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An Audit Report on

The Health and Human Services Commission's Administration of Home Health Services within the Texas Health Steps Program

September 2012

Report No. 13-005



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Overall Conclusion

The Health and Human Services Commission (Commission) paid \$612.4 million for home health services that clients received through the Texas Health Steps program in fiscal year 2011. (See text box for additional information and Appendix 2 for detailed descriptions of each type of home health service.)

Issues Regarding Personal Care Services

Among the various types of home health services that clients can receive, personal care services present the highest risk of inefficient or inappropriate use of resources. The levels of personal care services that clients receive are determined using unverified information that clients' parents or guardians provide about barriers that prevent them from caring for the clients themselves. In addition, the attendants who deliver personal care services are not regulated by professional boards and are often members of a client's family. The Commission should significantly strengthen its oversight of personal care services in the following areas:

- **Obtaining required documentation of prospective clients' medical need for personal care services.** Case managers from the Department of State Health Services (Department) conduct assessments of prospective clients for personal care services, and they are required to obtain practitioners'¹ statements indicating that prospective clients have a medical need for personal care services. However, 28 (23 percent) of 120 personal care

Background Information

This audit focused on home health services provided through the Comprehensive Care Program within the Texas Health Steps program.

Home health services include:

- **Personal care services.** In fiscal year 2011, 10,980 clients received personal care services, and expenditures for those services totaled \$105.8 million.
- **Therapy services.** In fiscal year 2011, 24,461 clients received therapy services, and expenditures for those services totaled \$136.7 million.
- **Private duty nursing.** In fiscal year 2011, 4,051 clients received private duty nursing, and expenditures for those services totaled \$369.9 million.

Because this is a Medicaid program, the federal government pays for approximately 60 percent of the cost of these services, and the State pays for the remaining 40 percent.

While the Health and Human Services Commission (Commission) is responsible for the administration and oversight of home health services, other entities perform certain functions related to home health services. Specifically:

- The Department of State Health Services performs case management services for the personal care services benefit.
- The Department of Aging and Disability Services licenses, inspects, investigates, and sanctions the providers that deliver most home health services.
- The Texas Medicaid & Healthcare Partnership (TMHP) is the Commission's contracted Medicaid claims administrator, and it processes authorizations and pays claims for home health services.

Source: Unaudited information provided by the Commission from the Medicaid Management Information System.

¹ According to the *Texas Medicaid Provider Procedures Manual*, a licensed physician, advanced practice registered nurse, or physician assistant must sign a statement of need.

services client case files that auditors tested had no practitioner statements indicating that the clients had a medical need for personal care services. In contrast, medical need documentation was not obtained for 4 (7 percent) of 60 selected claims for therapy services and private duty nursing services.²

- **Collecting and analyzing information about diagnoses and practitioners for clients who receive personal care services.** This could enable the Commission to understand the growth of those services and the significant differences in the use of those services in different parts of the state.
- **Monitoring attendants for clients who receive personal care services.** When a client receives personal care services, an attendant assists the client with the activities of daily living, such as bathing and dressing. However, the Department does not verify that the attendant delivered those services.

Issues Regarding All Texas Health Steps Program Home Health Services

For all types of home health services, the Commission should strengthen the oversight of its contracted claims administrator to ensure that it pays only valid claims. Auditors identified payment errors in 38 (23 percent) of 165 judgmentally selected home health services claims that the Commission's contracted claims administrator (the Texas Medicaid & Healthcare Partnership, or TMHP) paid in fiscal year 2011. Those errors resulted in overpayments totaling \$15,141 (19 percent) of the \$81,206 in claims tested. The Commission should ensure that TMHP corrects errors in its processes that resulted in TMHP making multiple payments for the same service and paying for more services than were authorized.

Auditors communicated other, less significant issues to the Commission and the Department in writing. Those issues involved inconsistent use of therapy payment rates and authorization periods, supervisory reviews of personal care services case files, data errors in the personal care services case management system, contract monitoring, and minor billing errors.

Key Points

The Commission should ensure that the Department consistently establishes clients' medical need for personal care services.

As discussed above, 28 (23 percent) of 120 personal care services case files did not contain a statement from a practitioner establishing the clients' medical need for those services. Those statements are required by Title 1, Texas Administrative Code, Section 363.605. The files contained evidence that Department case managers often made repeated attempts to obtain those statements. However, the Commission and the Department did not terminate services when they did not

² For those four claims, managed care organizations referred clients for home health services.

obtain a practitioner's statement within 60 days of the start of service (as provided for in the Texas Administrative Code).

In addition, when practitioner statements were in the case files, the statements were not always related to clients' need for personal care services. Department case managers also do not obtain documentation indicating that practitioners who sign those statements are familiar with the clients' conditions, as required by Title 1, Texas Administrative Code, Section 363.605.

In the absence of a statement from a practitioner, information about a client's medical need comes from a case manager's assessment of the client. However, case managers are not trained to diagnose clients' conditions. In two cases that auditors sampled, case managers authorized personal care services based on discussions with parents and on their own observations, but they later received practitioners' statements indicating that the clients did not have conditions that made them eligible for personal care services. Those cases underscore the importance of obtaining a practitioner's statement regarding the needs of personal care services clients.

The Commission should ensure that the Department verifies information that parents or guardians provide because that information affects the amount of personal care services a client receives.

The Department does not have a policy requiring case managers to ask for verification of the information that parents and guardians provide regarding barriers that prevent them from caring for the clients themselves. Case managers ask for verification of that information only when there are inconsistencies in what parents and guardians say or when what they say is not supported by the case manager's observations. Case managers usually do not verify information about barriers—such as employment, education, or medical conditions—that parents or guardians report prevent them from being able to care for their own children. Verification of those barriers is important because they are a key part of a case manager's determination of the amount of personal care services to authorize.

The Commission and the Department should collect and analyze information to improve monitoring of personal care services.

Information about clients' diagnoses and need for personal care services is available only in hard-copy form in case files at the Department's regional offices. That information is not captured in an automated system and, therefore, it is not available for analysis.

Having information about clients' diagnoses that could be analyzed would enable the Commission and the Department to better understand growth and changes in the program. For example:

- Personal care services expenditures increased from \$27 million in fiscal year 2008 to almost \$106 million in fiscal year 2011.

- After an enhanced payment rate for behavioral diagnoses was implemented in June 2009, personal care services expenditures for clients with behavioral diagnoses increased to 57 percent of total personal care services expenditures in fiscal year 2011.
- Department regions vary widely in the amount of personal care services they authorize. The south Texas region (Harlingen) had significantly more expenditures for personal care services than any other region in fiscal year 2011.

The Commission and the Department should collect and review information about the identities of individuals who serve as attendants for personal care services clients.

The Commission and the Department do not collect information about the identity of paid attendants who provide services directly to personal care services clients. Not analyzing that information increases the risk that the Commission could pay individuals who are ineligible to serve as paid attendants to personal care services clients. In a limited sample, auditors identified seven parents or guardians who served as personal care services paid attendants for their own children. That was a violation of federal regulations, state regulations, and the Department's policy.

Collecting and analyzing information on paid attendants also would help the Commission ensure that clients receive appropriate services and that it spends Medicaid funds effectively.

Auditors also identified specific ways in which the Commission should strengthen the claims payment process for all types of home health services.

To strengthen the claims payment process for all types of home health services, the Commission should:

- Address weaknesses in TMHP's claims processing that resulted in overpayments.
- Assign billing codes for different categories of expenditures.
- Ensure that TMHP makes payments only to providers with valid licenses.

Summary of Management's Response

The Commission and the Department generally agreed with the recommendations in this report, and management's full response is presented in Appendix 6 of this report.

Summary of Information Technology Review

The Medicaid Management Information System (MMIS) is TMHP's claims processing system. Auditors interviewed TMHP staff, reviewed access controls to certain

applications within that system, reviewed controls over migration and storage of claims information in the data warehouse for that system, and tested the operating effectiveness of selected edit checks to assess the reliability of data in the system. Auditors also reviewed user access to several applications within the system and determined that TMHP did not ensure appropriate segregation of duties among users to prevent unauthorized changes that could result in inappropriate payments.

Summary of Objective, Scope, and Methodology

The objective of this audit was to determine whether the Commission and the Department have controls to help ensure that home health providers enrolled in the Texas Health Steps program are:

- Qualified according to applicable policies and procedures.
- Monitored for accurate and appropriate service delivery.
- Sanctioned or removed from provider rolls as appropriate.

The scope of this audit covered Texas Health Steps program personal care services, private duty nursing, and therapy services authorized and provided to clients during fiscal years 2010 and 2011.

The audit methodology included reviewing policies and procedures, and rules related to Texas Health Steps program home health services; interviewing staff at the Commission, the Department, the Department of Aging and Disability Services, and TMHP; and reviewing documentation of medical need for home health services.

Auditors also tested personal care services case files at Department regional offices and reviewed employee records and supporting documentation for home health services claims at 10 providers. Based on a review of MMIS controls described in the Summary of Information Technology Review above, auditors determined that data in that system was sufficiently reliable for the purposes of this audit.

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Detailed Results

Chapter 1

The Commission and the Department Should Strengthen Processes for Eligibility, Monitoring, and Attendant Assignment for the Personal Care Services Portion of Home Health Services

The Health and Human Services Commission (Commission) and the Department of State Health Services (Department) should strengthen processes for eligibility determination, monitoring, and attendant assignment for the personal care services portion of home health services provided through the Texas Health Steps program. Specifically, the Commission and the Department should:

Personal Care Services

Personal care services are Texas Medicaid benefits that assist eligible clients who require assistance with activities of daily living because of a physical, cognitive, or behavioral limitation related to their disability, physical or mental illness, or chronic condition.

Eligible clients:

- Are younger than 21 years of age.
- Are enrolled in Medicaid.
- Have physical, cognitive, or behavioral limitations related to a disability or chronic health condition that inhibits their ability to accomplish activities of daily living.

If a client meets the above criteria, Department case managers determine the level of personal care services by considering the parent's or guardian's:

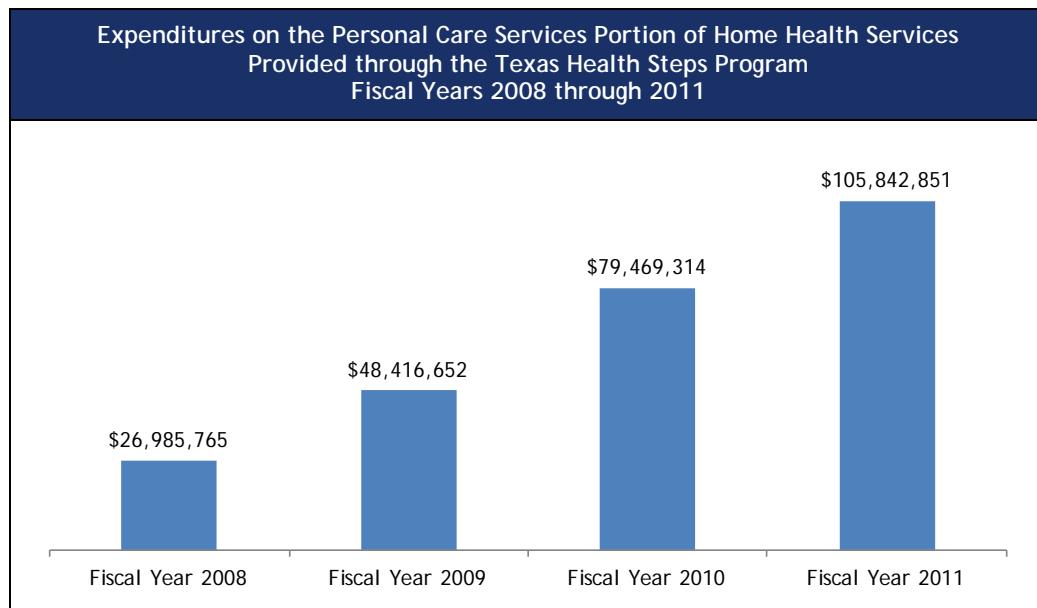
- Need to sleep, work, attend school, or meet his or her own medical needs.
- Ability to meet the needs of other dependents.
- Physical ability to perform the personal care services.

Source: The Department's *Personal Care Services Handbook*.

- Ensure that case managers obtain the required practitioner's statement regarding a client's need for personal care services and verify that barriers prevent the client's parents or guardians from providing care themselves.
- Collect and analyze information about client diagnoses and practitioners who sign statements indicating clients have a need for personal care services. For example, this could help the Commission and the Department understand why, after an enhanced payment rate for behavioral diagnoses was implemented in June 2009, expenditures for clients with those diagnoses grew to 57 percent of all personal care service expenditures in fiscal year 2011. Collecting and analyzing information about diagnoses and practitioners also could enable both agencies to focus policies, training, and monitoring to ensure Medicaid funds are spent effectively and efficiently.
- Maintain information about the individuals who serve as paid attendants for personal care services clients to help ensure that only appropriate individuals serve as attendants.

The State spent \$105,842,851 in Medicaid funds on personal care services in the Texas Health Steps program in fiscal year 2011. In addition, as Figure 1 shows, there has been significant growth in expenditures on personal care services since fiscal year 2008. When a client receives personal care services, a paid attendant assists the client with the activities of daily living, such as bathing and dressing.

Figure 1



Source: Unaudited expenditure information provided by the Commission from the Medicaid Management Information System.

Chapter 1-A

The Commission and the Department Should Strengthen Processes for Establishing Medical Need and Conducting Assessments for Personal Care Services

Department case managers determine a prospective client's eligibility for personal care services and the amount of personal care services to provide through two processes:

- Establishing the prospective client's medical need for personal care services by obtaining a statement from a practitioner.
- Establishing through a case manager's assessment that the prospective client's parents or guardians have barriers that prevent them from assisting the clients with activities of daily living themselves.³

³ The case manager also determines the specific activities of daily living with which a client needs help during the assessment.

The Commission and the Department should address weaknesses in both of those processes to better ensure that they provide appropriate levels of personal care services to eligible clients.

The Commission and the Department should improve compliance with the requirement to obtain practitioner statements regarding clients' need for personal care services.

Case managers do not always obtain required practitioner statements regarding clients' need for personal care services. A total of 28 (23 percent) of a sample of 120 personal care services case files that auditors tested had no practitioner statement indicating that the client had a need for personal care services, as required by Title 1, Texas Administrative Code, Section 363.605. While the files contained evidence that case managers often made repeated attempts to obtain those statements⁴, the Commission and the Department did not terminate services when they did not obtain a practitioner's statement within 60 days of the start of service in accordance with Title 1, Texas Administrative Code, Section 363.605.

Practitioner statements were not always related to prospective clients' need for personal care services. The practitioner statements that auditors reviewed sometimes listed conditions that were not related to the conditions that parents or guardians reported during case managers' assessments of clients for personal care services. For example:

- One case file that auditors sampled documented client conditions that the parent reported, including depression, intellectual disability, and attention deficit hyperactivity disorder. However, the practitioner's statement in that client's file included a single condition: "abnormal gait."
- In two other case files that auditors sampled, the practitioner's statements did not include any diagnoses.

In part, this issue may be a result of the Department's policy that case managers are required to obtain the practitioner's statement from a client's primary care practitioner; however, other practitioners who are specialists treating the client may be the practitioners who are most familiar with the conditions that make the client eligible for personal care services. Department staff asserted that primary care practitioners may hesitate to sign statements for conditions that other specialists are treating.

⁴ Auditors tested 60 of the 120 personal care services files sampled for evidence that case managers had made attempts to obtain practitioner statements when they did not initially receive those statements. For 31 of those 60 files, case managers did not receive a practitioner's statement within 60 days, and 29 of those 31 files contained evidence indicating that case managers attempted to obtain those statements.

Case managers do not obtain evidence that the practitioner who signs a statement regarding a client's need for personal care services is familiar with the client's conditions. Title 1, Texas Administrative Code, Section 363.605, requires "a practitioner with ongoing clinical knowledge of, and a therapeutic relationship with, the beneficiary" to sign the statement indicating that a client has a need for personal care services. However, the Commission and the Department do not require case managers to collect and maintain evidence of compliance with that requirement in personal care services case files. None of the case files auditors sampled that included practitioner statements contained evidence that the practitioner had an ongoing clinical relationship with the client.

Practitioners who sign statements regarding clients' need for personal care services are not always qualified to do so. Two (2 percent) of 92 individuals who signed the statements of need in auditors' sample were not qualified to provide medical diagnoses for clients. In those cases, the statements were signed by a non-certified radiologic technician with an expired license and a physician in training. The *Texas Medicaid Provider Procedures Manual* specifies that only licensed physicians, advanced practice registered nurses, or physician assistants can sign those statements. The Commission and the Department do not review the credentials of the individuals who sign the statements to ensure that they are qualified to sign (see Chapter 1-B for additional details).

The Commission and the Department should strengthen the client assessment process for personal care services.

A prospective client who wishes to receive personal care services must undergo an assessment conducted by a Department case manager. When case managers do not obtain a practitioner's statement regarding need (as discussed above), evidence of a client's medical need for personal care services comes from (1) statements made by the prospective client's parent or guardian and (2) a case manager's direct observation of the prospective client during an assessment.

Case managers who perform the assessments receive two important types of information from the prospective client's parents or guardians:

- Information about the prospective client's conditions and needs.
- Information about barriers that prevent the parent or guardian from caring for the prospective client.

Case managers usually do not verify information obtained during assessments. The Department does not require case managers to ask for verification of the information that parents and guardians provide about a prospective client's eligibility unless there are inconsistencies in what those individuals say or unless what they say is not supported by the case manager's observations. Case managers can compare parents' and guardians' statements regarding a prospective client's conditions and needs to their own observations of a

prospective client. However, case managers are usually licensed social workers, rather than medical professionals, and, therefore, are not qualified to make a diagnosis.

In two cases that auditors sampled, case managers authorized personal care services based on discussions with parents and on their own observations, but they later received practitioners' statements indicating that the clients did not have conditions that made them eligible for personal care services. Those cases illustrate the risk of relying on case managers' observations and discussions with parents and guardians to establish medical need for personal care services, and they underscore the importance of obtaining the required practitioner statement of need.

In addition, case managers usually do not verify information about barriers⁵ that parents or guardians report prevent them from being able to care for their own children, such as employment, education, or medical conditions.

Verification of parents' and guardians' barriers is important because the nature of the barriers is a key part of a case manager's determination of the amount of personal care services to authorize. If case managers had access to the Texas Integrated Eligibility Redesign System (TIERS)—the eligibility determination system for a variety of public assistance programs—they could verify parents' or guardians' assertions about whether other individuals in the household are available to help care for their children. That could help case managers to verify the extent of the barriers that parents and guardians report and determine the appropriate level of personal care services for a client.

Some personal care services providers solicit and may coach the parents or guardians of prospective clients on assertions they should make during case managers' assessments. The absence of a Department policy requiring case managers to verify the information that parents and guardians provide is especially important because some personal care services providers solicit and may coach the parents or guardians of prospective clients on the best responses to case managers' questions during an assessment. Department regional staff informed auditors about instances in which providers solicited prospective clients with pamphlets and radio ads, often promising to maximize personal care services for prospective clients who choose them as providers.

Additionally, Department case managers informed auditors that they routinely heard phrases from parents and guardians during assessments that indicated that those individuals could have been coached by someone familiar with the terminology of personal care services. For example, Department staff in two regions informed auditors that, during assessments, parents would often say that their children needed "cueing and redirecting" because of an attention

⁵ Barriers include the parent's or guardian's (1) need to sleep, work, attend school, and meet their own medical needs; (2) legal obligation to care for, support, and meet the medical, educational, and psycho-social needs of their other dependants; and (3) physical ability to perform the personal care services.

deficit disorder. Those terms are included in the assessment form that case managers use, but it would be unusual to hear them in a consistent manner from parents when they are describing their children's conditions and needs.

It is important to note that, when parents and guardians use phrases indicating their children have attention deficit disorder, case managers categorize the conditions as behavioral conditions in their assessments. Behavioral conditions qualify for a higher payment rate to the provider (see Chapter 1-B for additional details). The potential for providers to solicit and coach parents or guardians of prospective clients reinforces the importance of case managers obtaining the required practitioner's statement regarding a client's need for personal care services.

Individuals who are denied personal care services may request another assessment without waiting for a specified period of time. There is no requirement that an individual to whom a case manager has denied personal care services as a result of an assessment must wait for a specified period of time before requesting another assessment. Department staff informed auditors that some parents or guardians have requested assessments immediately after a case manager has determined that their children are not eligible for personal care services. Performing repeated assessments for the same individual is not an efficient use of resources, especially considering that prospective clients have access to a fair hearing process when they believe they have been denied services in error.⁶ Additionally, allowing repeat assessments may foster a sense that parents or guardians can "shop" for a case manager who will determine a client is eligible. This possibility reinforces the importance of case managers obtaining the required practitioner's statement regarding a prospective client's need for personal care services.

Recommendations

The Commission and the Department should:

- Provide personal care services only to clients for whom they receive a practitioner statement of need within 60 days of the start of service, in accordance with Title 1, Texas Administrative Code, Section 363.605.
- In the absence of a practitioner statement of need, begin termination of personal care services after 60 days from the start of services.
- Revise the practitioner statement of need for personal care services so that it relates directly to conditions that qualify a client for those services, and

⁶ According to Title 1, Texas Administrative Code, Section 363.605, clients have access to a fair hearings process when case managers determine that they are not eligible for personal care services or when clients feel the level of services they are receiving is too low.

indicate on the statement whether the practitioner has an ongoing therapeutic relationship with the client.

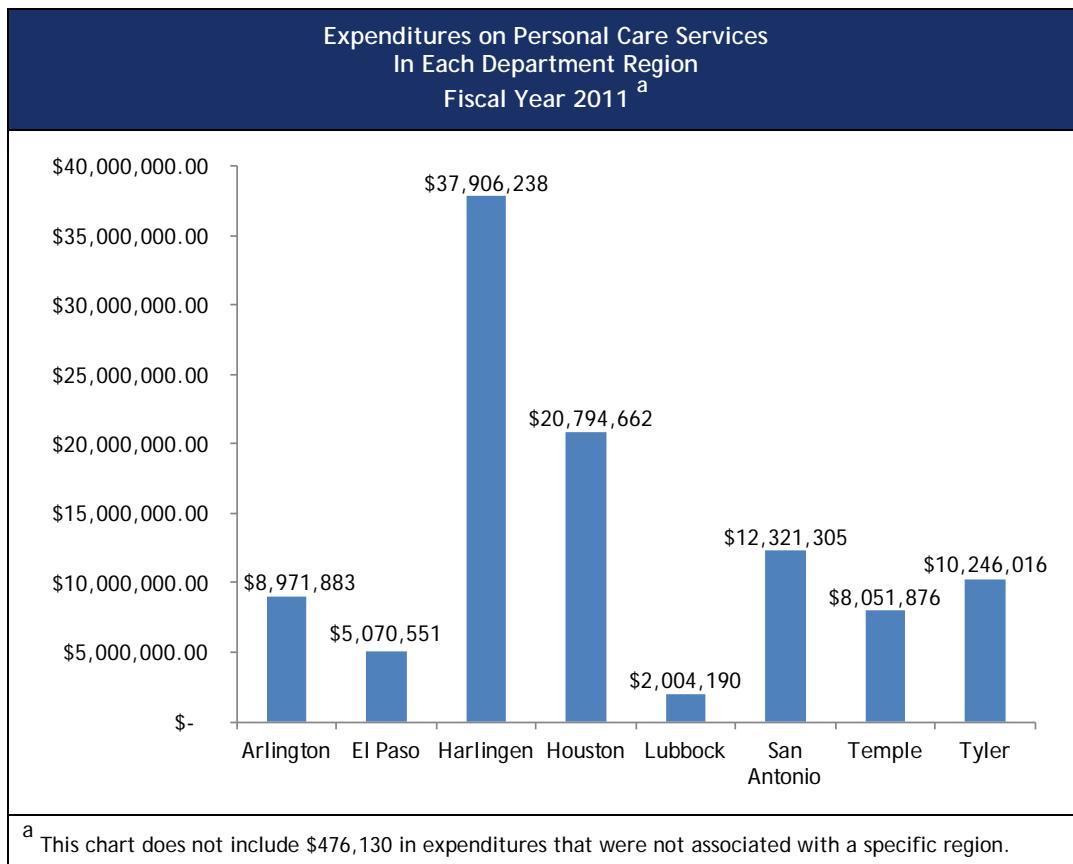
- Request a practitioner statement of need from a practitioner most familiar with the conditions that may make a client eligible for personal care services.
- Ensure that each individual who signs a practitioner statement of need has a valid license and is qualified to determine a client's need for personal care services.
- Require case managers to verify the barriers that parents and guardians report prevent them for caring for their children.
- Consider making information from TIERS available to all case managers to help them to verify information reported by parents and guardians of prospective personal care services clients.
- Consider establishing a waiting period for an individual who requests subsequent assessments after a case manager has determined the individual is not eligible for personal care services.

Chapter 1-B

The Commission and the Department Should Improve Monitoring of Personal Care Services by Collecting and Analyzing Information

The Commission and the Department should improve monitoring of personal care services by collecting and analyzing information about clients' diagnoses and practitioners. Collecting and analyzing that information would help the Commission and the Department better understand the growth of personal care services since fiscal year 2008, and it could help explain significant differences in the use of personal care services in different parts of the state. Figure 2 shows the fiscal year 2011 personal care services expenditures within each of the Department's eight administrative regions. (See Appendix 3 for additional information on personal care services and case managers in the Department's regions.)

Figure 2



Source: Unaudited expenditure information provided by the Commission from the Medicaid Management Information System.

Four Entities Are Responsible for Administering Personal Care Services

Four entities are responsible for administering various aspects of personal care services provided through the Texas Health Steps program. Specifically:

- The Commission is responsible for policy development and provider contract oversight.
- The Department of State Health Services conducts client assessments, authorizes personal care services, and maintains client case files.
- The Department of Aging and Disability Services licenses the providers that deliver personal care services and inspects those providers every 36 months.
- The Texas Medicaid & Healthcare Partnership (TMHP), which is the Commission's contracted Medicaid claims administrator, reviews and pays providers' claims for personal care services (see Chapter 2 for additional details).

Responsibility for administering personal care services is divided across multiple agencies (see text box). The Commission has not assigned overall responsibility for the administration of all aspects of personal care services to any single program manager, which could increase the difficulty in monitoring regional differences, growth, and other trends in personal care services. Assigning overall responsibility for personal care services to a single program manager could help the Commission enhance the administration of personal care services, provide guidance, and better ensure the efficient use of Medicaid funds.

The Commission and the Department should collect and analyze information on clients' diagnoses to improve monitoring of personal care services.

The Commission and the Department do not analyze information on personal care services clients' diagnoses. Personal care services case files usually contain some information about a client's diagnosis that was the basis for establishing the client's medical need for personal care services. However, that information is available only in hard-copy form in case files at the Department's regional offices. That information is not captured in an automated system and, therefore, it is not available for analysis. Having information about clients' diagnoses that could be analyzed would enable the Commission and the Department to better understand the growth in personal care services and focus policies

and training to ensure that Medicaid funds are spent effectively and efficiently.

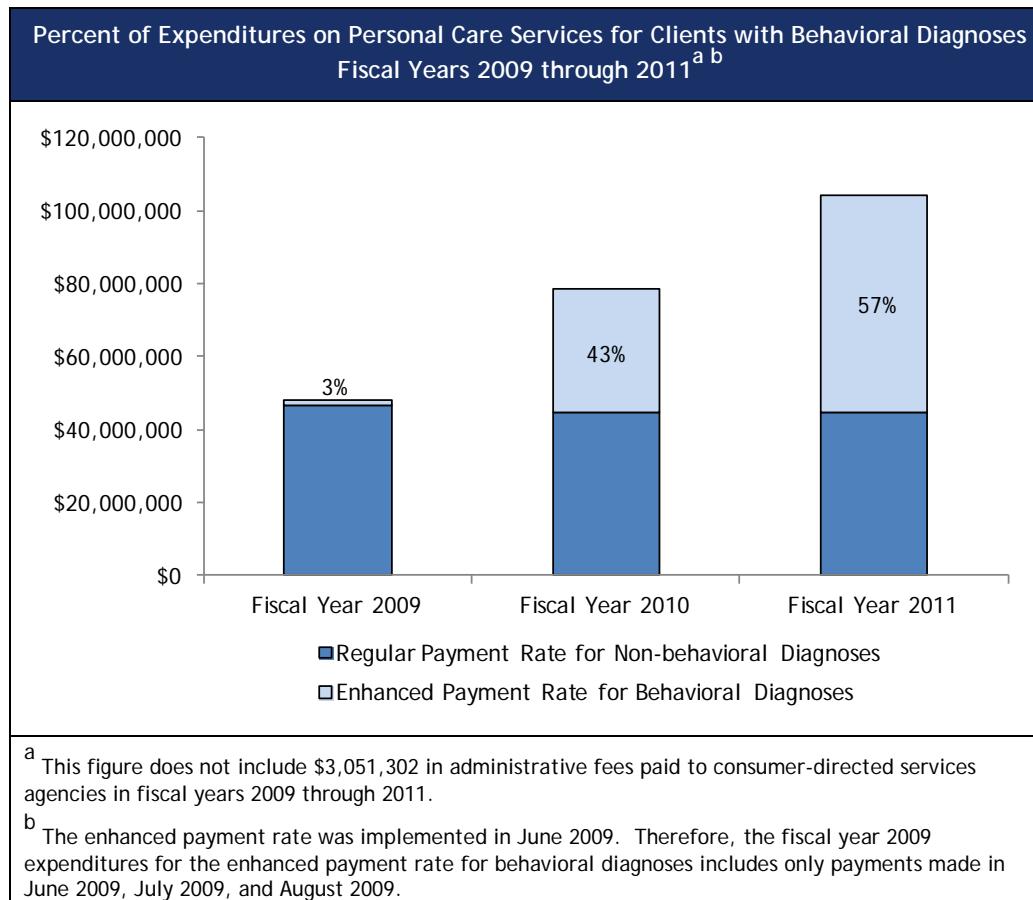
For example, staff in one of the Department's regional offices informed auditors that attention deficit hyperactivity disorder is a common diagnosis in that region and is sometimes the sole diagnosis qualifying a client for personal care services. However, because they do not collect diagnosis information in a form that could be analyzed, the Commission and the Department are unable to determine how common that diagnosis is and whether it is commonly associated with certain geographic regions, practitioners, and/or providers.

Receiving personal care services for behavioral diagnoses is becoming more common. Monitoring information on diagnoses is important because, according to payment information in the Medicaid Management Information System, as of fiscal year 2011, the majority of personal care services expenditures were for clients with behavioral diagnoses.⁷ The provider payment rate for a client with a behavioral diagnosis is higher than the provider payment rate for a client with a non-behavioral diagnosis.

⁷ As discussed above, the Commission does not collect information on specific diagnoses in an automated system; however, it pays providers of personal care services for all clients with behavioral diagnoses at a higher rate. Therefore, payments for personal care services for all clients with behavioral diagnoses are identifiable in Medicaid payment data.

As Figure 3 shows, after an enhanced payment rate for behavioral diagnoses was implemented in June 2009, expenditures for personal care services clients with a behavioral diagnosis increased to 57 percent of all personal care services expenditures in fiscal year 2011. (See Appendix 4 for additional information on payment rates for home health services.)

Figure 3



Source: Unaudited expenditure information provided by the Commission from the Medicaid Management Information System

The Commission asserts that it expected a significant growth in personal care services after it began providing those services to clients with behavioral diagnoses in September 2007. However, the growth in behavioral diagnoses also may be related to the implementation of the enhanced payment rate, as well as issues discussed in Chapter 1-A:

- Case managers may not obtain a practitioner statement of need, or that statement may not relate to client behavioral conditions that parents and guardians report.

- Providers may coach prospective clients to maximize the amount of personal care services that are paid at the higher payment rate for behavioral conditions.

In a sample of 34 case files for clients with behavioral conditions (and for which the provider received a higher payment rate):

- Eight files (24 percent) had no statement from a practitioner indicating a need for personal care services.
- Six files (18 percent) had a practitioner's statement of need that did not relate to the behavioral conditions that the clients' parents or guardians had reported.

If a case manager documents a behavioral condition based on information that a parent or guardian reports or on their own observations during a client assessment, that client's provider will be paid at the higher payment rate, regardless of the conditions specified on the practitioner's statement. This could create an incentive for providers to coach parents and guardians to emphasize behavioral conditions during the client assessment.

The Commission and the Department should collect and analyze information about practitioners who sign statements of need for personal care services clients.

Collecting information regarding the practitioners who sign statements of need for personal care services clients would enable the Commission and the Department to more easily check the credentials and licensure status of those practitioners. It would also enable them to identify (1) whether specific providers routinely rely on a specific practitioner to establish medical need for their clients and (2) trends in practitioners' use of certain diagnoses. The results of those efforts could help the Commission and the Department ensure that only eligible clients receive personal care services.

The Commission and the Department also could use that information to better target provider monitoring and training efforts and to develop policies to address changes in the use of personal care services.

Recommendations

The Commission should consider assigning overall responsibility for the administration of all aspects of personal care services to a single program manager.

The Commission and the Department should:

- Collect and analyze information on clients' diagnoses to improve monitoring of personal care services.

- Authorize the higher payment rate for behavioral conditions only when the practitioner's statement of need indicates that a client has a behavioral condition that qualifies the client for personal care services.
- Collect and analyze information about practitioners who sign statements of need for personal care services clients to verify credentials and licensure status, and to identify potential relationships between specific practitioners and specific providers and/or diagnoses.

Chapter 1-C

The Commission and the Department Should Ensure that Providers Assign Eligible and Appropriate Attendants to Care for Personal Care Services Clients

The Commission and the Department should collect and analyze information regarding paid attendants for personal care services.

The Commission and the Department do not collect information about the identity of paid attendants who provide services directly to personal care services clients. Not analyzing that information increases the risk that the Commission could pay individuals who are ineligible to serve as paid

attendants to personal care services clients. Collecting and analyzing information on paid attendants would help the Commission ensure that clients receive appropriate services and that it spends Medicaid funds effectively and efficiently.

Prohibitions on Parents and Guardians Serving as the Paid Attendants for Their Own Children

- Title 42, Code of Federal Regulations, Section 440.167, specifies that personal care services must be provided by an individual who is not a member of the client's family (defined as a legally responsible relative).
- Title 1, Texas Administrative Code, Section 363.603, specifies that personal care services must be provided by an individual who is not a legal or foster parent or guardian of the beneficiary who is a minor child.
- The Department's *Personal Care Services Manual* specifies that a personal care services attendant cannot be the legal parent, legal guardian, stepparent, or foster parent of a minor-age client.

Auditors identified parents and guardians who served as the paid attendants for their own children. In a limited sample⁸, auditors identified seven parents or guardians⁹ who served as personal care services paid attendants for their own children. That was a violation of federal regulations, state regulations, and the Department's policy (see text box). The personal care services benefit is intended to assist a parent or guardian by providing attendant care for a child while the parent or guardian is unable to provide that care. A child's eligibility for personal care services is dependent not only on medical necessity, but also on barriers that prevent the parent or guardian from caring for the child. Therefore, when parents or guardians serve as paid attendants for their own children, this is an indicator that the parents or guardians may not have a barrier and that clients may not be eligible for the level of personal care services they are receiving.

⁸ The sample of attendants was necessarily limited because information on the attendants for personal care services clients is available only in the hard-copy files that providers maintain in their offices.

⁹ Those individuals were identified as the clients' parents or guardians in the Phoenix module of the Medicaid Management Information System as of May 2012.

Auditors also identified parents or guardians of personal care services clients who were listed as employees of the providers that delivered personal care services to their children. There are no policies or rules that prohibit parents or guardians from working as paid attendants for the provider that delivers personal care services to their children; however, that practice could result in case managers authorizing more personal care services than are appropriate. For example, in one case that auditors discussed with Department staff, two siblings worked as paid attendants for each other's children. In that case, both siblings reported barriers to caring for their own children during the time that they served as attendants for the other sibling's child.¹⁰

In addition, parents or guardians sometimes care for their own children after those children have reached age 18. There are no rules preventing parents or guardians from serving as a paid attendant for their own, non-minor children. However, in the absence of monitoring, those arrangements could increase the risk that the State could pay for more personal care services than are delivered.

Paid attendants are frequently family members of personal care services clients. A total of 27 (41 percent) of 66¹¹ sampled personal care services attendants were family members of the clients to whom they provided personal care services.¹² Fifteen of those 27 family members also resided at the same address as the client. In most cases, family members (other than parents, guardians, or spouses) are allowed to work as paid attendants. However, having family members as paid attendants could increase the risk that the State could pay for more services than are actually delivered because parents and guardians may be less likely to express concerns to providers about relatives who do not work the full amount of time for which they are paid.¹³

Analyzing information regarding the individuals who serve as clients' attendants also could help to ensure clients' safety. For example, Department staff informed auditors that a provider had inquired about whether a client in the custody of a grandparent could have his mother serve as a paid attendant, even though Child Protective Services had removed the client from the mother's custody. The Department's staff reported that they made it clear to the provider that the client's mother could not be the attendant, but it is important to note that the provider was not required to make that inquiry.

¹⁰ Assessment documentation indicated that one sibling asserted that both siblings were flexible with each other regarding start and stop times for their shifts as attendants for each other's child.

¹¹ Auditors selected the sample of 66 based on characteristics of claims and not based on information about attendants.

¹² Attendants for other clients also may be related to the clients in auditors' sample, but they were not identified in case files as family members.

¹³ This risk is greater when a personal care services client chooses the consumer-directed services option (see Chapter 2-B for additional details) because in that option the attendant is an employee of the parent or guardian.

This example underscores the need for the Commission and the Department to know the identity of attendants caring for personal care services clients.

It is important to note that providers consistently perform background checks on attendants for personal care services. For all 66 attendants that auditors sampled, providers had background checks in the client files at their offices. However, one of those attendants had multiple DWI convictions, had at least one assault conviction¹⁴ documented on the attendant's background check, and had been imprisoned before becoming an attendant for a personal care services client. Because of the types of convictions and the amount of time that had passed since the convictions, the individual was not excluded from serving as an attendant. However, this example illustrates the importance of the Commission and the Department knowing the identities of attendants for personal care services clients.

The Commission and the Department do not visit personal care services clients in their homes to verify that paid attendants provide services. The Commission and the Department rely on the providers that employ the paid attendants to ensure that the paid attendants actually provide personal care services.¹⁵ However, it is unclear how consistently providers perform that type of monitoring to identify instances in which services are not delivered. Additionally, staff at providers that auditors visited indicated that clients might choose other providers if their current provider did not allow a family member to serve as a paid attendant. This may create an incentive for providers to avoid monitoring attendants who are clients' family members.

The Commission has not provided guidance on the additional skills and training required of attendants for clients with behavioral conditions. The Commission asserts that it is a provider's responsibility to match the appropriate attendant with the needs of a personal care services client. However, the Commission does not monitor the assignment of attendants, and the providers generally defer to the preferences of clients' parents and guardians when assigning attendants. As a result, the Commission and the Department have no evidence that attendants for clients with behavioral diagnoses have additional training and skills that would justify the higher payment rate paid for those clients. It is important that the Commission provide stronger guidance to providers on this issue because a majority of the Commission's personal care services expenditures are now for attendants of clients with behavioral conditions (see Chapter 1-B for additional details on behavioral diagnoses).

¹⁴ The disposition of a second alleged assault on a family member was not documented on the background check.

¹⁵ When a client chooses the consumer-directed services option, the parent or guardian employs the attendant directly (see Chapter 2-B for additional details).

Recommendations

The Commission and the Department should:

- Collect information on (1) the identity of paid attendants for personal care services clients and (2) relationships between paid attendants and personal care services clients to help ensure compliance with restrictions on certain family members serving as paid attendants.
- Consider implementing a system to verify whether attendants are at the clients' homes when they are scheduled to provide personal care services.
- Develop guidance on additional training and qualifications required of attendants for personal care services clients with behavioral conditions.

The Commission Should Address Weaknesses in Claims Processing That Result in Overpayments for Home Health Services and Strengthen Its Monitoring of Home Health Services Claims

Auditors identified payment errors for 38 (23 percent) of 165 judgmentally selected claims that the Commission's contracted claims administrator paid in fiscal year 2011 for home health services provided through the Texas Health

Steps program. The Texas Medicaid & Healthcare Partnership (TMHP) is the Commission's contracted claims administrator (see text box for additional details.)

The Texas Medicaid & Healthcare Partnership

The Texas Medicaid & Healthcare Partnership (TMHP) is a group of contractors responsible for administering claims for the Texas Medicaid program and other state health care programs.

TMHP began administering claims on January 1, 2004. According to the Commission, payments to TMHP for fiscal years 2008 through 2011 totaled \$749,292,748.

Source: The Commission and the TMHP Web site.

The Commission should ensure that TMHP addresses weaknesses that resulted in TMHP making the following types of errors when it paid home health services claims:

- Multiple payments for the same home health services.
- Payments that exceeded authorized amounts.
- Payments for services that were not supported by providers' time sheets.

The Commission also should ensure that TMHP periodically reviews user access to its claims processing system (the Medicaid Management Information System) to verify that users have appropriate levels of access and that TMHP has established adequate segregation of duties within that system.

In addition, auditors identified other ways in which the Commission should strengthen its monitoring of claims to ensure that TMHP makes payments only to eligible providers for medically necessary home health services that they actually deliver. Specifically, the Commission should:

- Monitor payments to consumer-directed services agencies to ensure that TMHP does not pay for home health services that were not delivered or for unallowable expenditures.
- Collect and analyze information about clients' diagnoses and the practitioners who prescribe private duty nursing and therapy services.
- Ensure that TMHP maintains current information on home health services provider licenses.
- Ensure that TMHP maintains documentation of medical necessity for home health services authorized by managed care organizations.

Chapter 2-A

The Commission Should Ensure That TMHP Corrects Weaknesses in Claims Processing for Home Health Services

TMHP made errors when it paid claims for home health services. Auditors identified payment errors for 38 (23 percent) of 165 judgmentally¹⁶ selected home health services claims that TMHP paid in fiscal year 2011. Those errors resulted in overpayments totaling \$15,141 (19 percent) of the \$81,206 in claims tested.¹⁷ Table 1 summarizes the errors auditors identified.

Table 1

Summary of Claims Payment Errors Auditors Identified In Home Health Services Claims			
Type of Home Health Service	Number of Claims Tested	Number of Errors	Amount Paid in Error
Personal Care Services	69	22	\$ 9,678
Private Duty Nursing	41	4	373
Therapy	55	12	5,090
Totals	165	38	\$15,141

Source: Auditors' tests of claims payments.

The errors summarized in Table 1 included multiple payments for the same home health services, payments that exceeded authorized amounts, and payments for services that were not supported by providers' employee time sheets. The errors occurred for the following reasons:

- Automated controls in the Medicaid Management Information System did not identify multiple payments to providers for the same services provided to the same clients on the same day.
- TMHP overrode automated edit checks in the Medicaid Management Information System and paid claims for (1) more than 24 hours of personal care services and private duty nursing services in a single day and (2) more units of service than were authorized.
- For certain overpayments that auditors identified, employee time sheets in providers' documentation did not support the amount of services in providers' claims. However, providers are not required to submit documentation (such as employee time sheets) to support their claims. Therefore, TMHP did not prevent payments for services that were not supported by providers' employee time sheets.

¹⁶ To select 10 home health services providers' claims for review, auditors considered the type of services providers delivered, geographical location of the providers, and total amounts paid to the providers. For each of the 10 providers selected, auditors selected a sample of clients based on the number of claims, amounts of services, and amounts paid.

¹⁷ TMHP asserted that providers refunded \$7,622, associated with 16 claims paid in error, during the audit.

TMHP did not monitor clients' weekly use of home health services. Although physicians, nurses, and others determine the amount of home health services a client needs per week, TMHP monitors only clients' annual and semi-annual use of home health services. As a result, TMHP sometimes pays providers for more home health services in a week than are authorized. For example, auditors tested a sample of claims for 60 clients who received personal care services and determined that TMHP paid providers for more units of service in a week than were authorized for 2 (3 percent) of those 60 clients.

TMHP did not appropriately manage access to the Medicaid Management Information System. Prior to February 2012, TMHP did not perform periodic reviews of user access to the Medicaid Management Information System to verify that (1) users had appropriate levels of access to modify prior authorization and claims data and (2) it had established adequate segregation of duties within that system. Auditors identified 154 users with access to modify prior authorization and claims data. According to TMHP, 150 (97 percent) of those 154 users did not require that level of access to perform their job duties. Inappropriate access could allow users to make unauthorized changes to prior authorization and claims data and make inappropriate payments.

Recommendations

The Commission should:

- Require TMHP to enhance Medicaid Management Information System controls to identify and prevent duplicate payments for home health services.
- Strengthen its oversight to ensure that TMHP appropriately processes home health services claims that the Medicaid Management Information System suspends for manual review in accordance with its procedures.
- Consider having the Office of Inspector General audit home health services providers to verify that providers' employee time sheets support the services documented on providers' claims.
- Require TMHP to implement Medicaid Management Information System controls to ensure that payments for home health services are within authorized weekly amounts.
- Ensure that TMHP periodically reviews user access to the Medicaid Management Information System to verify that users have appropriate levels of access and that adequate segregation of duties exists within that system.

Chapter 2-B

The Commission Should Strengthen Its Monitoring of Claims That Home Health Services Providers Submit for Payment

Payments to consumer-directed services agencies for personal care services clients present additional risks. Personal care services clients may choose to have a home health agency manage their services (referred to as the “agency option”) or they manage their own services through the consumer-directed services option (see Appendix 5 for additional information).

When clients choose the consumer-directed services option, there is an increased risk that the Commission could pay for services that were not provided or for unallowable expenditures (see text box for additional details on the consumer-directed services option).

The Consumer-directed Services Option

The consumer-directed services option allows clients to hire and manage the individuals who provide their home health services. Under this option, clients develop service budgets to ensure that payments are within spending limits. Those budgets may include wages and benefits (such as bonuses and health insurance for attendants) and up to \$600 per year in other expenses (such as office equipment and supplies required to perform tasks).

The Commission pays consumer-directed services agencies a monthly administrative fee to process attendant payroll and taxes. Consumer-directed services agencies pay attendants based on time sheets the client or client’s parent or guardian approves.

The consumer-directed services option is the result of Senate Bill 1586 (76th Legislature), which created a voucher payment option enabling clients to make personal decisions related to the delivery of personal assistance and respite services within their current home and community-based program.

Source: Title 40, Texas Administrative Code, Chapter 41, and the Department of Aging and Disability Services’ Web site.

Consumer-directed services agencies use a single procedure code to submit personal care services claims. As a result, when the Commission receives a claim from a consumer-directed services agency, it cannot distinguish the amount of personal care services from other expenditures for items such as bonuses for attendants and office supplies and equipment. For example, the overpayments for personal care services discussed in Chapter 2-A included \$1,290 in attendant bonuses that were submitted as part of a claim for personal care services. Both the bonuses and the personal care services were billed as a single amount and coded as personal care services.

The Commission also does not monitor the personal care services that clients receive through the consumer-directed services option. When clients choose the agency option for personal care services, attendants are employed by home health providers that have procedures for monitoring the delivery of services. Those home health providers are also licensed by the Department of Aging and Disability Services.¹⁸ However, when clients choose the consumer-directed services option, the client or client’s parent or guardian monitors the delivery of services. Because consumer-directed services agencies do not deliver attendant services directly, they are not required to be licensed home health agencies; therefore, they are not required to be inspected by the Department of Aging and Disability Services.

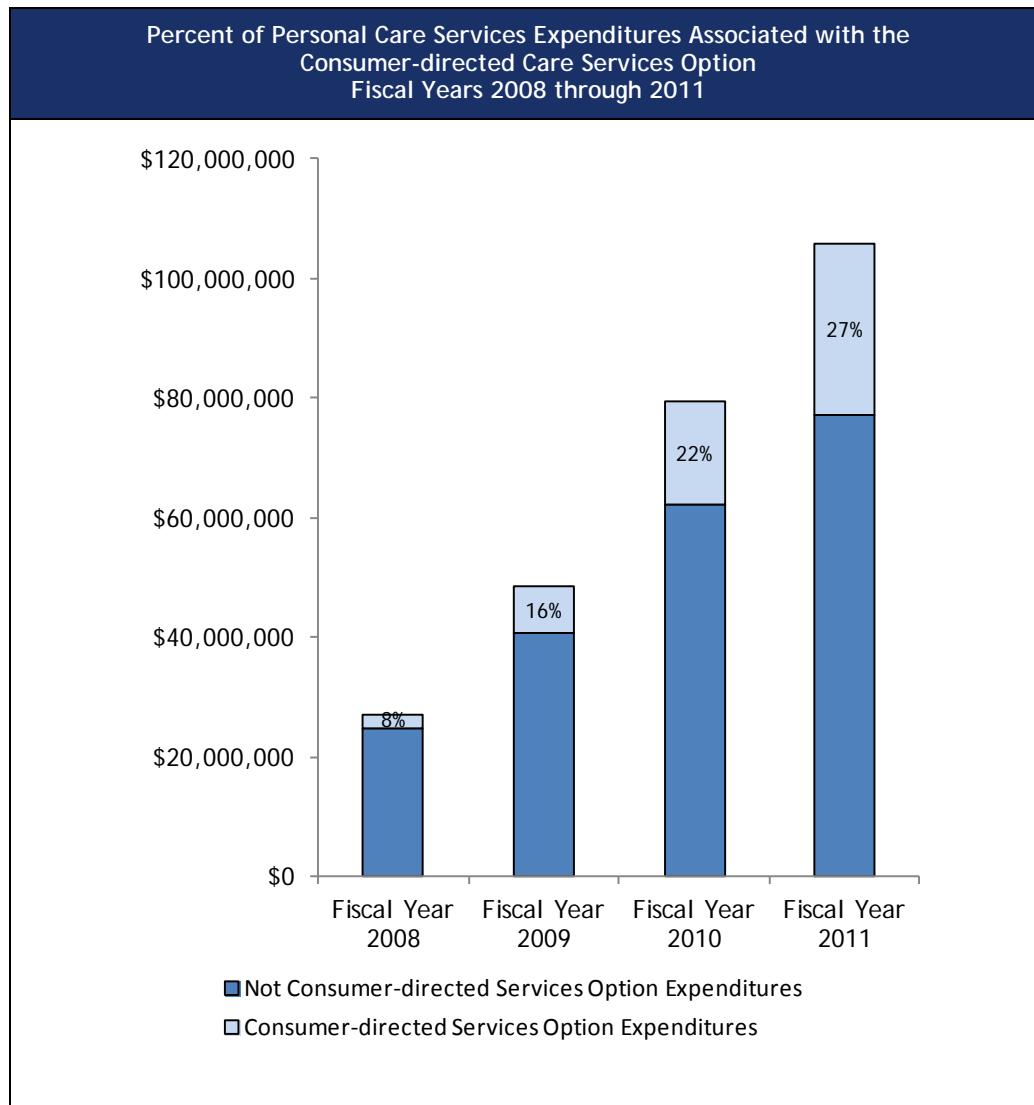
In addition, consumer-directed services are often delivered by a family member. Auditors determined that 8 (50 percent) of 16 sampled clients who chose the consumer-directed services option had family members serving as their personal care services attendants. As discussed in Chapter 1, the client or the client’s parent or guardian is less likely to report concerns about the

¹⁸ The Department of Aging and Disability Services licenses home health agencies and inspects them every 36 months.

quality or amount of service delivered when family members serve as attendants.

The Commission's expenditures for clients receiving personal care services through the consumer-directed services option grew from \$2.1 million in fiscal year 2008 to \$28.6 million in fiscal year 2011. As Figure 4 shows, those expenditures accounted for 27 percent of total personal care services expenditures in fiscal year 2011.

Figure 4



Source: Unaudited expenditure information provided by the Commission from the Medicaid Management Information System.

TMHP does not capture information about clients' diagnoses or the practitioners who prescribe home health services in the Medicaid Management Information System. If TMHP captured information about clients' diagnoses and the practitioners

who prescribe private duty nursing and therapy services in the Medicaid Management Information System, the Commission could:

- Compare practitioner information to provider ownership information and identify potentially inappropriate financial relationships between practitioners and the providers who deliver home health services to clients.¹⁹
- Compare practitioners' license numbers to licensing board records to verify that practitioners are qualified to prescribe home health services.
- Analyze information about clients' diagnoses to identify patterns across practitioners, providers, and geographical regions of the state and use that information to focus training and monitoring.

TMHP does not always have the most current information on provider licenses.

Providers of home health services must have the appropriate Department of Aging and Disability Services license or certification and enroll with TMHP. TMHP did not have accurate license information for 48 home and community support services agencies; as a result, it made \$1,712 in inappropriate payments to one of those providers, which was not licensed at the time services were delivered.²⁰

When clients enroll in managed care organizations, TMHP does not maintain documentation of medical necessity for private duty nursing and therapy services. TMHP had supporting documentation for the medical necessity of private duty nursing and therapy services it authorized in 56 (93 percent) of 60 files auditors tested. TMHP did not have that documentation for the remaining four clients because those clients were enrolled in managed care organizations, which authorized those clients' services.

Managed care organizations provide most of the services their clients need, and the Commission pays those organizations a capitation rate for each enrolled client. When managed care organizations authorize services that are not included in the capitation rate, TMHP makes payments directly to the providers that deliver the services. Because TMHP does not receive documentation of medical necessity from managed care organizations that authorize services, there is a risk that it could pay for services that are not medically necessary.

¹⁹ Title 42, Code of Federal Regulations, Section 424.22 (Requirements for Home Health Services), limits a physician from certifying or recertifying the need for services to be provided by a home health agency if the physician has a financial relationship with that agency.

²⁰ TMHP made payments to 567 home and community support services agencies for delivering personal care services, private duty nursing, and/or therapy services during fiscal years 2010 and 2011.

Recommendations

The Commission should:

- Require consumer-directed services agencies to use separate procedure codes to submit claims for services, benefits (bonuses and wages), and office supplies and equipment.
- Require TMHP to capture information about clients' diagnoses and practitioners who prescribe services in the Medicaid Management Information System so that the Commission's Office of Inspector General and staff who oversee Texas Health Steps program home health services can use that information to identify inappropriate financial relationships between practitioners and providers and monitor home health services.
- Ensure that TMHP maintains accurate home health services provider license information and prevents payments to unlicensed providers.
- Require TMHP to collect and retain consistent documentation showing medical necessity for home health services, including names and license numbers of practitioners who refer clients from managed care organizations.

Appendices

Appendix 1

Objective, Scope, and Methodology

Objective

The objective of this audit was to determine whether the Health and Human Services Commission (Commission) and the Department of State Health Services (Department) have controls to help ensure that home health providers enrolled in the Texas Health Steps program are:

- Qualified according to applicable policies and procedures.
- Monitored for accurate and appropriate service delivery.
- Sanctioned or removed from provider rolls as appropriate.

Scope

The scope of this audit covered Texas Health Steps program personal care services, private duty nursing, and therapy services authorized and provided to clients during fiscal years 2010 and 2011.

Methodology

The audit methodology included reviewing policies and procedures, and rules related to Texas Health Steps program home health services; interviewing staff at the Commission, the Department, the Department of Aging and Disability Services, and the Texas Medicaid & Healthcare Partnership (TMHP); and reviewing documentation of medical need for home health services.

Auditors also tested personal care services case files at Department regional offices and reviewed employee records and supporting documentation for home health services claims payments at 10 providers visited.

Auditors assessed the reliability of TMHP's Medicaid Management Information System by interviewing TMHP staff, reviewing access controls to certain applications within that system, reviewing controls over migration and storage of claims information in the data warehouse for that system, and testing the operating effectiveness of selected edit checks. Based on the controls reviewed, auditors determined that data in that system was sufficiently reliable for the purposes of this audit.

Information collected and reviewed included the following:

- Texas Medicaid provider enrollment application.
- Fee schedules for Texas Health Steps program personal care services, private duty nursing, and therapy services.
- The Department's log of personal care services issues submitted through emails from its regional office.
- Provider ownership information on the Web site of the Office of the Secretary of State.
- License records from the Texas Medical Board, the Texas Board of Nursing, the Executive Council of Physical Therapy and Occupational Therapy Examiners, and the State Board of Examiners for Speech-Language Pathology and Audiology.

Procedures and tests conducted included the following:

- Conducted interviews with key personnel at the Commission, the Department, the Department of Aging and Disability Services, the Commission's Office of Inspector General, and TMHP.
- Observed processes for authorizing home health services and processing claims.
- Reviewed and tested personal care assessments and documentation of medical need for personal care services.
- Tested documentation of medical need for private duty nursing and therapy services.
- Surveyed Department regional staff and home health providers.
- Reviewed credentials of practitioners who referred clients for home health services and therapists and nurses who delivered services.
- Reviewed license statuses of providers that were paid to provide home health services.

Criteria used included the following:

- Title 42, U.S. Code of Federal Regulations, Part 440.
- Title 1, Texas Administrative Code, Chapter 363.
- Title 40, Texas Administrative Code, Chapter 97.

- Title 40, Texas Administrative Code, Chapter 41.
- *Texas Medicaid Provider Procedures Manual*
- *Texas Medicaid Medical Policy Manual.*
- The Department's *Personal Care Services Policies Handbook*.
- The Department's *Personal Care Assessment Form Manual*.

Project Information

Audit fieldwork was conducted from March 2012 through July 2012. 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:

- Scott Boston, MPAff (Project Manager)
- Tessa Mlynar, CFE (Assistant Project Manager)
- Kristina Aguilar
- George Eure, MPA
- Chris Ferguson
- Steven Summers, CPA, CISA
- Jesse Williams
- Dana Musgrave, MBA (Quality Control Reviewer)
- John Young, MPAff (Audit Manager)

Description of Home Health Services the Commission Provides through the Texas Health Steps Program

Personal Care Services

Personal care services are support services provided to clients who meet the definition of medical necessity and require assistance with the performance of activities of daily living and instrumental activities of daily living due to a physical, cognitive, or behavioral limitation related to a client's disability or chronic health condition. Activities of daily living and instrumental activities of daily living include a range of activities that a typically developing child of the same chronological age could safely and independently perform without adult supervision. Table 2 lists examples of activities of daily living and instrumental activities of daily living.

Table 2

Activities That Personal Care Services Support	
Activities of Daily Living	Instrumental Activities of Daily Living
▪ Bathing	▪ Accessing and utilizing health services
▪ Dressing	▪ Application/maintenance of prosthetics and orthotics
▪ Eating	▪ Communication
▪ Grooming	▪ Grocery/household shopping
▪ Maintaining continence	▪ Light housework
▪ Mobility	▪ Laundry
▪ Positioning	▪ Meal preparation
▪ Transferring	▪ Personal hygiene
▪ Toileting	▪ Medical Transportation

Source: *Texas Medicaid Provider Procedures Manual, Children's Services Handbook*.

Private Duty Nursing

According to the *Texas Medicaid Medical Policy Manual*, private duty nursing services are defined as follows:

...nursing services, as described by the Texas Nursing Practice Act and its implementing regulations, for clients who meet the medical necessity criteria, and who require individualized, continuous, skilled care beyond the level of Skilled Nursing (SN) visits normally authorized under Texas Medicaid Home Health (SN) and Home Health Aide (HHA) Services. PDN services may be provided by a registered nurse (RN) or a licensed vocational nurse (LVN).

Therapy

Therapy services include physical, occupational, and speech therapy. According to the *Texas Medicaid Medical Policy Manual*, those services are defined as follows:

- Physical therapy is the use of physical agents such as massage, electricity, traction, or exercises in the treatment of disease.
- Occupational therapy is the use of physical agents such as massage, electricity, traction, or exercises in the treatment of disease for the treatment of individuals whose ability to function in life roles is impaired.
- Speech therapy is for acute or sub-acute pathological or traumatic conditions of the head or neck, which affect speech production.

Personal Care Services Expenditures, Clients, and Case Managers by Region

Table 3 shows the fiscal year 2011 personal care services expenditures, client count, case manager count, and average caseload in each of the eight Department of State Health Services administrative regions.

Table 3

Summary of Personal Care Services Information By Department of State Health Services Region Fiscal Year 2011				
Region	Expenditures on Personal Care Services	Number of Personal Care Services Clients	Number of Department of State Health Services Case Managers	Number of Clients per Case Manager (Average Caseload)
Arlington	\$ 8,971,883	1,033	17	61
EI Paso	5,070,551	579	8	72
Harlingen	37,906,238	4,566	46	99
Houston	20,794,662	1,682	25	67
Lubbock	2,004,190	232	8	29
San Antonio	12,321,305	1,226	13	94
Temple	8,051,876	800	10	80
Tyler	10,246,016	887	17	52
Totals	\$105,366,721 ^a	11,005 ^b	144	76

^a The total for expenditures in this table does not include \$476,130 in expenditures that were not associated with a specific region.
^b The total for clients in this table does not include clients who were not associated with a specific region, and it duplicates clients who received services from more than one region. The total, unduplicated number of clients was 10,980.

Sources: Unaudited information provided by the Department of State Health Services and by the Commission from the Medicaid Management Information System.

Payment Rates for Home Health Services in the Texas Health Steps Program

Table 4 shows the payment rates for personal care services, private duty nursing, and therapy services for the Texas Health Steps program in fiscal year 2011.²¹

Table 4

Personal Care Services, Private Duty Nursing, and Therapy Payment Rates Texas Health Steps Program Fiscal Year 2011			
Service	Rate for a 15- minute Increment	Hourly Rate	Description
Personal Care Services	\$2.89	\$11.56	Regular attendant rate (agency option).
	\$3.43	\$13.72	Enhanced rate for clients with behavioral diagnoses (agency option).
	\$2.69	\$10.76	Regular attendant rate (consumer-directed services option).
	\$3.23	\$12.92	Enhanced rate for clients with behavioral diagnoses (consumer-directed services option).
	\$108.90 ^a	Not applicable	Monthly administrative fee (consumer-directed services option).
Private Duty Nursing ^b	\$11.05	\$44.20	Services provided by a registered nurse.
	\$12.71	\$50.84	Enhanced rate for services provided by a registered nurse.
	\$8.09	\$32.36	Services provided by a licensed practical nurse or licensed vocational nurse.
	\$8.87	\$35.48	Enhanced rate for services provided by a licensed practical nurse or licensed vocational nurse.
Therapy ^c	\$17.50 - \$35.00	\$70.00 - \$140.00	Physical, occupational, and speech therapy.
^a This is a monthly rate and not a rate for a 15-minute increment.			
^b The enhanced rate for private duty nursing is for clients who have either had a tracheostomy or are ventilator-dependant.			
^c Payment rates are the payment rates for Comprehensive Care Program providers. Payment rates for therapy services vary based on the type of provider delivering services, the type of therapy provided, and the procedure code. There are 44 procedure codes for Comprehensive Care Program therapy services.			

Source: Texas Medicaid & Healthcare Partnership static fee schedules.

²¹ Therapy services also can be billed at a statewide visit rate, which is a rate paid for one visit per day per therapy, regardless of the duration of the visit. The statewide visit rates for home health providers ranged from \$70 to \$140 in fiscal year 2011.

Service Delivery Options for Personal Care Services

Table 5 compares the responsibilities of the provider agency and the responsibilities of the client (or the client's parent or guardian) for the two service delivery options available to personal care services clients. In the consumer-directed services option, the client (or the client's parent or guardian) is responsible for most administrative tasks. In the agency option, the provider agency is responsible for all administrative tasks.

Table 5

Service Delivery Options for Personal Care Services				
Task	Entity or Individual Responsible for Task			
	Consumer-directed Services Option		Agency Option	
	Client or Client's Parent or Guardian	Agency	Client or Client's Parent or Guardian	Agency
Managing attendants	X			X
▪ Recruiting	X			X
▪ Screening	X			X
▪ Interviewing	X			X
▪ Training	X			X
▪ Supervising	X			X
Determining attendant salaries and benefits	X			X
Monitoring and managing quality of service	X			X
Administering payroll	X			X

Source: The Department of State Health Services' *Choosing a Personal Care Services Provider* pamphlet.

Management's Response

Summary of Management Responses

The federal lawsuit Alberto N., et al. v. Suehs requires the Health and Human Services Commission (HHSC) to comply with Title XIX of the Social Security Act (42 U.S.C. §1396 et seq.) by providing all medically necessary in-home Medicaid services to children under 21 years of age that are eligible for the Comprehensive Care Program through the Texas Health Steps Program.

Responsibility for delivery of these services, which include home health services, was transferred from the Department of Aging and Disability Services to HHSC on September 1, 2007. Case managers within the Department of State Health Services (DSHS) assess Comprehensive Care Program beneficiaries to determine eligibility for and the amount of services to be authorized. Services are provided to eligible beneficiaries who require assistance with activities of daily living and health-related functions due to physical, cognitive, or behavioral limitations related to the beneficiary's disability or chronic health condition.

After HHSC assumed responsibility in 2007, the program was changed significantly, in accordance with the Alberto N. settlement agreement, to make home health services more readily available to those that had previously been on waiting lists and to a population of persons with behavioral health conditions that had not previously been eligible.

The trends which indicate expenditures for home health services for individuals with behavioral health diagnoses have increased significantly, however, were anticipated, and are not solely attributable to increases in payment rates. In order to meet the funding needs required to come into compliance with the Alberto N. settlement agreement regarding services to children, HHSC submitted an exceptional item funding request to the state legislature, through the Legislative Appropriation Request process for fiscal year 2008 and 2009, totaling \$180.6 million for fiscal year 2008 and \$195.1 million for fiscal year 2009.

While HHSC and DSHS, through efforts such as increasing the rate paid for personal care services to clients with a behavioral health diagnosis, have made services significantly more available to those that need them, HHSC acknowledges that further improvement is needed.

HHSC agrees that it is essential for the ongoing success and viability of personal care services within the Texas Health Steps Program that responsibility be assigned to a single program manager. To facilitate this, HHSC will make a determination of the optimal placement of personal care

services within the Health and Human Services (HHS) enterprise, and assign responsibility of administration and operations accordingly.

HHSC appreciates the recommendations offered by the State Auditor's Office and will use those recommendations as a guide for further improvement throughout the operation, monitoring, and payment of personal care services, to ensure that HHSC effectively ensures that clients who need personal care services and meet the requirements are able to receive those services.

Detailed responses to the State Auditor's Office recommendations follow.

Chapter 1 - A

SAO Recommendation:

The Commission and the Department should:

- *Provide personal care services only to clients for whom they receive a practitioner statement of need within 60 days of the start of service, in accordance with Title 1, Texas Administrative Code, Section 363.605.*
- *In the absence of a practitioner statement of need, begin termination of personal care services after 60 days from the start of services.*
- *Revise the practitioner statement of need for personal care services so that it relates directly to conditions that qualify a client for those services, and indicate on the statement whether the practitioner has an ongoing therapeutic relationship with the client.*
- *Request a practitioner statement of need from a physician most familiar with the conditions that may make a client eligible for personal care services.*
- *Ensure that each individual who signs a practitioner statement of need has a valid license and is qualified to determine a client's need for personal care services.*

Management Response:

HHSC agrees that its administrative rules require a statement of need for personal care services—executed either by a physician or a practitioner who is clinically knowledgeable of and has a therapeutic relationship with the child—must be placed on file within 60 days following the start of personal care services. In the absence of a client appeal or a court order or settlement, HHSC agrees that personal care services must be terminated when no statement of need is placed in the file as required by HHSC rules.

To the degree that current program practice (as distinguished from program administrative rules or written policy) does not assure that a statement of need from either a physician or a health care practitioner with clinical knowledge or a therapeutic relationship with a child is obtained within 60 days, or to the degree that DSHS program staff suspect that children without an underlying disability or chronic health condition are inappropriately referred or approved for personal care services, HHSC and DSHS will implement the following corrective action:

- *HHSC and DSHS will verify the beneficiary's need for personal care services, either through a physician or a practitioner with clinical knowledge or a therapeutic relationship with the recipient within 60 days of the implementation of the corrective action.*
- *If such efforts to obtain a current statement of need for personal care services are unsuccessful, or if the statement of need does not support the current level of services, HHSC will initiate a termination or reduction of personal care services.*
- *HHSC and DSHS will instruct staff on methods to verify the underlying diagnosis of disability or chronic health condition.*
- *To the degree DSHS program staff suspect that fraud, abuse, or waste has occurred in either the referral or approval of a child for personal care services, HHSC and DSHS will remind staff of their obligation to refer such suspicions to the HHSC Office of Inspector General, the Office of the Attorney General, or the State Auditor's Office.*

Estimated Completion Date:

- *April 2013*

Title of Responsible Person:

Deputy Director, Contract Management and Operations, Medicaid/CHIP Division

SAO Recommendation:

The Commission and the Department should:

- *Require case managers to verify the barriers that parents and guardians report prevent them from caring for their children.*

Management Response:

Personal care services policy states that eligibility is initially based on a parent or guardian's report of the client's health condition and statement describing barriers that prevent the parent or guardian from being able to assist the client with activities of daily living. Parent or guardian barriers may include working, attending school, meeting their own medical needs, sleeping, or meeting the needs of their other children.

A requirement does not currently exist for a case manager to validate barriers a parent reports, primarily because some information (a) is not possible to verify, (b) would be inappropriate or illegal to verify (such as a parent or guardian's health information), or (c) could change from one day to the next. If, however, the case manager is concerned that there is a question about the validity of information the parent or guardian provides, the case manager should, when applicable, request verification from the physician or practitioner who submits the statement of need on behalf of the client. HHSC may need to amend current program rules and policy to implement such a requirement. And HHSC must examine the potential impact of such a policy change on HHSC's obligation to avoid imposing additional conditions of eligibility in violation of the maintenance of effort requirement of Section 2001 of the Affordable Care Act.¹

¹ *Section 2001 amended §1902 of the Social Security Act (42 U.S.C. §1396a) by adding subsection (gg), which requires a state that participates in the Medicaid program to ensure that it "shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act" until the Secretary of Health and Human Services determines that the state has a fully operational state insurance exchange as authorized elsewhere in the Affordable Care Act.*

Routine verification of some information by case workers may help confirm that at least some parent or guardian barriers exist. Consequently, HHSC will review the nature of these barriers, determine whether any can and should be routinely verified by case workers, and draft policy changes, as applicable, for approval. Proposed policy changes may result in the need for rule changes.

To ensure that a request for personal care services is supported by adequate verification of the barriers that prevent a parent from assisting the client with the activities of daily living, HHSC proposes the following corrective action:

- *HHSC will review and revise current policy and administrative rules to require the physician or practitioner to certify the degree to which the parent is able or unable to assist the client with the activities of daily living*
- *If a physician or practitioner is unable to certify a parent's capability, HHSC will deny the request for personal care services*
- *HHSC and DSHS will remind staff of their obligation to refer suspected Medicaid fraud, abuse, or waste to the HHSC Office of Inspector General, the Office of the Attorney General, or the State Auditor's Office*

Estimated Completion Date:

- *October 2012 – Review policy and recommend changes*
- *October 2013 – Formalize policy changes through the rule making process*

Title of Responsible Person:

Deputy Director, Contract Management and Operations, Medicaid/CHIP Division

SAO Recommendation:

The Commission and the Department should:

- *Consider making information from TIERS available to all case managers to help them to verify information reported by parents and guardians of prospective personal care services clients.*

Management Response:

TIERS includes information about persons living in the home that might help case managers assess the child's familial situation and environment for

personal care services. For example, TIERS access would provide the case manager with the Medicaid Case Name and the name, age, and gender of all associated recipients in the household.

While TIERS would probably not be able to help the case manager determine whether other individuals in the household are available to help care for the child, because another adult in the household that is not a parent or guardian of the child may not have a legal obligation to care for the child, the information that is in TIERS may provide enough helpful information to the case manager to merit providing access.

HHSC will evaluate information contained in TIERS, and potentially other information sources that may assist case managers in making an appropriate evaluation, and request access for case managers to systems with a high potential to be useful.

Estimated Completion Date:

- *March 2013*

Title of Responsible Person:

Deputy Director, Contract Management and Operations, Medicaid/CHIP Division

SAO Recommendation:

The Commission and the Department should:

- *Consider establishing a waiting period for an individual who requests subsequent assessments after a case manager has determined the individual is not eligible for personal care services.*

Management Response:

HHSC will evaluate the feasibility of establishing a waiting period for an individual to request a subsequent assessment after the individual was determined ineligible for services. If it is determined that a waiting period should be implemented, rule development may be necessary to enforce and support a waiting period. HHSC must examine the potential impact of such a policy change on HHSC's obligation to avoid imposing additional conditions of eligibility in violation of the maintenance of effort requirement of Section 2001 of the Affordable Care Act.²

² *Id.*

Estimated Completion Date:

- *October 2012 – Determine whether a waiting period should be established and, if so, how long the period should be*
- *October 2013 – Formalization of a waiting period requirement through the rule making process*

Title of Responsible Person:

Deputy Director, Contract Management and Operations, Medicaid/CHIP Division

Chapter 1 - B

SAO Recommendation:

The Commission should consider assigning overall responsibility for the administration of all aspects of personal care services to a single program manager.

Management Response:

HHSC agrees that it is essential for the ongoing success and viability of personal care services within the Texas Health Steps Program that responsibility be assigned to a single program manager. To facilitate this, HHSC will make a determination of the optimal placement of personal care services within the HHS enterprise, and assign responsibility of administration and operations accordingly.

Estimated Completion Date:

- *December 2012 – Determination of where personal care services should be placed within the HHS enterprise*
- *January 2014 – Complete transition of responsibilities under a single program manager*

Title of Responsible Person:

Chief Deputy Commissioner

SAO Recommendation:

The Commission and the Department should:

- *Collect and analyze information on clients' diagnoses to improve monitoring of personal care services.*
- *Authorize the higher payment rate for behavioral conditions only when the practitioner's statement of need indicates that a client has a behavioral condition that qualifies the client for personal care services.*
- *Collect and analyze information about practitioners who sign statements of need for personal care services clients to verify credentials and licensure status, and to identify potential relationships between specific practitioners and specific providers and/or diagnoses.*

Management Response:

HHSC collects data related to the diagnoses reported on individual claims for personal care services from case files. For example, in 2010 and 2011, the most common diagnoses included attention deficit disorder, autism, cerebral palsy, convulsions, intellectual disabilities, and Down's syndrome.

HHSC will evaluate options to ensure a cost effective solution that makes more comprehensive and useful data analysis possible. HHSC will also evaluate how the results of this analysis can enhance its monitoring efforts, including ensuring that the higher payment rate is used only when the statement of need indicates that a client has a behavioral health condition.

The trends which indicate expenditures for home health services for individuals with behavioral health diagnoses have increased significantly, however, were anticipated, and are not solely attributable to increases in payment rates. When HHSC assumed responsibility from the Department of Aging and Disability Services in 2007, the program was changed significantly, as part of a court settlement alleging noncompliance with federal law, to make home health services more readily available to those that had previously been on waiting lists and to a population of persons with behavioral health conditions that had not previously been eligible.

HHSC will also evaluate whether cost effective automated solutions can be developed to verify licensure status and help identify potentially unusual or inappropriate relationships between specific physicians or practitioners and specific providers. To the degree that DSHS or HHSC staff suspect that fraud, abuse, or waste is occurring in the referral, request, or approval of personal care services, HHSC and DSHS will remind staff of their obligation to refer such suspicions to the HHSC Office of Inspector General, the Office of the Attorney General, or the State Auditor's Office

Estimated Completion Date:

- August 2013

Title of Responsible Person:

Deputy Director, Contract Management and Operations, Medicaid/CHIP Division

Chapter 1 - C

SAO Recommendation:

The Commission and the Department should:

- *Collect information on (1) the identity of paid attendants for personal care services clients and (2) relationships between paid attendants and personal care services clients to help ensure compliance with restrictions on certain family members serving as paid attendants.*

Management Response:

Current processes do not include gathering information about attendants who provide personal care since personal care services agencies or the family select an attendant after case managers issue an authorization for services.

HHSC will review its policy to determine opportunities to improve the ability to enforce the federal and state regulations and rules that prohibit parents and guardians from being paid for providing personal care services. HHSC will consider the following during this review: (a) how to better communicate requirements to agencies and families, (b) whether it would be feasible to collect some form of attestation from agencies and families that requirements will be followed, (c) whether there should be sanctions or penalties for parents or guardians that do not follow the requirements or who falsify the attestations, and (d) whether there should be rules that prohibit a parent or guardian from working as a paid attendant for the provider that delivers personal care services to their children. Proposed policy changes may result in the need for rule changes. HHSC must examine the potential impact of such policy changes on HHSC's obligation to avoid imposing additional conditions of eligibility in violation of the maintenance of effort requirement of Section 2001 of the Affordable Care Act.³

³ *Id.*

Estimated Completion Date:

- *December 2012 – Review policy and recommend changes*
- *December 2013 – Formalize policy changes through the rule making process*

Title of Responsible Person:

Deputy Director, Contract Management and Operations, Medicaid/CHIP Division

SAO Recommendation:

The Commission and the Department should:

- *Consider implementing a system to verify whether attendants are at the clients' homes when they are scheduled to provide personal care services.*

Management Response:

HHSC is planning to procure an electronic visit verification (EVV) system. EVV is a telephone and computer-based system that electronically verifies when service visits in the home occur, and documents the precise time service provision begins and ends. The EVV system will also document who delivered the service.

Estimated Completion Date:

- *February 2014*

Title of Responsible Person:

Deputy Director, Contract Management and Operations, Medicaid/CHIP Division

SAO Recommendation:

The Commission and the Department should:

- *Develop guidance on additional training and qualifications required of attendants for personal care services clients with behavioral conditions.*

Management Response:

HHSC will evaluate which specific skills and knowledge are needed to adequately provide personal care services to clients with behavioral health conditions, develop criteria to define them, and offer guidance to personal care services agencies and families (for those choosing the consumer-directed services option) to help ensure attendants (a) have the needed qualifications or (b) attend training to obtain needed skills.

Estimated Completion Date:

- *March 2013*

Title of Responsible Person:

Deputy Director, Contract Management and Operations, Medicaid/CHIP Division

Chapter 2 - A

SAO Recommendation:

The Commission should:

- *Require TMHP to enhance Medicaid Management Information System controls to identify and prevent duplicate payments for home health services.*
- *Strengthen its oversight to ensure that TMHP appropriately processes home health services claims that the Medicaid Management Information System suspends for manual review in accordance with its procedures.*
- *Require TMHP to implement Medicaid Management Information System controls to ensure that payments for home health services are within authorized weekly amounts.*

Management Response:

HHSC directed the claims administrator to reprocess and recoup the inappropriately paid claims identified during this audit.

HHSC will work with the claims administrator to improve controls over home health services payments in an effort to eliminate duplicate payments, appropriately process claims suspended for manual review, and ensure payments do not exceed authorized weekly amounts.

Estimated Completion Date:

- August 2013

Title of Responsible Person:

Deputy Director, Contract Management and Operations, Medicaid/CHIP Division

SAO Recommendation:

The Commission should:

- Consider having the Office of Inspector General audit home health services providers to verify that providers' employee time sheets support the services documented on providers' claims.

Management Response:

The HHSC Office of Inspector General is completing its annual risk assessment and audit plan for fiscal year 2013. This plan contains audits of several home health service providers. The Office of Inspector General will review the providers for compliance with applicable statutes, service delivery, contractual provisions, and other applicable performance attributes. The Office of Inspector General will issue a report on each service provider as well as an overall summary report on the provider audits to HHSC management.

Estimated Completion Date:

- August 2013

Title of Responsible Person:

Deputy Inspector of Compliance, Office of Inspector General

SAO Recommendation:

The Commission should:

- Ensure that TMHP periodically reviews user access to the Medicaid Management Information System to verify that users have appropriate levels of access and that adequate segregation of duties exists within that system.

Management Response:

HHSC will review claims administrator (a) policies and procedures regarding user access to the claims processing system and (b) guidelines for determination of user access appropriate to job functions and adequate segregation of duties. HHSC will require updates to the policies, procedures, and guidelines if they are not adequate, and monitor the claims administrator to ensure user access is regularly and accurately performed in accordance with approved policies and guidelines.

Estimated Completion Date:

- November 2012

Title of Responsible Person:

Deputy Director, Contract Management and Operations, Medicaid/CHIP Division

Chapter 2 - B

SAO Recommendation:

The Commission should:

- *Require consumer-directed services agencies to use separate procedure codes to submit claims for services, benefits (bonuses and wages), and office supplies and equipment.*

Management Response:

Although claims for consumer-directed services agencies use one procedure code, there are three modifiers used along with that code. One modifier is for the attendant fee, one is for the behavioral health enhanced rate attendant fee, and one is for administrative fees that include both benefits and office supplies and equipment.

HHSC will evaluate whether adding a fourth modifier to distinguish the nature of specific administrative expenditures would increase its ability to effectively monitor home health provider claims, and add another modifier if needed.

Estimated Completion Date:

- March 2013

Title of Responsible Person:

Deputy Director, Contract Management and Operations, Medicaid/CHIP Division

SAO Recommendation:

The Commission should:

- *Require TMHP to capture information about clients' diagnoses and physicians who prescribe services in the Medicaid Management Information System so that the Commission's Office of Inspector General and staff who oversee home health services can use that information to identify inappropriate financial relationships between physicians and providers and monitor home health services.*

Management Response:

HHSC collects diagnosis information from claims submitted for payment, and will implement Affordable Care Act requirements that include additional standards for provider enrollment and claims information. One of the new provisions will require ordering and prescribing provider information for the services provided to recipients. In addition, stricter ownership and controlling interest requirements in the Affordable Care Act that will assist HHSC in identifying potentially inappropriate financial relationships which HHSC Office of Inspector General can investigate. The new Affordable Care Act provisions also require related system updates and enhancements.

Estimated Completion Date:

- *January 2014*

Title of Responsible Person:

Deputy Director, Contract Management and Operations, Medicaid/CHIP Division

SAO Recommendation:

The Commission should:

- *Ensure that TMHP maintains accurate home health services provider license information and prevents payments to unlicensed providers.*

Management Response:

While TMHP has controls in place to ensure it does not make payments to unlicensed providers, sometimes the licensing information TMHP uses is not current.

The Affordable Care Act will require providers to be screened every three to five years. In addition, HHSC will be required to run licensing checks on a monthly basis. To implement these requirements, HHSC will be coordinating with licensing agencies to automate the receipt of licensure information and to perform monthly verifications of data in the enrolled provider database. TMHP will use this information when performing its payment edits to ensure payments are made only to licensed providers.

Estimated Completion Date:

- January 2014

Title of Responsible Person:

Deputy Director, Contract Management and Operations, Medicaid/CHIP Division

SAO Recommendation:

The Commission should:

- *Require TMHP to collect and retain consistent documentation showing medical necessity for home health services, including names and license numbers of physicians who refer clients from managed care organizations.*

Management Response:

This issue is fully resolved. The finding was based on data for Medicaid clients that received services in a managed care service area prior to March 1, 2012; specifically, SSI-disabled children enrolled in STAR for whom the Managed Care Organization received an enhanced case management fee, as compared to the fee paid under the Primary Care Case Management program (which operated in non-managed care areas of the state until its elimination on March 1, 2012). After March 1, 2012, this payment arrangement was eliminated. These Medicaid clients are now given the option to either remain in Fee For Service without managed care case management or enroll in STAR+PLUS and receive all services through that program under a fully-capitated arrangement with the Managed Care Organization in which they are enrolled. Therefore, resolution of this issue is considered complete as of March 1, 2012.

Title of Responsible Person:

Deputy Director, Medicaid/CHIP Managed Care Operations

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The Honorable Joe Straus III, Speaker of the House, Joint Chair
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