State Auditor's Office

John Keel, CPA
State Auditor

An Audit Report on

The Children with Special Health Care Needs Services Program at the Department of State Health Services

August 2013

Report No. 13-046

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Overall Conclusion

The Department of State Health Services (Department) has implemented effective processes for the Children with Special Health Care Needs Services Program (Program) to help ensure that it (1) determines that clients are eligible for the Program and (2) manages the Program's waiting list in accordance with applicable laws, rules, and Department policies and procedures. In addition, the Department has implemented effective processes for monitoring the Program's community-based contractors to determine whether they are providing allowable services to eligible Program clients (see text box for additional details).

Background Information

The Department of State Health Services manages the Children with Special Health Care Needs Services Program (Program), which serves clients who meet certain financial, residency, age, and medical requirements. During fiscal year 2012, the Program provided services to 1,875 clients.

The Program pays for health care benefits and services not covered by other payers. The Program covers health care benefits for clients with extraordinary medical needs; disabilities; and chronic health conditions, such as cystic fibrosis, hemophilia, and kidney disease. The Program also contracts with community-based organizations to provide case management, family support, community resources, and clinical services.

During fiscal years 2011 and 2012, the Program's expenditures totaled approximately $74 million. The Department paid for those expenditures using approximately $21 million in federal funds; it paid for the remainder with state funds.

Source: The Department.

However, the Department does not sufficiently monitor the contractor that processes and pays Program claims[1] to ensure that expenditures for clients' medical services comply with applicable laws, rules, and Department policies and procedures. The Department relies primarily on the contractor to process and pay claims correctly. For example:

- The Department's monitoring does not focus on ensuring that Program claims the contractor pays are appropriate and accurate. The Department's procedures require it to select and review at least 30 various claims (claims with different statuses, claims with different provider types, and high-dollar claims) on a quarterly basis. However, the Department has not implemented those procedures. Instead, the Department reviews appeals of denied claims that it receives from clients or providers.
- The Department determined that, for 65 percent of appealed Program claims it reviewed in fiscal years 2011 and 2012, the contractor's original decision on the claims was incorrect. That underscores the importance of proactively monitoring

[1] The contractor, the Texas Medicaid and Healthcare Partnership (TMHP), processes and pays Program medical claims. The contractor processes Program pharmacy claims but does not pay those claims.

claims the contractor pays and implementing procedures to regularly sample and review various types of claims.

- Auditors tested a sample of 90 pharmacy and medical expenditures associated with Program claims the contractor processed in fiscal years 2011 and 2012 and determined that expenditures were for active clients; were paid to providers enrolled in the Program; had appropriate prior authorization, if required; and were for allowable services. However, in two cases, the Department did not ensure that clients' other insurance was billed.

- While the Department monitored the contractor's call center, it did not do so consistently. The Department also did not maintain documentation to support that it consistently monitored provider enrollment and prior authorization of Program claims during fiscal years 2011 and 2012.

Auditors communicated other, less significant issues to Department management separately in writing.

Summary of Management's Response

The Department agreed with the recommendations in this report.

Summary of Information Technology Review

Auditors reviewed controls related to eligibility and waiting list management processes in the Department's Children with Special Health Care Needs Services Program Management Information System (CMIS). That work included reviewing user access, change management, data input controls, data transfers, and tests of data for completeness. The Department has developed and implemented information technology controls over CMIS; however, those controls are not sufficient to ensure that Program data in CMIS is accurate (see Chapter 5 for additional details).

Summary of Objectives, Scope, and Methodology

The objectives of this audit were to:

- Determine whether the Department has designed and implemented effective processes and related controls for the Program to help ensure that only eligible persons receive services through the Program and that it manages the Program's waiting list in accordance with applicable laws, rules, and Department policies and procedures.

- Determine whether the Department has designed and implemented effective processes and related controls for the Program to help ensure that Program

expenditures are allowable and made in accordance with applicable laws, rules, and Department policies and procedures.

The audit scope covered the time period from September 1, 2010, through September 1, 2012, and included Program client eligibility, the Department's management of the Program's waiting list, the Department's monitoring of the Program's community-based contractors, and the Department's monitoring of the contractor that processes and pays Program claims.

The audit methodology included collecting information and documentation related to eligibility, waiting list management, and contractor monitoring processes. Auditors conducted interviews with Department and contractor personnel, observed processes, and analyzed accounting data and medical and pharmacy claims data. Auditors performed testing and evaluated the results. Auditors also reviewed Department policies and procedures, the Texas Administrative Code, and statutes.

Auditors assessed the reliability of CMIS data by interviewing information technology personnel, reviewing processes that limited access to authorized users, and reviewing change management processes. Auditors assessed the completeness of CMIS data by reconciling it with medical and pharmacy claims data the contractor provided and the Department's accounting data. Auditors could not determine whether CMIS data was reliable and, therefore, used that data only for limited purposes during the audit. Auditors relied on previous audit work to determine that medical and pharmacy claims data and Department accounting data was sufficiently reliable for the purposes of this audit.

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Detailed Results

Chapter 1

The Department Ensures That Program Clients Are Eligible for Services, But It Should Consistently Perform Secondary Reviews of Client Information

The Department of State Health Services (Department) has designed and implemented an effective process for ensuring that only eligible clients receive services through the Children with Special Health Care Needs Services Program (Program). In addition, the Department has detailed, written procedures for the eligibility determination process that include reviewing applications, assessing supporting documentation, and entering information into its Children with Special Health Care Needs Services Program Management Information System (CMIS).

Program Eligibility

To be eligible for Program benefits, individuals must meet the following requirements:

Financial requirements. Every six months, an individual who wishes to receive Program services must provide evidence that his or her income level does not exceed 200 percent of the federal poverty level. (According to the U. S. Department of Health and Human Services, in 2012 the federal poverty level for a family of four was $23,050. Therefore, 200 percent of that poverty level was $46,100.)

Residency requirements. An individual who wishes to receive Program services must be a Texas resident.

Age and medical requirements. At least annually, a physician or dentist must certify that an individual who wishes to receive Program services (1) is younger than 21 years of age and has a chronic physical or developmental condition or (2) has cystic fibrosis, regardless of the individual's age.

Sources: Title 25, Texas Administrative Code, Section 38.3, and the U. S. Department of Health and Human Services.

A potential Program client must submit an application and provide proof that he or she meets eligibility requirements (see text box for additional details). Department regional offices input application information into CMIS for eligibility determination; however, not all of the Department's regional offices review that information for accuracy. Only one of the three regional offices auditors contacted performed a secondary review of data entered into CMIS to help ensure the accuracy of that data. Performing a secondary review of the data entered into CMIS would help to ensure that the eligibility determinations CMIS makes are based on accurate information.

Auditors tested documentation from a sample of 30 Program client files from various regional offices for compliance with financial, residency, and age requirements. Results of those tests were as follows:

- Twenty-seven (90 percent) of the 30 client files tested contained documentation to establish that the clients met financial, residency, and age requirements.
- One (3 percent) of the 30 client files tested contained documentation to establish that the client met age requirements. However, that file did not contain documentation showing that the client met financial and residency requirements. According to the Department, a fire in one of its regional offices destroyed that documentation.
- For 2 (7 percent) of the 30 client files tested, the Department could not provide documentation to show that the clients met the financial,

residency, and age requirements. According to the Department, a fire in one of its regional offices destroyed that documentation.

Physicians and dentists are required to complete physician assessment forms annually to certify that clients have diagnoses that made them eligible for Program services. Auditors tested a sample of 38 client files[2] and found that all 38 files contained completed physician assessment forms to establish that the clients had diagnoses that made them eligible for Program services.

Recommendation

The Department should implement a review process to help ensure that the data it enters into CMIS is accurate.

Management's Response

The Department agrees that accurate, reliable information is important. The Program will establish procedures for training staff and conducting reviews, using a sampling methodology, of client application information entered into CMIS at the regional level.

Target Implementation date: May 1, 2014

Title of individual(s) with responsibility for this response:
Purchased Health Services Unit Manager
Assistant Commissioner, Division for Regional and Local Health Services

[2] The sample included the 30 client files discussed previously and an additional 8 client files.

Chapter 2

The Department Manages the Program's Waiting List in Accordance with Requirements, But It Should Consistently Maintain Supporting Documentation for Its Waiting List Decisions

The Department has designed and implemented effective processes and related controls to help ensure that it manages the Program's waiting list in accordance with applicable laws, rules, and Department policies and procedures. According to the Department, it established a Program waiting list in 2001. All clients on the waiting list must maintain their eligibility to remain on the waiting list.

The Department analyzes Program expenditures and makes reasonable waiting list decisions. When the amount of funds available for the Program exceeds projected Program expenditures, the Department can (1) provide limited medical benefits to clients on the waiting list or (2) remove clients from the waiting list and approve them to receive full Program services. According to the Department, in fiscal year 2011 no clients on the waiting list received limited medical benefits and the Department did not remove any clients from the waiting list. In fiscal year 2012, the Department provided limited medical benefits to 930 clients on the waiting list. The Department removed 160 clients from the waiting list at the beginning of fiscal year 2013 and approved them to receive full Program services.

The Department uses actuarial expenditure projections to monitor the Program's available funds on a monthly basis to determine whether it is appropriate to remove clients from the waiting list and approve them to receive full Program services or provide clients on the waiting list with limited medical benefits. The Department estimates the Program's available funds for the next fiscal year by subtracting projected Program expenditures from the sum of state appropriations and federal grants. The Department does not have complete, documented, and approved policies and procedures for the Program's expenditure projection process.

In addition, while the Department complied with the Texas Administrative Code by analyzing actual and projected Program expenditures on a monthly basis, it did not maintain all supporting documentation for or perform a review of the projections or the method of finance report it used to project the amount of Program funds available. Without performing that type of review, the Department could make an incorrect decision to remove clients from the waiting list or to provide clients on the waiting list with limited medical benefits. However, auditors determined that the Department's decision to remove clients from the waiting list and approve them to receive full Program services and to provide limited medical benefits to clients remaining on the waiting list was reasonable.

The Department appropriately ranks clients for waiting list removal. Auditors reviewed the Department's analysis of expenditure projections for fiscal year 2013 and used estimated available funds to recalculate the number of clients to be removed from the Program waiting list. That analysis showed that the Department's decision to remove 160 clients from the waiting list at the beginning of fiscal year 2013 and approve them for receiving full services was appropriate.

Program Waiting List Rules

The Department removes a client from the Program's waiting list and approves the client to receive full services according to the original date and time of the client's most recent, uninterrupted sequence of eligibility and in the following order:

1. Clients who are younger than 21 years old and who have an urgent need for health care benefits.
2. Clients who are 21 years of age or older and who have an urgent need for health care benefits.
3. All other clients who are younger than 21 years old and who do not have an urgent need for health care benefits.
4. All other clients who are 21 years of age or older and who do not have an urgent need for health care benefits.

Source: Title 25, Texas Administrative Code, Section 38.16.

According to the Texas Administrative Code, the Department should rank each client for waiting list removal based on uninterrupted time spent on the waiting list, the client's age, and whether the client has an urgent need for health care benefits (see text box for additional details). The Texas Administrative Code defines urgent need as a medical determination that a delay in receiving health care benefits would result in loss of the client's life, a permanent increase in the client's disability, intense pain and suffering for the client, or an imminent risk of institutionalization of the client. In addition, urgent need includes the determination that the client has no other source of health care coverage.

Auditors recalculated the rankings of all clients for waiting list removal at the beginning of fiscal year 2013 and determined that the Department ranked clients in accordance with Texas Administrative Code requirements. However, the Department did not maintain support for a change it made in the ranking for one client it removed from the waiting list and to whom it approved receiving full Program services. Maintaining support for changes in rankings would help to ensure that all of the Department's waiting list decisions are supported and appropriate.

Recommendations

The Department should:

- Develop and approve policies and procedures for its Program expenditure projection process.
- Implement a review process to help ensure that the reports the Department uses to make Program waiting list decisions are accurate.
- Consistently maintain supporting documentation for Program financial reports and changes it makes to a client's ranking on the Program waiting list.

Management's Response

The Department agrees that programmatic procedures for documenting management decisions for expenditure projections and relating to waiting list

placement at the time of a waiting list removal for clients to receive health care benefits can be formalized. The Program will develop, approve, and implement internal procedures by April 1, 2014.

The Department agrees that maintaining supporting documentation and the review of the report is important to assure accuracy. As of April 26, 2013, the Department began retaining supporting system records for similar reports in a PDF format. The Department will revise internal processes to insure the summary reports are properly prepared and reviewed before projections are sent to Program.

Target Implementation date: April 1, 2014

Title of individuals with responsibility for this response:
Purchased Health Services Unit Manager
Budget Director

Chapter 3

The Department Monitors the Program's Community-based Contractors to Help Ensure That They Provide Allowable Services to Eligible Clients

Program Community-based Contractors

The Department has contracts with 21 community-based contractors to provide case management, family support, community resources, and clinical services to Program clients and their families. During fiscal years 2011 and 2012, the Department paid $5.4 million to those community-based contractors.

The Department has appropriate controls to help ensure that the Program's community-based contractors provide allowable services to eligible Program clients. Community-based contractors provide non-medical services to any eligible client and the client's family, including clients who are ineligible for the Program's direct health care benefits (see text box for additional details). The Department reviews and approves the community-based contractors' monthly payment vouchers and conducts on-site Program and financial reviews.

Department Payment Voucher Reviews. The Department has a process to review and approve monthly payment vouchers the community-based contractors submit for reimbursement for Program expenditures. That process includes a comparison of the payment voucher to the community-based contractor's approved annual budget. The Department appropriately reviewed and approved all 30 payment vouchers auditors tested and accurately paid the approved amounts to the community-based contractors. In addition, all of the community-based contractors tested remained within their approved annual budgets.

Department On-site Program Reviews. The Department has procedures for monitoring community-based contractors that include specific criteria for performing on-site Program reviews. Auditors tested 4 of the 16 on-site Program reviews the Department performed between September 2010 and August 2012. For all on-site Program reviews auditors tested, the Department followed review guidelines and determined that the community-based contractors complied with client eligibility and expenditure allowability requirements.

While conducting on-site Program reviews, the Department determines whether a community-based contractor is providing services to eligible clients and their families, providing only services not available through other sources, and helping clients and their families to find and apply for additional services or potential medical insurance coverage. According to the Department, it has performed on-site Program reviews at all 21 community-based contractors. The average amount of time between on-site Program reviews was approximately two years.

Department On-site Financial Reviews. The Department performs on-site financial reviews to determine whether community-based contractors' expenditures are allowable, reasonable, necessary, properly supported, and authorized. The Department examines and analyzes supporting documentation for payroll and other contract expenditures, subcontracts, and equipment; it also reviews

general compliance with contract provisions. Auditors reviewed 4 of the 13 on-site financial reviews the Department performed between September 2010 and August 2012. The Department identified questioned costs for unallowable expenditures in two of those financial reviews and took corrective action to ensure that the community-based contractors did not use Program funds inappropriately.

Eighteen of the 21 community-based contractors had received a Department on-site financial review since the beginning of fiscal year 2011. According to the Department, the allowability of the other three community-based contractors' expenditures is tested during the Statewide Single Audit; however, auditors noted that Program expenditures would not meet materiality thresholds for testing during the Statewide Single Audit.

Recommendation

The Department should perform on-site financial reviews or ensure adequate audit coverage of the Program's community-based contractors to help ensure that Program expenditures are allowable, reasonable, necessary, properly supported, and authorized.

Management's Response

The Department agrees that all contractors should receive financial review consideration. The Department's Contract Oversight and Support Section (COS) will ensure all of this Program's community-based contractors are included in its risk assessment. COS will continue to perform a variety of financial monitoring activities, to include on-site reviews on those contractors identified as having relatively higher risks.

Target Implementation date: January 2014

Title of individual with responsibility for this response:
Contract Oversight Section Director

Chapter 4

The Department Should Strengthen Its Monitoring of the Contractor That Processes and Pays Program Claims

The Department's monitoring of the Program's claims payment contractor does not sufficiently ensure that medical expenditures for Program clients comply with applicable laws, rules, and Department policies and procedures. The contractor (1) processes pharmacy claims for the Program and notifies the Department which vendors to pay for those claims and (2) processes medical claims for the Program, submits payment vouchers associated with medical claims to the Department, and pays providers for medical claims after it receives funds from the Program. During fiscal years 2011 and 2012, the contractor paid more than $41 million[3] in medical Program claims.

Pharmacy Claims. Pharmacies submit claims information to the contractor, which immediately approves or denies the claims based on whether the drugs are included on the Program's list of approved drugs (formulary) and whether the quantities requested are appropriate. The Department provides prior authorization approval for certain drugs and helps resolve problems related to pharmacy claims; the Vendor Drug Program at the Health and Human Services Commission is responsible for reviewing pharmacy claims the contractor processes.

Auditors tested 30 Program expenditures for pharmacy claims the contractor processed during fiscal years 2011 and 2012. All 30 expenditures were for active clients; were paid to providers enrolled in the Program; had appropriate prior authorizations, if required; and were for allowable services. However, for one pharmacy expenditure, the client had other medical insurance coverage that should have been billed but was not billed. Title 25, Texas Administrative Code, Section 38.10(2), requires that other insurance be billed first. The other medical insurance provider was not billed because of an error in the Department's transmission of data to the contractor (see Chapter 5 for additional details).

Medical Claims. Medical providers submit medical claims to the contractor for processing. The contractor verifies whether a client is eligible for the Program, whether a claim is complete, and whether the claim meets the Program's requirements for payment.

While the Department performs several processes to monitor the contractor, most of those processes do not focus on paid medical claims. The Department did not implement its procedures to, on a quarterly basis, select and review a sample of at least 30 various medical claims (claims with different statuses,

[3] In addition to the $41 million in Program medical claims the contractor paid, Program expenditures included $13 million in payments to pharmacy and other service providers, $9 million in payroll expenditures, $6 million in other operating costs, and $5 million in payments to community-based contractors.

claims with different provider types, and high-dollar claims) that the contractor paid.

The Department performed 51 administrative reviews related to appealed claims during fiscal years 2011 and 2012. For 33 (65 percent) of those 51 reviews, the Department determined that the original action by the contractor was incorrect. That underscores the importance of proactively monitoring medical claims the contractor pays.

Auditors tested 60 Program expenditures from medical claims the contractor processed during fiscal years 2011 and 2012. All 60 expenditures were for active Program clients; were paid to providers enrolled in the Program; had appropriate prior authorization, if required; and were for allowable services. However, for one medical expenditure, the client had other medical insurance coverage the Department should have billed, but it could not provide evidence that it did so in accordance with Texas Administrative Code requirements.

Monitoring Activities. The Department has procedures for investigating appeals of denied claims, performing policy changes, and following up on claims affected by policy changes. However, Department procedures did not contain enough detail to guide other monitoring activities such as monitoring calls in the contractor's call center, enrolling providers, receiving prior authorizations, and reviewing various types of claims.

Auditors identified the following:

- The Department substantially complied with rules and procedures for performing an administrative review of denied claims a client or provider appealed. However, it did not comply with a requirement to communicate its appeal decision to the client or provider within 30 days for 1 (14 percent) of 7 administrative reviews that auditors tested (see text box for additional details.) In that case, the Department took 75 days to respond in writing. However, according to the Department, it kept the provider informed via the telephone.

- The Department designed a process for performing policy changes and following up on claims affected by these changes. According to the Department, it communicates policy changes to the contractor for implementation. When the contractor implements the policy changes, the Department reviews claims affected by the policy changes to help ensure that the contractor processes the claims appropriately. The Department provided an example of documentation to support that process, but documentation of all policy changes it made during the audit period was unavailable.

- The Department reviewed at least 10 client and provider calls, as required by its procedures, for 9 (75 percent) of 12 months in both fiscal years 2011 and 2012.

Texas Administrative Code Requirements for Appeals

If the Program receives a written request for administrative review within 30 days of the date of the notification, the Program shall conduct an administrative review of the circumstances surrounding the proposed action. The Program shall give the applicant, client, family, or provider written notice of the Program decision and the supporting reasons for the decision within 30 days of receipt of the request for administrative review.

Source: Title 25, Texas Administrative Code, Section 38.13 (a)(7).

- Auditors could not determine the frequency or adequacy of the Department's monitoring of provider enrollment or prior authorizations because the Department did not consistently maintain evidence of the monitoring activities it performed in those areas. However, the Department had evidence that it requested that the contractor correct certain issues the Department identified in those areas during its monitoring of the contractor.

Recommendations

The Department should:

- Implement its procedures to regularly review a sample of Program claims the contractor processes and pays.
- Ensure that its written procedures contain sufficient detail to guide the performance and documentation of all Program monitoring activities.
- Consistently perform and document all monitoring of the contractor that processes Program claims.

Management's Response

The Department agrees that monitoring of the contractor that processes and pays program claims can be strengthened. The Program understands that a variety of sampling yields the best results to evaluate the contractor's performance in adjudicating claims. Therefore, the Program will revise its claims monitoring and documentation procedures to include sampling methods in addition to the monitoring activities presently used by the Program. Additionally, the Program will review monitoring requirements with staff to ensure the requirements are understood, and the resulting monitoring is appropriately performed and documented.

Target Implementation date: April 1, 2014

Title of individual with responsibility for this response:
Purchased Health Services Unit Manager

Chapter 5

The Department Should Strengthen Certain Information Technology Controls

The Department has developed and implemented information technology controls over the Children with Special Health Care Needs Services Program Management Information System (CMIS); however those controls are not sufficient to ensure that Program data in CMIS is accurate. While auditors were generally able to reconcile data in CMIS with expenditures in the Department's accounting system and the contractor's Program claims data, auditors also identified the following:

- **Change management controls are weak.** The Department's change management process lacks segregation of duties because programmers can make programming changes and move those changes into the production environment. Title 1, Texas Administrative Code, Section 202.20(8), requires state agencies to ensure that there are adequate controls and separation of duties for tasks that are susceptible to fraudulent or other unauthorized activity.

- **Password controls for CMIS are weak.** CMIS passwords do not comply with Department requirements for expiration, minimum length, and complexity.

- **The Department has a generic user ID with high-level administrator access for user maintenance.** The use of that generic user ID does not provide for individual accountability for changes made in CMIS.

The Department asserted that it is replacing CMIS in 2014. The Department acknowledges the deficiencies in CMIS and reports that it plans to address the deficiencies described above in the new system.

In addition, the Department's process for transmitting Program claims data between the contractor and the Department has sufficient controls. However, the Department did not have adequate controls over the transmission of Program client eligibility data for pharmacy claims to the contractor from April 2011 through September 2012. Although the Department was aware there were problems with data transmission, it did not reconcile the data to verify the accuracy and completeness of file transmission. As a result, for one pharmacy expenditure that auditors tested, a Program client had other medical insurance coverage that should have been billed but was not billed (that expenditure also is discussed in Chapter 4).

Recommendations

The Department should:

- Implement segregation of duties in the change management process for CMIS.
- Strengthen password controls for CMIS to comply with Department requirements.
- Ensure that CMIS user IDs provide for individual accountability.
- Ensure that Program eligibility data it transmits to the claims payment contractor is complete and accurate.

Management's Response

The Department agrees that certain information technology controls can be improved. The first two recommendations are being addressed immediately. Processes have been implemented that require separation of duties when making changes to the CMIS application. The Program is working with Information Technology staff to ensure login passwords for the group of servers used to provide remote access to the application comply with Department requirements by October 31, 2013.The remaining recommendations will be fully addressed with the deployment of the new information system application in the summer of 2014.

Target Implementation date: Summer 2014

Title of individuals with responsibility for this response:
IT Application Development Unit Manager supporting Family & Community Health Support Branch
Purchased Health Services Unit Manager

Appendices

Appendix 1

Objectives, Scope, and Methodology

Objectives

The objectives of this audit were to:

- Determine whether the Department of State Health Services (Department) has designed and implemented effective processes and related controls for the Children with Special Health Care Needs Services Program (Program) to help ensure that only eligible persons receive services through the Program and that it manages the Program's waiting list in accordance with applicable laws, rules, and Department policies and procedures.

- Determine whether the Department has designed and implemented effective processes and related controls for the Program to help ensure that Program expenditures are allowable and made in accordance with applicable laws, rules, and Department policies and procedures.

Scope

The audit scope covered the time period from September 1, 2010, through September 1, 2012, and included Program client eligibility, the Department's management of the Program's waiting list, the Department's monitoring of the Program's community-based contractors, and the Department's monitoring of the contractor that processes and pays Program claims.

Methodology

The audit methodology included collecting information and documentation related to eligibility, waiting list management, and contractor monitoring processes. Auditors conducted interviews with Department and contractor personnel, observed processes, and analyzed accounting data and medical and pharmacy claims data. Auditors performed testing and evaluated the results. Auditors also reviewed Department policies and procedures, the Texas Administrative Code, and statutes.

Auditors selected random samples of the following:

- Expenditures from medical and pharmacy claims the Program paid, to test whether clients were eligible and whether expenditures were allowable.

- Expenditures from pharmacy claims the Program paid that required prior authorization, to test whether expenditures had appropriate prior authorization.

- Program clients older than age 21, to test whether the Department obtained the required physician assessment form and to verify client diagnoses.

- Denied Program claims that a client or provider appealed, to test whether the Program's appeals process was effective and adequately documented, and whether the Department processed appeals in accordance with the Texas Administrative Code and Department policy. Auditors stratified the sample of appeal reviews by fiscal year and type of review (for example, administrative reviews or quality reviews) to obtain equitable coverage of fiscal years 2011 and 2012 and of each type of review.

Auditors selected the following samples based on auditor judgment:

- Weekly vouchers the Department used to pay the contractor for Program medical claims, to test the accuracy of data in the Department's accounting system.

- Monthly Program community-based contractor payment vouchers, to test whether the Department reviewed and approved those vouchers prior to payment.

- Program and financial reviews the Department conducted at Program community-based contractors, to test whether the Department followed review guidelines and whether community-based contractors complied with client eligibility and expenditure requirements.

Auditors used non-statistical sampling methods to select samples. The results from the samples selected cannot be projected to the entire population.

Auditors concluded that the reliability of the data in the Department's Children with Special Health Care Needs Services Program Management Information System (CMIS) was of undetermined reliability. Auditors interviewed the Department and contractor staff with knowledge about that data, reviewed user access controls, performed general controls work, compared a sample of eligibility data to hard-copy support, and reconciled that data to the Department's accounting system. Because those procedures identified access control weaknesses and general controls weaknesses in CMIS, auditors determined that controls were not adequate to ensure that data in CMIS was accurate (see Chapter 5 for additional details). However, auditors were able to compare a sample of eligibility data to hard-copy support and reconcile expenditure data with the Department's accounting system within tolerable levels.

To assess the reliability of pharmacy claims data the Department's contractor provided, auditors reviewed the associated report on American Institute of Certified Public Accountants' Statement on Standards for Attestation Engagements No. 16 and reconciled detailed expenditure data to the

Department's accounting system. Auditors determined that the pharmacy claims data was sufficiently reliable for the purposes of this audit.

Auditors also relied on prior audit work the State Auditor's Office conducted to assess the reliability of Health and Human Services Administrative System (HHSAS) data and Medicaid Management Information System (MMIS) data. Auditors determined that HHSAS data and MMIS data was sufficiently reliable for the purposes of this audit.

Information collected and reviewed included the following:

- Population of all Program expenditures for fiscal years 2011 and 2012 from CMIS.
- Population of paid Program medical and pharmacy claims the contractor processed for fiscal years 2011 and 2012.
- Population of all Program expenditures from HHSAS for fiscal years 2011 and 2012.
- Population of all Program expenditures from the Uniform Statewide Accounting System (USAS) for fiscal years 2011 and 2012.
- List of valid International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes (codes for diagnoses and procedures) for the Program from CMIS.
- Program client physician assessment forms.
- Program client Texas residency documentation.
- Program client income documentation.
- Client applications for the Program.
- Initial determinations of client eligibility for Medicaid, the Children's Health Insurance Program (CHIP), or the Medicaid Buy-in for Children Program (MBIC).
- Program provider and pharmacy agreements.
- Program prior authorization approval and supporting documentation.
- List of clients on the Program waiting list for fiscal years 2011 and 2012.
- Documentation of Program expenditures data the Department submitted to its actuary.
- User access lists for network drives and CMIS.

- Department organizational chart.
- Proposals for providing limited services to clients on the Program waiting list and proposals for removing clients from the Program waiting list, as well as supporting documentation, for fiscal years 2011 and 2012.
- General Appropriations Acts (81st and 82nd Legislatures).
- Monthly Program expenditure and budget reports for fiscal years 2011 and 2012.
- List of proposals for providing limited services to clients on the Program waiting list and proposals for removing clients from the Program waiting list.
- List of Program client status changes in CMIS for fiscal years 2011 and 2012.
- Audit log of all changes to Program clients' statuses in CMIS.
- Program medical and pharmacy fee schedules.
- Population of Program claims appealed to the Department.

Procedures and tests conducted included the following:

- Tested a sample of paid Program claims for physician assessment forms; Texas residency documentation; verification of income; associated applications; determination of client eligibility for Medicaid, CHIP, or MBIC; provider agreements; prior authorizations (if required); and allowability of services.
- Compared Program expenditures in CMIS, Program expenditures in HHSAS, Program expenditures in USAS, and paid Program claims the Department's contractor processed.
- Reviewed clients' rankings on the Program waiting list.
- Reviewed the query language the Department used to extract data from CMIS to submit to the actuary that makes monthly Program expenditure projections.
- Reviewed the Department's process for preparing Program expenditure data to submit to the Department's actuary.
- Reviewed network user access related to Program expenditure data.
- Reviewed proposals for providing limited services to clients on the Program waiting list and proposals for removing clients from the Program

waiting list to determine whether the types of service to be provided to clients were reasonable based on supporting documentation.

- Compared Program expenditures to available Program funds.
- Verified that Program amounts used in the Department's expenditure/budget report accurately reflected the Program's budget.
- Reviewed Program client status changes from the CMIS audit log to determine whether those changes were appropriate.
- Recalculated all proposals for removing clients from the Program waiting list to determine whether the Department correctly determined the number of clients to remove from the waiting list.
- Reviewed file transfer protocols for data transfers between the Program and the contractor that processes claims and eligibility changes.
- Reviewed Program policies and procedures.
- Reviewed the Program's monitoring of the contractor that processes and pays Program claims.
- Reviewed the Department's monitoring of the Program's community-based contractors.

Criteria used included the following:

- Texas Health and Safety Code.
- Texas Administrative Code.
- The Department's *Program Eligibility Procedures Manual*.
- The Department's *Program Medical and Program Policy Manual*.
- Federal poverty levels from the U. S. Department of Health and Human Services.
- Department policies and procedures.
- Program fee schedules.

Project Information

Audit fieldwork was conducted from January 2013 through July 2013. 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.

The following members of the State Auditor's staff performed the audit:

- Michael F. Boehme, CIA, PHR (Project Manager)
- Hillary Eckford, CIA (Assistant Project Manager)
- Ishani Baxi, CIDA
- Nick Cadena
- Brian Jones
- Melissa Jones, CGAP
- Marlen Randy Kraemer, MBA, CISA, CGAP
- Nicole McClusky-Erskine
- Kelley Ngaide, CIA, CFE
- Tony White, CFE
- Charles P. Dunlap, Jr., CPA (Quality Control Reviewer)
- Nicole M. Guerrero, MBA, CIA, CGAP, CICA (Audit Manager)

Appendix 2

Information on Program Clients Served in Fiscal Year 2012

Table 1 summarizes information regarding the income levels of clients in the Department of State Health Services' (Department) Children with Special Health Care Needs Services Program (Program) in fiscal year 2012.

Table 1

Program Client Income Information Fiscal Year 2012		
Income as a Percent of the Federal Poverty Level	**Number of Clients Served**	**Percent of Clients Served**
100% and less	1,167	62.24%
101% to 150%	453	24.16%
151% to 200%	222	11.84%
201% or above [a]	33	1.76%
Totals	**1,875**	**100.00%**

[a] Proof of spenddown is required for all clients above 200 percent of the federal poverty level (FPL). Spenddown is defined as financial eligibility achieved when household income exceeds 200 percent of the FPL, if the client's family can document its responsibility for household medical bills that are equal to or greater than the amount in excess of 200 percent of FPL.

Source: The Department.

Table 2 summarizes information regarding the medical insurance held by the clients in the Program in fiscal year 2012.

Table 2

Program Client Medical Insurance Information Fiscal Year 2012		
Type of Insurance [a]	**Number of Clients Served**	**Percent of Clients Served**
Medicaid	106	5.65%
Children's Health Insurance Program (CHIP)	56	2.99%
Private Insurance	53	2.83%
None	1,660	88.53%
Totals	**1,875**	**100.00%**

[a] The Program requires that clients potentially eligible for Medicaid or CHIP apply to those programs, and the Program is the payer of last resort. A client who is eligible to receive Program services who has an alternate form of insurance may still be covered by the Program to cover services that are not covered by the client's primary insurance type.

Clients may be eligible for more than one type of coverage (Medicaid, CHIP, or private insurance) at different times in the reporting year. Any clients who were eligible for Medicaid at any time in the year were included in this table under Medicaid. From the remaining client pool, any client who was eligible for CHIP at any time in the year was included in this table under CHIP. All remaining clients who had private insurance were included under private insurance in this table, and all clients with no other coverage during the year were listed under none in this table.

Source: The Department.

Table 3 summarizes citizenship information regarding the clients in the Program in fiscal year 2012.

Table 3

Program Client Citizenship Information Fiscal Year 2012		
Citizenship [a]	Number of Clients Served	Percent of Clients Served
Citizen/Legal Resident	289	15.41%
Non-citizen	1,586	84.59%
Unknown	0	0.00%
Totals	**1,875**	**100.00%**

[a] The Program is a maternal and child health block (Title V) program. Clients are not required to produce proof of citizenship to be provided health services under Title V. Clients voluntarily self-report citizenship/legal residency at the time of application, and the accuracy of that information is not validated.

Source: The Department.

Copies of this report have been distributed to the following:

Legislative Audit Committee

The Honorable David Dewhurst, Lieutenant Governor, Joint Chair
The Honorable Joe Straus III, Speaker of the House, Joint Chair
The Honorable Thomas "Tommy" Williams, Senate Finance Committee
The Honorable Jim Pitts, House Appropriations Committee
The Honorable Harvey Hilderbran, House Ways and Means Committee

Office of the Governor

The Honorable Rick Perry, Governor

Health and Human Services Commission

Dr. Kyle L. Janek, Executive Commissioner

Department of State Health Services

Dr. David L. Lakey, Commissioner