

An Audit of MCNA Insurance Company, a Medicaid and CHIP Dental Maintenance Organization

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Overall, MCNA Insurance Company (MCNA) complied with the State's reporting requirements for its fiscal year 2024 dental expenses related to services provided to Medicaid and Children's Health Insurance Program (CHIP) members. Additionally, it processed dental services in accordance with applicable requirements.

However, MCNA should strengthen its processes for preparing and reviewing its financial statistical reports (FSRs) it submitted to the Health and Human Services Commission (Commission) to verify that it did not overstate its dental or administrative expenses. Overstating expenses could result in the Commission setting higher future premiums paid to dental maintenance organizations, thereby increasing the cost to the State for Medicaid and CHIP programs.

In addition, it should update its processes to ensure that it reports all possible fraud, waste, and abuse recoupments to the Commission's Office of Inspector General (OIG) as required. It is important that all recoupments be reported because the State is entitled to a portion of certain recoupments.

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This audit was conducted in accordance with Texas Government Code, Sections 321.013 and 321.0132.

MEDIUM

DENTAL EXPENSES

MCNA accurately reported and complied with processing requirements for most of its dental services; however, it should strengthen its review processes to prevent it from reporting unallowable expenses in its FSRs.

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HIGH

ADMINISTRATIVE EXPENSES

MCNA overstated its reported administrative expenses in its fiscal year 2024 FSR by $2.0 million, or 5.1 percent of the $39.5 million total reported administrative expenses, due to errors in calculating its FSR.

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MEDIUM

FRAUD, WASTE, AND ABUSE

MCNA reported all investigations and most recoupments related to fraud, waste, and abuse to the OIG as required. However, it omitted some recoupments from its reporting.

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For more information about this audit, contact Audit Manager Jeannette Garcia or State Auditor Lisa Collier at 512-936-9500.

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Summary of Management's Response

Auditors made recommendations to address the issues identified during this audit, provided at the end of each chapter in this report. MCNA agreed with the recommendations.

Ratings Definitions

Auditors used professional judgment and rated the audit findings identified in this report. The issue ratings identified for each chapter were determined based on the degree of risk or effect of the findings in relation to the audit objective(s).

PRIORITY: Issues identified present risks or effects that if not addressed could ***critically affect*** the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern(s) and reduce risks to the audited entity.

HIGH: Issues identified present risks or effects that if not addressed could ***substantially affect*** the audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern(s) and reduce risks to the audited entity.

MEDIUM: Issues identified present risks or effects that if not addressed could ***moderately affect*** the audited entity's ability to effectively administer the program(s)/function(s) audited. Action is needed to address the noted concern(s) and reduce risks to a more desirable level.

LOW: The audit identified strengths that support the audited entity's ability to administer the program(s)/function(s) audited or the issues identified do not present significant risks ***or*** effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.

For more on the methodology for issue ratings, see Report Ratings in Appendix 1.

Background Information

MCNA Insurance Company

MCNA Insurance Company (MCNA) provides a dental plan that serves people under 21 throughout Texas and who are covered by either Medicaid or the Children's Health Insurance Program (CHIP). From September 1, 2023, through August 31, 2024, the Health and Human Services Commission (Commission) paid $397.3 million to MCNA for dental premiums for a monthly average of 1.1 million people enrolled in Medicaid and approximately 38,000 children enrolled in CHIP dental programs.

Financial Statistical Reports

The Commission receives financial statistical reports from dental maintenance organizations (DMOs) quarterly and annually. Those reports are the primary statements of a DMO's financial results and a key source of claims and administrative expense information that the Commission uses to set the premiums paid to DMOs.

Fraud, Waste, and Abuse

The DMO is responsible for investigating possible acts of fraud, waste, and abuse for all services, including those that the DMO subcontracts to outside entities. To accomplish this, the DMO must arrange for a special unit to investigate fraudulent claims and other types of program abuse by recipients and providers and submit every year a fraud, waste, and abuse compliance plan to the Commission's Office of Inspector General 90 days before the end of each fiscal year. The plan must include activities to prevent and reduce fraud, waste, and abuse.

MEDIUM

Chapter 1
Dental Expenses

Overall, MCNA Insurance Company (MCNA) complied with the State's reporting requirements for its fiscal year 2024 dental expenses related to services provided for Medicaid and Children's Health Insurance Program (CHIP) members. However, it should improve its processes for preparing and reviewing its financial statistical reports (FSRs) to verify that it did not overstate its dental expenses by including services provided to ineligible members or interest paid to dental providers.

MCNA accurately reported and complied with processing requirements for most of its dental services; however, it should strengthen its review processes for unallowable expenses.

Reporting. MCNA accurately reported $347.4 million, or 99.9 percent of its dental expenses totaling $347.7 million, on its fiscal year 2024 FSR and submitted accurate encounter data to the Health and Human Services Commission (Commission) (see text box for information about encounter data).

Processing. MCNA denied or approved and paid for dental procedures in accordance with the Commission's *Uniform Managed Care Manual*. MCNA also had review processes to determine the appropriateness of certain types of dental procedures. Specifically:

Encounter Data

Dental Maintenance Organizations (DMOs) are required to submit encounter data to the Commission each month. The data contains detailed member, provider, procedure, and payment information for services provided to Medicaid and CHIP members. Encounter data is a key source of claims expense information used to pay premiums to DMOs.

Source: The Commission.

- For all 105 approved dental procedures tested[1], staff reviewed the procedure prior to payment, and the provider was paid the correct amount for the procedure.
- For all 60 denied dental procedures tested[2], staff reviewed the procedure, and the procedure was appropriately denied.

Ineligible Members. Overall, the dental expenses that MCNA reported in its fiscal year 2024 FSR were paid to eligible dental providers for eligible Medicaid and CHIP members. However, it reported $153,952 in unallowable dental expenses for services it provided for 420 ineligible Medicaid and CHIP members. While MCNA can pay for dental services for ineligible Medicaid and CHIP members, it should not include those costs in its FSR to the Commission (see text box).

This occurred because of a system issue that did not correctly terminate the members. As a result, MCNA continued to provide dental coverage, and its FSR reviews did not identify the error. MCNA asserted that it corrected the system issue in fiscal year 2026.

Unallowable Interest. MCNA complied with processing 98 percent of its claims within 30 days and appropriately paid interest to dental providers for claims paid after 30 days in accordance with the *Uniform Managed Care Manual.* However, it incorrectly reported the $152,014 in interest it paid for the claims processed late in its FSR. This occurred because MCNA did not have adequate procedures in place to review its FSR and prevent the reporting of unallowable expenses.

Allowable Costs

The Commission's *Uniform Managed Care Manual* defines the cost principles that establish the allowability of expenses related to selected Medicaid and Dental programs that a DMO can report on its FSR. A designation of "allowable" or "unallowable" does not generally govern whether the DMO can incur a cost or make a payment; allowability reflects only what is reportable on the FSR.

To be allowable, expenses must conform to the requirements of the Commission's cost principles, which include being reasonable, allocable, and reported as they are incurred.

Source: The Commission.

[1] The 105 approved dental procedures tested included 2 samples: a sample of 30 approved dental procedures with prior authorizations and 75 approved dental procedures that did not require prior authorization.

[2] The 60 denied dental procedures tested included 2 samples: a sample of 30 denied dental procedures that required prior authorizations and a sample of 30 denied dental procedures that did not require prior authorizations.

When a dental maintenance organization reports unallowable expenses in its FSR, it overstates the dental expenses, which can result in the Commission setting higher future premiums paid to DMOs and increasing the cost to the State for Medicaid and CHIP programs.

Recommendation

MCNA Insurance Company should strengthen its review process of its financial statistical reports to prevent the reporting of unallowable dental expenses related to (1) dental services paid for ineligible Medicaid and CHIP members and (2) interest paid for late payments to dental providers.

Management's Response

MCNA agrees with this recommendation.

The $153,952 in unallowable dental expenses associated with services provided to 420 ineligible Medicaid and CHIP members resulted from an enrollment-processing issue involving overlapping enrollment segments and transitions between CHIP and Medicaid coverage. This issue prevented certain members' coverage from terminating correctly in MCNA's system. MCNA identified the issue through its enrollment-to-capitation reconciliation process and corrected it in October 2025 (SFY 2026). As an additional control, MCNA's FSR review process will confirm that reported dental expenses exclude claims paid for members who were not eligible on the applicable date of service.

The $152,014 in interest paid on late claim payments was not excluded from the SFY 2024 FSR because a formal process for identifying and excluding such amounts had not been established. Historically, these amounts had been immaterial, totaling $10,300 in SFY 2023 and $217 in SFY 2025. Beginning with the SFY 2025 334-Day FSR, MCNA's Controller implemented a control to identify and exclude interest paid on late claims from reported dental expenses. This control has also been incorporated into MCNA's FSR Reporting Policy and Procedure documentation.

Corrective Action	Response	Responsible	Timeline
Exclude dental expenses for ineligible members from the FSR	Agree	MCNA Controller (FSR review); MCNA Business Intelligence	System issue corrected October 2025; FSR eligibility check effective with the SFY 2026 334-Day FSR
Exclude interest paid on late claims from the FSR	Agree	MCNA Controller	Implemented beginning with the SFY 2025 334-Day FSR

HIGH

Chapter 2
Administrative Expenses

MCNA reported $39.5 million in expenses related to administering the Medicaid and CHIP programs on its fiscal year 2024 FSR, which was overstated by $2.0 million (or 5.1 percent). It also did not require its employees working for multiple states to certify their time for processing Texas claims.

Most of MCNA's reported administative expenses were accurate and allowable; however, it should strengthen its review process for unallowable expenses.

Reporting and Review Processes. MCNA reported $39.5 million in administrative expenses on its fiscal year 2024 FSR submitted to the Commission. Of that amount, MCNA's accounting data and reports supported the accuracy and allowability for $37.5 million (94.9 percent). In addition, MCNA had processes to review accounting transactions that included administrative expenses. Specifically, MCNA reviewed all 3 payroll vouchers tested and all 12 legal and professional services invoices tested to verify that they were accurate and allowable.

Unallowable Administrative Expenses. MCNA reported $2.0 million in unallowable expenses, or 5.1 percent of the $39.5 million reported administrative expenses, due to errors in calculating its FSR. Specifically:

- **Overstated Outsourced Expenses.** MCNA overstated its outsourced administrative services expenses by $1.0 million related to its third-party affiliate, which provided a variety of services for MCNA. MCNA did not periodically review its third-party affiliate fee and as a result, it incorrectly reported $554,905 in accounting services that the affiliate no longer provided. Additionally, the third-party affiliate credited MCNA's expenses for $447,442, but MCNA did not include that savings in its reported expenses. The *Uniform Managed Care Manual* requires that administrative expenses reported reflect the actual costs incurred.

- **Incorrectly Calculated Corporate Allocation Expenses**. MCNA overstated its share of indirect expenses from its parent company by $743,247 because it based the calculation on budgeted instead of actual amounts and on the incorrect reporting period (calendar year instead of fiscal year).
- **Unallowable Bonus Expenses.** MCNA overstated bonuses by $66,667 because it incorrectly included an unallowable retention bonus. Although DMOs are allowed to award bonuses, the *Uniform Managed Care Manual* requires that bonuses be submitted to the Commission prior to being awarded. MCNA did not report the retention bonus to the Commission as required; therefore, it is unallowable and should not have been included in MCNA's reported administrative expenses.
- **Other Errors.** MCNA also reported an additional $183,486 in unallowable expenses due to errors, such as overstating payroll costs because it had listed 6 employees twice and other calculation mistakes.

MCNA asserted it had a review process for its FSR; however, its review did not identify those administrative expenses errors.

Overstating administrative expenses can result in the Commission setting higher future premiums paid to DMOs, thereby increasing the cost to the State for Medicaid and CHIP programs.

MCNA employees working for multiple states did not certify their time as required.

MCNA used annual payroll reports to determine the salaries and wages and bonuses included in its FSR. However, it did not require employees who worked for multiple states to prepare and sign time distribution reports at least monthly as required by the *Uniform Managed Care Manual*. Of the 19 employees tested, 13 performed activities for Texas and other states. None of those 13 employees certified their time working on tasks for Texas. As a result, there is a risk that the $688,882 in salaries and wages and bonuses that MCNA reported for those 13 employees tested may not accurately reflect the time those employees actually worked on Texas-specific claims.

Recommendations

MCNA Insurance Company should:

- Periodically review its third-party affiliate fee to verify that it correctly reflects actual services provided.
- Strengthen its FSR preparation and review processes to ensure that it is reporting actual costs incurred for the correct reporting period, correctly allocating administrative expenses, and preventing the inclusion of unallowable costs.
- Implement a time distribution reporting and certification process for employees who work for multiple states in accordance with the *Uniform Managed Care Manual* requirements.

Management's Response

MCNA agrees with all three recommendations. Its response to each recommendation follows.

Recommendation 1: Periodic review of the affiliate fee

The $554,905 in outsourced accounting service expense resulted from the same services being reflected in both the fair market value third-party administrator (TPA) fee of $2.55 per member per month (PMPM), which included $0.0422 PMPM for financial reporting and accounting administrative services, and MCNA's corporate overhead allocation. MCNA pays the $2.55 PMPM fee to its affiliate for TPA services provided on MCNA's behalf.

The duplication arose following a payroll system change that resulted in accounting salaries no longer being allocated to the affiliate and instead being allocated to MCNA through the parent company's corporate overhead allocation. As a result, the $0.0422 PMPM component of the TPA fee represented services also included in the corporate overhead allocation. Accordingly, $554,905, calculated as 13,149,416 SFY 2024 member months multiplied by $0.0422 PMPM, should have been excluded from the FSR.

Beginning with the SFY 2025 334-Day FSR, the MCNA Controller implemented a control to remove the $0.0422 PMPM component, as

applicable, to prevent duplication of these expenses. This control has also been incorporated into MCNA's FSR Preparation Policy and Procedure documentation. In addition, the Controller will review the affiliate fee build-up at least annually, prior to preparation of each 334- Day FSR, to confirm that the fee continues to reflect the services provided by the third-party affiliate and to prevent duplication with amounts allocated through corporate overhead.

Recommendation 2: FSR preparation and review

MCNA has strengthened its FSR preparation and review process by implementing multiple levels of review, including an initial review between the report preparer and the MCNA Finance Director; subsequent review by the report preparer, Finance Director, and MCNA Controller; and a final review that includes the MCNA Chief Financial Officer. These procedures were implemented beginning with the SFY 2025 334-Day FSR. Evidence of the required reviews and approvals is retained in accordance with MCNA's FSR Preparation Policy and Procedure documentation.

The specific items identified by SAO have been addressed as follows:

- **Outsourced service expense TPA credit:** This amount represented a one-time adjustment resulting from a departmental restructuring and was necessary to prevent the duplication of amounts paid to Managed Care of North America, Inc., for TPA services. The adjustment was inadvertently omitted from the SFY 2024 334-Day FSR. As this was a one-time adjustment, it is not expected to recur. The enhanced review procedures described above, which became effective with the SFY 2025 334-Day FSR, are designed to identify and prevent similar reporting omissions.
- **Corporate overhead allocation adjustment:** This adjustment resulted from the use of a budgeted amount provided by MCNA's parent company, rather than actual costs for the applicable state fiscal year, in allocating allowable corporate costs to the Texas contract. Beginning with the SFY 2025 334-Day FSR, the MCNA Controller implemented a control requiring these allocations to be reconciled and adjusted to actual costs for the applicable state fiscal year reporting period.
- **Retention bonus:** This amount resulted from the inclusion of a retention bonus paid pursuant to a written compensation agreement in the FSR bonus line without prior submission to HHSC for approval.

Going forward, MCNA will obtain HHSC approval before reporting any bonus outside the HHSC-approved Rewarding Results Plan on the FSR.

- **Calculation adjustment:** This amount resulted from calculation errors during preparation of the FSR, including the duplicate inclusion of 6 employees in a census report received from Human Resources. Beginning with the SFY 2025 334-Day FSR, the MCNA Controller implemented an additional control designed to identify and prevent such calculation and duplication errors. This control has also been incorporated into MCNA's FSR Preparation Policy and Procedure documentation.

Recommendation 3: Time distribution reporting and certification

Beginning in September 2026 (SFY 2027), MCNA implemented a monthly time-allocation process requiring employees who perform work across multiple MCNA contracts to attest to the percentage of time devoted to each contract. Each employee's direct supervisor is required to review and certify the accuracy of the reported allocations. The certified time-allocation results will be used to support FSR reporting beginning with the SFY 2027 submission.

Recommendation	Response	Responsible	Timeline
1. Periodic review of the affiliate fee	Agree	MCNA Controller	Duplicate charge removed beginning with the SFY 2025 334-Day FSR; annual review before each 334-Day FSR
2. FSR preparation and review	Agree	MCNA Controller	Implemented beginning with the SFY 2025 334-Day FSR; bonus approval requirement effective November 2026
3. Time distribution reporting and certification	Agree	MCNA Chief Financial Officer	Implemented September 2026; applied to FSRs beginning with SFY 2027

MEDIUM

Chapter 3
Fraud, Waste, and Abuse

MCNA complied with reporting fraud, waste, and abuse cases to the Commission's Office of Inspector General (OIG). However, it did not report all recoupments for fiscal years 2024 and 2025, as required by the Commission's *Uniform Managed Care Manual*.

MCNA did not report all recoupments as required.

The *Uniform Managed Care Manual* required DMOs to report all recoupments in an annual Overpayment Recoveries Report. This is important because the State is entitled to a portion of certain recoupments. MCNA reported most, but not all, of its recoupments for fiscal years 2024 and 2025. For fiscal years 2024 and 2025, MCNA reported $695,213 in total fraud, waste, and abuse recoupments for 73 investigations to the OIG. That amount was understated by $55,400 (7.4 percent) due to mistakes and omissions made during its process for tracking and reporting recoupments, which contained several manual steps. In addition, MCNA did not have any evidence that it conducted reviews to verify the accuracy of the reported amount.

MCNA complied with reporting fraud, waste, and abuse cases to the OIG.

MCNA had processes to review and process allegations of fraud, waste, and abuse. Specifically, MCNA opens a complaint and conducts a preliminary investigation. For all 24 received and closed complaints tested, MCNA documented the results of the preliminary investigations and obtained appropriate approvals.

MCNA escalates a complaint to a case when it has determined there is credible proof of fraud, waste, or abuse and a full investigation is required. It reported monthly to the OIG all its open cases for fiscal years 2024 and 2025 as required. In addition, for the 11 closed cases tested, MCNA complied with

the required timelines for conducting the investigations, received appropriate approvals, and reported those cases to the OIG.

Recommendation

MCNA should develop and implement a review process for calculating and reporting total recoupments to verify that it includes all recoupments in its reporting to the OIG.

Management's Response

MCNA agrees with this recommendation.

The $55,400 in recoupments that were not included in MCNA's Overpayment Recoveries Reports for SFY 2024 and SFY 2025 consisted of two components. The $48,262 associated with 6 Special Investigations Unit (SIU) cases resulted from data-entry and compilation errors in a manual reporting process. MCNA acknowledges that these recoveries should have been reported. The amounts had been identified, collected, and recorded in MCNA's systems but were inadvertently omitted from the applicable report.

The $7,138 associated with 13 complaints resulted from MCNA's prior interpretation that recoveries related to complaints were outside the scope of the reporting requirement. SFY 2024 was the first reporting year for the Overpayment Recoveries Report. Following discussions with the HHSC OIG regarding SFY 2025 reporting expectations, MCNA revised its reporting methodology to include complaint-related recoveries beginning with its SFY 2025 reporting.

To ensure that all recoupments are included in its reporting to the OIG, MCNA has strengthened its review process by (1) reducing the number of employees responsible for entering reportable recoupments from 6 to 2 designated employees; (2) reconciling total recoupments recorded in MCNA's financial records to the Overpayment Recoveries Report before each submission; and (3) requiring review and approval of each report by the Program Integrity/SIU Director before submission. Evidence of each reconciliation, review, and approval is retained to document completion.

Recommendation	Response	Responsible	Timeline
Review process for calculating and reporting total recoupments	Agree	Program Integrity / SIU Director	Complaint-related recoveries included beginning with the SFY 2025 report; designated staff, reconciliation, and review procedures in place beginning with the SFY 2026 report

Appendix 1

Objective, Scope, and Methodology

Objective

The objective of this audit was to determine whether selected financial processes and related controls at selected managed care organizations (MCOs) are designed and operated to ensure (1) the accuracy and completeness of data that the MCOs report to the Health and Human Services Commission (Commission) and (2) compliance with applicable requirements.

Scope

The Commission administers Medicaid and the Children's Health Insurance Program (CHIP) through contracts with MCOs for medical services and dental maintenance organizations (DMOs) for dental care.

Auditors selected MCNA Insurance Company (MCNA), a DMO that provides dental services to Medicaid and CHIP members in Texas. The scope of the audit included MCNA's Medicaid, CHIP, and Administrative financial statistical reports (FSRs) for fiscal year 2024, reported dental claims for fiscal year 2024, and fraud, waste, and abuse reporting for fiscal years 2024 and 2025.

The scope also included a review of significant internal controls related to MCNA's financial processes, dental claims processes, and fraud, waste, and abuse reporting processes.

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

- Anca Pinchas, CPA, CISA, CIDA, MAcy, MS (Project Manager)
- Alex Franklin, CFE, MPP (Assistant Project Manager)
- Jamie Clark, MIA (Assistant Project Manager)
- Lilian Alvarez
- Charles Guymon
- Louis Holley, CFE, CICA
- Josh Lee
- Quang Tran, CFE
- Michele Yonkeu, CFE
- Robert G. Kiker, CFE, CGAP (Quality Control Reviewer)
- Dana Musgrave, MBA, CFE (Quality Control Reviewer
- Jeannette Quiñonez Garcia, CPA (Audit Manager)

Methodology

We conducted this performance audit from February 2026 through November 2026 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. In addition, during the audit, matters not required to be reported in accordance with *Government Auditing Standards* were communicated to MCNA's management for consideration.

Addressing the Audit Objective

During the audit, we performed the following:

- Interviewed MCNA management to gain an understanding of processes and related controls over its financial, dental claims, and fraud, waste, and abuse processes.
- Identified the relevant criteria:
  - The contract between MCNA and the Commission.
  - The Commission's *Uniform Managed Care Manual*.
  - MCNA policies and procedures.
  - Texas Administrative Code, Title 1, Chapter 353.
  - Code of Federal Regulations, Title 42.
- Tested MCNA's fiscal year 2024 FSR to determine if it was certified by appropriate personnel and submitted to the Commission timely.
- Reconciled the fiscal year 2024 FSR to MCNA's accounting data, dental procedures data, and other supporting documentation.

- Performed data analysis on MCNA's approved and paid dental procedures for services rendered during fiscal year 2024 to determine if:
  - Dental services were paid to eligible providers for eligible Medicaid or CHIP members.
  - Dental procedures automatically processed through the system were for appropriate procedure codes.
- Performed data analysis on dental procedures processed during fiscal year 2024 to determine if:
  - Dental procedures were processed within 30 days from received date and the amount of interest paid for those procedures paid late.
  - System edit checks worked as intended regarding specific codes requiring oral evaluations or requiring an automatic denial when a claim was filed 95 days after the service date.
  - Clinical reviewers were dentists certified to practice in Texas.
- Verified that recoupment payments MCNA collected during fiscal years 2024 and 2025 were calculated accurately and reported to the Commission's Office of the Inspector General.
- Determined if monthly case reports for fiscal years 2024 and 2025 were reviewed in accordance with MCNA policy.
- Tested samples of approved dental procedures to determine if they were reviewed by a clinical reviewer, were accurately paid, and prior authorizations were obtained if needed.
- Tested samples of denied dental procedures to determine if they were accurately denied and reviewed by a clinical reviewer.
- Tested samples of monthly payroll vouchers and legal and professional services invoices to determine whether they were reviewed, accurate, and allowable.
- Tested a sample of salaries and bonuses to determine whether they were accurately calculated, supported, and allowable.

- Tested a sample of closed cases for fiscal years 2024 and 2025 to determine whether the cases were investigated, documented, reported, and approved in accordance with applicable requirements.
- Tested a sample of received complaints for fiscal years 2024 and 2025 to determine whether requested recoupment amounts were supported and complaints were approved in accordance with MCNA policy.

Figure 1 shows the populations and samples selected for testing.

Figure 1

Total Populations and Samples Selected

Description	Population	Sample Size	Sampling Methodology[3]
Approved procedures for $5 or more with prior authorizations	79,744	30	Random
Approved procedures for $5 or more that did not require prior authorizations	482,810	75	60 random, 15 targeted
Denied procedures that required prior authorizations	15,674	30	Random
Denied procedures that did not require prior authorizations	241,046	30	Random
Payroll vouchers	12	3	Targeted
Legal and professional services invoices	121	12	Targeted
Salaries and bonuses	191	19	Random
Closed cases	52	11	Random
Received complaints	119	24	Random

[3] The **random** samples are representative. That sample design was chosen so the sample could be evaluated in the context of the population. It would be appropriate to project those test results to the population, but the accuracy of the projection cannot be measured. The **targeted** samples (including those with a mix of random and targeted selected items) are not representative, and it would not be appropriate to project those test results to the populations. Those samples were designed to obtain coverage through the fiscal year and/or of high-risk items.

Data Reliability and Completeness

Auditors determined that the dental claims data, revenue and expense data, and fraud, waste, and abuse data sets were sufficiently reliable for the purposes of the audit. To assess if the data sets were complete and accurate, auditors interviewed MCNA staff, observed data extractions from DentalTrak and PeopleSoft and/or reviewed report parameters, and compared them to corroborating information.

Report Ratings

In determining the ratings of audit findings, auditors considered factors such as financial impact; potential failure to meet program/function objectives; noncompliance with state statute(s), rules, regulations, and other requirements or criteria; and the inadequacy of the design and/or operating effectiveness of internal controls. In addition, evidence of potential fraud, waste, or abuse; significant control environment issues; and little to no corrective action for issues previously identified could increase the ratings for audit findings. Auditors also identified and considered other factors when appropriate.

Copies of this report have been distributed to the following:

Legislative Audit Committee

The Honorable Dan Patrick, Lieutenant Governor, Joint Chair

The Honorable Dustin Burrows, Speaker of the House, Joint Chair

The Honorable Joan Huffman, Senate Finance Committee

The Honorable Robert Nichols, Member, Texas Senate

The Honorable Greg Bonnen, House Appropriations Committee

The Honorable Morgan Meyer, House Ways and Means Committee

Office of the Governor

The Honorable Greg Abbott, Governor

Health and Human Services Commission

Ms. Stephanie Muth, Executive Commissioner

MCNA Insurance Company

Ms. Shannon LePage, Chief Executive Officer

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