, evaluating and reporting the Work Plan progress daily and weekly; comparing estimated completion of hourly burn rate for status; and imposing sanctions as remedy for failure to meet contract performance.*

*The Department has developed a contingency plan in case NHIC fails to perform, but we do not expect this to occur. The Department will consider the suggestions of the PS-TAG in future procurements.*

## Objective, Scope, and Methodology

### Objective

The objective of this audit was to evaluate the adequacy of the Department's contract monitoring of NHIC and to evaluate controls in the Medicaid Management Information System at NHIC. Specifically, the following questions were addressed:

- Is the contractual relationship between the Department and NHIC fair and competitive?
- Can the Department rely on the integrity of the claims data processed by the Medicaid Management Information System at NHIC?

### Scope

The scope of the audit included examining the duties and responsibilities of the Department's Health Care Financing Division. We reviewed policy and operations, budget and support services, information resources, and contract compliance.

### Methodology

We applied conventional audit procedures to collecting information, including interviews with management and staff of the Department of Health, the Health and Human Services Commission, Health Care Financing Administration, and National Heritage Insurance Company. We analyzed operational data and relevant reports and documentation.

#### Information collected:

- Request for Proposal, Texas Medicaid Claims Administrator, Texas Department of Health, December 11, 1996
- Texas Medicaid Claims Administrator Contract between the Department of Health and National Heritage Insurance Company, including amendments
- Medicaid Management Information System documentation prepared by NHIC
- *Compass 21 IV & V Final Report Findings and Recommendations*, Version 1.0, May 8, 2000, prepared by Renaissance Government Solutions
- *National Heritage Insurance Company Financial Statements* for years ended December 31, 1994, through December 31, 1999.
- Various management reports from the Department
- Agency documents, memoranda, and publications

- Policy and procedure manuals and provider handbooks
- Department general ledger and expenditure data
- Department internal audit reports on the Title XIX Medicaid contract administered by National Heritage Insurance Company
- Prior State Auditor's Office reports
- Sunset Report to 76th Legislature, February 1999

Procedures and tests conducted:

- Reviewed and analyzed documentary evidence and results of interviews
- Survey of potential bidders for the Claims Administrator contract
- Survey of other state Medicaid agencies, including Alabama, Florida, Indiana, New York, Pennsylvania, Virginia, and Wisconsin
- Tested automated audits and edits of MMIS by submitting dummy claims through a test environment at NHIC
- Trend and ratio analysis of relevant financial and operational statistics

We conducted fieldwork from November 1999 to May 2000. The audit was conducted according to applicable professional standards, including:

- Generally accepted government auditing standards
- Generally accepted auditing standards

There were no instances of noncompliance with these standards.

The audit work was performed by the following members of the State Auditor's Office:

- Jon Nelson, CISA (Project Manager)
- Rodney Almaraz
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