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An Audit Report on

The Health and Human Services Commission's Oversight of the Medical Transportation Program

March 2022

Report No. 22-021

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Overall Conclusion

The Health and Human Services Commission (Commission) established various monitoring processes for its nonemergency Medical Transportation Program (transportation program). (See text box for program details.) However, it did not always administer select contract management processes to ensure that clients received services for claims submitted and that it monitored providers' compliance with contract terms, applicable laws, and Commission policies and procedures.

Transportation Claims. The Commission's processes ensured that transportation claims were for eligible clients. In addition, mileage claims tested in the Fee-for-Service region were supported and allowable, and the individual drivers were properly enrolled in the program.

However, the Commission did not effectively monitor transportation claims submitted by providers to ensure that:

- Providers maintained transportation documentation needed to verify that clients received the services.
- Individual transportation participants were properly enrolled to receive payment for mileage claims.

Monitoring Provider Compliance. The Commission implemented methods to monitor providers' compliance with key contract requirements, including desk reviews and detailed case monitoring of critical accidents/incidents and client complaints. However, it should strengthen those processes to address significant weaknesses in (1) all five desk review types tested, (2) investigating client-reported accidents/incidents, and (3) closing client complaints.

Nonemergency Medical Transportation Program

The Health and Human Services Commission (Commission) is responsible for the oversight of the Medical Transportation Program that provides nonemergency transportation services for clients of eligible programs (like Medicaid) to covered health care services.

From September 1, 2019, through March 31, 2021, the Commission had 2.4 million transportation claims totaling $142.6 million.

During that time, the Commission contracted with transportation providers to provide transportation services for clients. In addition, the Commission was responsible for administering certain transportation services for one region in Texas. The nonemergency Medical Transportation Program includes the following services:

- Demand response transportation services (for example, van transportation).
- Mass transit tickets.
- Mileage reimbursement (for individual transportation participants).
- Meal and lodging services (for overnight stays outside the client's county of residence).
- Advanced funds (for meals, lodging, or mileage).
- Airfare (if cost effective or necessary).

Sources: Texas Government Code, Chapter 531; the Commission's claims data; the Commission's transportation provider contracts; and Title 1, Texas Administrative Code, Chapter 380.

This audit was conducted in accordance with Texas Government Code, Section 321.0132.

For more information regarding this report, please contact Courtney Ambres-Wade, Audit Manager, or Lisa Collier, State Auditor, at (512) 936-9500.

Information Technology Controls. The Commission had certain application information technology controls over its Accidents/Incidents database and its HHS Enterprise Administrative Report and Tracking (HEART) complaints system. However, it should improve controls over date fields in its Accidents/Incidents database to increase the reliability of the data.

Transition to New Model. The Commission ensured an effective transition of the transportation program from a Managed Transportation Organization (MTO) model to the Medicaid Managed Care Organization (MCO) model for Medicaid managed care members as of June 1, 2021. Although certain transportation program contract requirements have changed with the new model, those changes do not affect the audit results, which apply to the future of the program.

Table 1

Summary of Chapters/Subchapters and Related Issue Ratings		
Chapter/ Subchapter	**Title**	**Issue Rating [a]**
1-A	The Commission Monitored Claims to Ensure That Clients Were Eligible to Receive Transportation Program Services	Low
1-B	The Commission Did Not Consistently Monitor Claims to Verify That Clients Received the Services or That All Mileage Claims Complied with Requirements	Medium
2	The Commission Had Desk Review Processes to Monitor Providers; However, It Had Significant Weaknesses in Its Monitoring of Provider Compliance in Certain Desk Review Areas	High
3-A	The Commission Adequately Monitored Provider-reported Accidents/Incidents; However, It Should Ensure That Providers Consistently Investigate and Resolve Client-reported Accidents/Incidents	Medium
3-B	The Commission Monitored Client Complaints, But It Should Strengthen Its Processes to Ensure That Complaints Are Closed Timely	Medium
4	The Commission Effectively Transitioned the Transportation Program to a Managed Care Organization Model	Low

[a] A chapter/subchapter is rated **Priority** if the 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 and reduce risks to the audited entity.

A chapter/subchapter is rated **High** if the 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 and reduce risks to the audited entity.

A chapter/subchapter is rated **Medium** if the 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 and reduce risks to a more desirable level.

A chapter/subchapter is rated **Low** if 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.

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

Background on the Medical Transportation Program

The Commission used Managed Transportation Organization (MTO) and Fee-for-Service (FFS) models to provide nonemergency Medical Transportation Program services to clients until June 1, 2021.

Under those models, the Commission was responsible for the oversight of transportation program services for:

- Four MTOs in 12 regions.
- Two FFS providers in one region that provide only demand response services (for example, van transportation) because the Commission provides other transportation program services for the region. (See text box for more information about the transportation providers.)

Figure 1 on the next page provides a timeline of important milestones related to the Commission and the transition to different transportation delivery models. The transportation program began using the FFS delivery model for clients in 2007, transitioned to the MTO delivery model in 2013 for all but one region, and transitioned to the Medicaid Managed Care Organization delivery model for Medicaid managed care members in 2021.

Transportation Providers

Managed Transportation Organization (MTO): These providers are paid a monthly rate ***per member*** (capitation rate), operate a call center, and provide all types of allowable nonemergency Medical Transportation Program services to eligible clients.

Fee-for-Service (FFS): These providers are paid a fixed rate ***per service*** and provide only demand response transportation services to eligible clients.

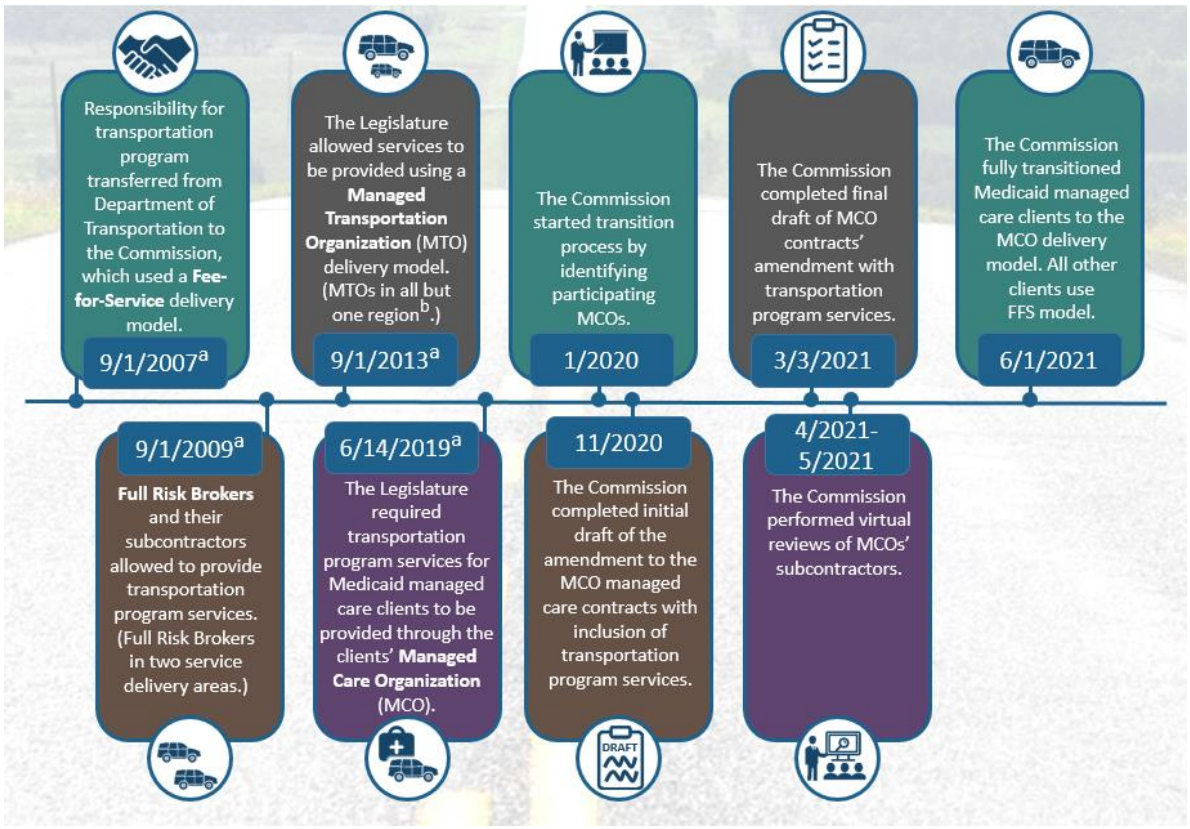
The Commission: In the FFS region, the Commission provides all other Medical Transportation Program services including mileage reimbursement (by contracting with Texas Medicaid & Healthcare Partnership), meals, lodging, advanced funds, and airfare.

Sources: Texas Government Code, Section 533.00257; the Commission's contracts with MTOs and FFS providers; and the Commission.

Figure 1

Timeline with Commission's Milestones Related to the Nonemergency Medical Transportation Program

As of June 1, 2021



[a] Dates reflect the effective date of the legislation and do not reflect the effective date of the contracts to implement the delivery model.

[b] The number of regions with MTOs presented is during the audit scope (September 1, 2019, through March 31, 2021). According to the Commission, all regions had MTOs during the initial implementation of legislation.

Sources: Texas Government Code, Chapter 531; Rider 55, page 216, the General Appropriations Act (81st Legislature); the Commission's contracts with MTOs and MCOs; and the Commission.

Summary of Management's Response

At the end of certain chapters in this report, auditors made recommendations to address the issues identified during this audit. The Commission agreed with the findings and recommendations in this report.

Audit Objectives and Scope

The objectives of this audit were to determine whether the Commission administers select contract management processes related to the transportation program in accordance with contract terms, applicable laws, regulations, and agency policies and procedures, including how the Commission ensures that:

- Required authorized services are provided to eligible clients.
- Providers meet key contract outcomes.

The scope of this audit covered the Commission's processes and controls related to transportation program claims data, transportation supporting documentation, transportation provider contracts, complaints, accident/incidents, and contract monitoring documentation between September 1, 2019, and March 31, 2021. The audit also covered the transition of the program to MCOs, including transition supporting documentation, through August 31, 2021. The scope also included a review of significant internal control components related to the Commission's oversight of the transportation program.

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Detailed Results

Chapter 1

The Commission Ensured That Transportation Program Clients Were Eligible for Services; However, It Did Not Always Have Effective Review Processes for Transportation Claims Submitted By Providers

The Health and Human Services Commission (Commission) is responsible for the oversight of the nonemergency Medical Transportation Program (transportation program). The Commission monitored claims to verify that clients receiving services were eligible for the transportation program. However, it should strengthen its reviews of claims submitted by providers to verify that clients received the services and individual drivers are properly enrolled in the program.

Chapter 1-A

The Commission Monitored Claims to Ensure That Clients Were Eligible to Receive Transportation Program Services

Chapter 1-A Rating:

Low [1]

To obtain payment, transportation providers must submit claims to the Commission. The Commission's process for monitoring claims verified that individuals receiving program services were eligible clients. To be eligible to receive transportation program services, clients have to be enrolled in a qualifying program (for example, Medicaid). Specifically, for all 145 transportation claims that auditors tested, the clients receiving the transportation program services were eligible.

[1] The risk related to the issues discussed in Chapter 1-A is rated as Low because 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.

Chapter 1-B

The Commission Did Not Consistently Monitor Claims to Verify That Clients Received Transportation Services or That All Mileage Claims Complied with Requirements

Chapter 1-B Rating:

Medium [2]

Transportation Claims

To monitor transportation claims submitted by providers, the Commission established an operational review process (see text box for information about those reviews). However, it did not consistently conduct those reviews since March 2020, including the scheduled reviews of its two largest providers and both Fee-for-Service (FFS) providers.

Operational Reviews

To determine provider compliance with various contract requirements, the Commission's procedures require operational reviews of each transportation provider to be conducted at least every two years. Those reviews include reviewing supporting documentation (i.e. signed driver logs) for claims to ensure that transportation program service(s) are valid.

The reviews are conducted on-site at the transportation providers' offices and include other procedures performed at the Commission's offices.

Sources: The Commission's *Medical Transportation Program Operational Review Procedures* and the Commission.

As a result, for 30 (21 percent) of the 145 transportation claims tested, the Commission did not have supporting documentation showing the client received the transportation service, as required by the provider contracts or the Commission's *Texas Medicaid Managed Care Handbook*. All but one of those unsupported claims were at those providers without an operational review. In addition, three unsupported claims included duplicate trips that were recorded in error.

Conducting the operational reviews as scheduled may have helped the Commission identify and address the unsupported claims. According to the Commission, those reviews were suspended because the COVID-19 pandemic prevented them from being on-site. However, the Commission did not modify its procedures to incorporate other review options (for example, conducting virtual or desk reviews).

It is important that the Commission adequately monitor its providers to help ensure that claims are valid and allowable, which limits the risk of the misuse of state funds.

[2] The risk related to the issues discussed in Chapter 1-B is rated as Medium because they 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 and reduce risks to a more desirable level..

Mileage Claims

To submit a mileage claim, a driver who is an Individual Transportation Participant (ITP) must be enrolled in the program (see text box for more information). For all 27 **FFS region** mileage claims tested, the Commission ensured that the ITPs were enrolled in the program as required. However, for 14 (50 percent) of the 28 **MTO regions'** mileage claims tested, the Commission did not have documentation showing that the individuals being paid for mileage costs were enrolled. The suspended operational reviews, if conducted, could have helped the Commission identify claims missing ITP enrollment documentation.

Individual Transportation Participant (ITP)

An ITP is a client, a relative, or a non-relative volunteer who drives a client to a covered healthcare service in a personal vehicle. These individuals receive reimbursement for mileage.

All individuals eligible for mileage reimbursement must enroll by completing an application, have a current valid driver's license, have current vehicle insurance and registration, and pass a criminal background check (if driving a non-relative).

Sources: Title 1, Texas Administrative Code, Sections 380.401 and 380.502; and the Commission's *Directive for Individual Transportation Participants*.

Recommendations

For future transportation claims, the Commission should:

- Resume operational reviews to verify that there is adequate documentation supporting that clients received the transportation program services and that ITPs are properly enrolled. This should include developing alternative procedures when on-site reviews are not practical.
- Verify that claims do not include duplicate trips that should not have been recorded.

Management's Response

Statement of Agreement/Disagreement

HHSC agrees with the findings and offers the following response to the recommendations.

Action Plan

In the past few years, HHSC staff has worked to strengthen monitoring processes for non-emergency medical transportation (NEMT) services. In October 2017, HHSC transitioned the oversight of NEMT services internally to begin to ensure monitoring and oversight of managed care entities was streamlined and comprehensive. Staff began the process of understanding where efficiencies could be found in the oversight of the transportation program. During this time, HHSC was in the process of procuring NEMT services statewide while simultaneously moving some administrative

functions to the contracted claims administrator in 2018. The procurement for statewide NEMT services was released, evaluated, but subsequently cancelled in 2019 due to the passage of House Bill (H.B.)1576, 86th Legislature, Regular Session, 2019. HHSC was legislatively directed to carve in NEMT services into the existing managed care contracts. As a result of the legislative decision, HHSC did not conduct transportation related Operational Reviews, as the same program resources were needed to ensure the seamless transition of NEMT services from the managed transportation organization model to managed care while simultaneously working on the statewide expansion of the Fee-for-Service (FFS) delivery model. Even as staff were engaged in these time-sensitive projects, HHSC continued monitoring activities of transportation contractors by concentrating on priority areas of review based on client safety and administration and delivery of transportation services. Staff performed Readiness Reviews on every MCO specifically focusing on the transition of NEMT services into managed care.

Operational Reviews provide a thorough independent and objective assessment of the contractor's operational and financial performance and the effectiveness of the contractor's control systems. Every MCO is reviewed every other year to ensure the MCOs are performing according to contractual requirements via these Operational Reviews. HHSC is modifying Operational Reviews to include compliance with contract requirements, agency policy and procedures, and state rules related specifically to transportation. Staff are prepared to conduct on-site or virtual reviews, as necessary. HHSC anticipates completing the Operational Review cycle specific to transportation oversight for the MCOs by March 2023. Subsequent to this review cycle, every MCO will be reviewed every other year to ensure the MCOs are performing according to contractual requirements.

As a next step to further strengthen oversight activities for all NEMT services, HHSC will create a centralized Transportation Oversight Workgroup tasked with improving cohesiveness and finding efficiencies in the monitoring of transportation-related requirements including, but not limited to, ensuring documentation is maintained at the provider level, providers are properly enrolled, and claims are accurate and complete with no duplicate entries. As the issues considered through this group are solved, Operational Reviews, routine monitoring, and desk reviews will be updated to reflect the changes.

HHSC will send a reminder notice to managed care organizations and FFS providers to reiterate the requirement to maintain all documents supporting that members received transportation services.

Responsible Manager

Deputy Executive Commissioner, Managed Care

Target Implementation Date

March 2022	*Transportation Oversight Workgroup initiated*
May 2022	*Notice sent to MCOs and FFS providers regarding required documentation*
March 2023	*MCO Operational Reviews focusing on transportation requirements complete*

Chapter 2

The Commission Had Desk Review Processes to Monitor Providers; However, It Had Significant Weaknesses in Its Monitoring of Provider Compliance in Certain Desk Review Areas

Chapter 2 Rating:

High [3]

To monitor providers' compliance with key contract requirements, applicable laws, and agency procedures, the Commission established desk review processes (see text box for information on desk reviews). Specifically, the Commission has created different types of desk reviews to help monitor providers' compliance with key areas and protect the clients using the transportation services. Auditors tested five desk review types and identified significant weaknesses that limit the Commission's ability to identify and address noncompliance. Figure 2 summarizes those weaknesses.

Desk Reviews

The Commission's desk reviews are conducted at the Commission's offices rather than on-site at the providers' locations. The desk reviews may involve reviewing the Commission's internal data and supporting documentation submitted by providers.

Source: The Commission.

Figure 2

Types of Desk Reviews and Weaknesses Identified During Testing

Desk Review Type	Purpose of Desk Review	Weaknesses Identified During Testing			
		Untimely Reviews	Improperly Designed Review	Inaccurate Results	Lack of Corrective Action Plans and/or Liquidated Damages for Noncompliance
Accident/Incident Reporting	Monitor timeliness of providers' reporting of accidents/incidents to the Commission (after an occurrence) for the quarterly review period.		X	X	X
Complaints Reporting	Monitor timeliness of responses (and resolutions) of client complaints against the provider for the semi-annual review period.	X	X	X	X
Healthcare Claims Matching	Identify unmatched transportation claims to corresponding healthcare claims to validate services rendered for the quarterly desk review period.	X			X
Driver Credential and Screening	Verify that a sample of provider's drivers meet the 10 different driver credential and screening requirements for the semi-annual review period.	X		X	X
Vehicle Registration	Verify that a sample of provider's vehicles (used for transportation services) have valid registration for the semi-annual review period.	X			X

[3] The risk related to the issues discussed in Chapter 2 is rated as High because they 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 and reduce risks to the audited entity.

Untimely Desk Reviews

The Commission conducted four of the desk review types tested (complaints reporting, healthcare claims matching, driver credential and screening, and vehicle registration desk reviews) from 218 days to 535 days *after* the end of the quarterly or semi-annual desk review period. Significant delays in conducting the desk reviews increase the risk to clients because noncompliant providers may continue to operate without correcting the issues.

As a result of the delays for the healthcare claims matching desk review, 24 (17 percent) of the 145 transportation claims tested by auditors did not have a corresponding healthcare claim to ensure that the claim was allowable. If conducted appropriately and in a timely manner, the healthcare claims matching desk review would help the Commission verify whether the claims are valid.

The complaints reporting and healthcare claims matching desk reviews rely on information extracted from other systems. According to the Commission, the delays in those desk reviews occurred because the Commission did not design those extractions in a timely manner. This resulted in a backlog of reviews, lengthening the time between the end of the desk review scope and when the Commission performed the reviews.

The delays in the driver credential and screening and vehicle registration reviews occurred because the Commission (1) did not establish a requirement for the timeliness of performing desk reviews in those areas and (2) did not have an effective process to monitor whether staff performed the desk reviews within a reasonable amount of time. While the Commission documents the dates when desk reviews are performed, it does not routinely review those dates.

In addition, the Commission's healthcare claims matching desk reviews are conducted for all regions except for the FFS region. For that region, the Commission did not have a desk review to match transportation program claims to a corresponding healthcare claim and follow-up on those without a matching claim, similar to its desk review process for MTO regions.

Improperly Designed Desk Reviews

The Commission did not properly design the accident/incident reporting and complaints reporting desk reviews. Specifically, the reports used to compile those desk reviews did not capture the necessary information or use the appropriate system's fields to calculate timeliness according to the contract terms.

According to the Commission, the staff who designed the reports used in the accident/incident reporting and complaints reporting desk reviews did not work with the staff performing those desk reviews. In addition, staff inaccurately entered provider due dates in the HHS Enterprise Administrative Report and Tracking (HEART) complaints system, which is important because it is used to calculate the timeliness of reporting complaints. As a result, those desk reviews did not produce accurate results to help ensure that clients arrived at their healthcare appointments safely and on time.

Inaccurate Review

For one of the three driver credential and screening desk reviews tested[4], the Commission did not use the appropriate information to allow it to verify compliance with a credentialing requirement. In addition, it did not identify that certain driver credential and screening checks had not been re-performed annually as required by the transportation provider contract (for example, annual reviews of the state criminal background check and drug test results). The Commission did not have a secondary review process to help ensure that desk reviews produce accurate results.

Lack of Corrective Action Plans or Liquidated Damages

The Commission established a policy for its healthcare claims matching desk reviews specifying when a Corrective Action Plan should be developed for a noncompliant provider. However, its policies and procedures do not provide sufficient guidance for the other desk review types on when the Commission should consider implementing Corrective Action Plans and assessing liquidated damages for identified noncompliance.

For example, the transportation provider contracts state that for accidents/incident reporting, the Commission is allowed to assess liquidated damages of up to $2,500 per day for reports that the provider submits late. Therefore, the Commission could have assessed potential liquidated damages of up to $75,000[5] for the late accidents/incident reports that the Commission identified in the three desk reviews that auditors tested. However, the Commission's desk review procedures do not provide guidance on when and how to apply the contract provision related to liquidated damages.

In addition, the Commission did not follow its policy for the noncompliance it identified in its healthcare claims matching desk reviews. Specifically, the Commission identified providers that had unmatched claims of 2 percent or

[4] Each of the desk reviews tested included multiple drivers and multiple driver credential and screening requirements.

[5] State auditors calculated the amount of potential liquidated damages by multiplying the total number of days late (30 days) by $2,500 per day.

more for 3 consecutive quarters, but it did not develop and implement Corrective Action Plans for that noncompliance, as required by its policy.

The Commission asserted that it needed time to gain an understanding of the program since it was transferred to a different department within the Commission in 2017. In addition, the Commission began transitioning the program to a different structural model in 2019. Corrective Action Plans and liquidated damages are important tools that can compel providers to meet contractual requirements and prevent continued or worsening noncompliance.

Recommendations

Because the Commission plans to continue to use the same desk reviews to monitor contract compliance, it should strengthen its processes and procedures by:

- Documenting required due dates for performing all desk reviews and developing and implementing an effective process for periodic monitoring to help ensure that staff meet those due dates.

- Developing a process for the timely matching of transportation claims to a corresponding healthcare claim for all regions, including those clients who receive transportation services under the FFS model.

- Redesigning the reports used for accident/incident reporting and complaint reporting desk reviews to ensure that those reports include the appropriate fields according to the new managed care contract requirements.

- Developing, documenting, and implementing a secondary review process for driver credential and screening desk reviews to help ensure the accuracy of those reviews, including the use of valid sources and proper renewal of requirements.

- Ensuring that the due date for the provider's response that is entered into the HEART system is accurate for each complaint; this could include designing the due date field to be an automatically calculated date field.

- Developing and implementing documented policies and procedures (1) describing when staff should consider placing a provider on a Corrective Action Plan and/or assessing liquidated damages and (2) requiring documented justifications for not applying corrective action for identified instances of noncompliance.

- Developing and implementing a documented process to monitor that staff are following its policies and procedures for applying corrective action for identified noncompliance.

Management's Response

Statement of Agreement/Disagreement

HHSC agrees with the finding and offers the following response to the recommendations.

Action Plan

HHSC is in the process of strengthening monitoring processes related to desk reviews, including processes to ensure accountability for contract management staff. HHSC will create a documented Monitoring and Accountability Plan specific to all desk reviews for transportation-related requirements. The Monitoring and Accountability Plan will include a quality assurance process to ensure the accuracy of driver credential and screening desk reviews, including the use of valid sources and proper renewal of requirements. The Transportation Oversight Workgroup will consider each desk review to ensure the reports are properly designed, producing accurate information, and updated to reflect the transition to managed care. The monitoring plan will leverage existing processes outlined in the Uniformed Managed Care Manual related to contract remedies to ensure staff are applying consistent contract remedies when requirements are not met.

The Transportation Oversight Workgroup (included in the resolution to Recommendation 1-B) will be tasked with exploring options for ensuring that transportation services match to a covered healthcare service. For the FFS delivery model, HHSC will use the existing Matching Process Protocol that it utilizes for the managed care delivery model. The Matching Process Protocol matches transportation expenditures to corresponding healthcare claims and encounters, pharmacy point of sale, and other insurance to support that transportation was used for its intended purpose. HHSC staff has initiated conversations with the MCOs to discern the best method to ensure that members are being transported only to covered healthcare services.

HHSC will ensure that the provider response due date that is entered into HEART is accurate for each complaint, including consideration for an automated calculation in the due date field and defined processes for communicating with transportation providers to verify they are meeting contractual requirements.

Responsible Manager

Deputy Executive Commissioner, Managed Care

Interim Deputy Executive Commissioner, Operations

Target Implementation Date

June 2022	*Monitoring and Accountability Plan specific to transportation oversight desk reviews initial template developed*
	Options for monitoring healthcare claims matching developed by Transportation Oversight Workgroup
August 2022	*Final decision for monitoring healthcare claims matching process selected*
September 2022	*Incorporate the Monitoring and Accountability Plan into the quarterly review cycle to evaluate consistency and accuracy*
October 2022	*Milestones for implementation of healthcare claims matching developed*
January 2023	*Monitoring and Accountability Plan review process established*

Chapter 3

The Commission Monitored Provider-reported Accidents/Incidents and Client Complaints, But It Should Ensure That Client-reported Accidents/Incidents are Investigated and That Complaints are Closed Timely

In addition to conducting desk reviews to monitor provider compliance with certain contract requirements, the Commission is responsible for monitoring accidents/incidents that occur during the course of transporting clients, including maintaining the Accidents/Incidents database with details related to cases. (Certain portions of that data are used in the desk reviews discussed in Chapter 2.) The Commission is also responsible for receiving and monitoring client complaints to ensure proper resolution.

Although the Commission had an adequate process for monitoring that provider-reported accidents/incidents are resolved, it should (1) improve the design of its process for investigating and resolving accidents/incidents for those cases received from clients and (2) close complaints within established timeframes. In addition, it should ensure the accuracy and completeness of data in its Accidents/Incidents database.

Chapter 3-A Rating:

Medium [6]

Chapter 3-A

The Commission Adequately Monitored Provider-reported Accidents/Incidents; However, It Should Ensure That Providers Consistently Investigate and Resolve Client-reported Accidents/Incidents

The Commission receives notice of accidents/incidents (see text box for definitions of accident and incident) through two methods:

- Reports from providers.
- Notifications from clients as complaints.

A majority of the accidents/incidents are reported by providers. Specifically, providers reported 79 percent of the accidents/incidents recorded by the Commission from September 1, 2019, through March 31, 2021. Figure 3 on the next page shows the accidents/incidents receiving and monitoring process.

Accident and Incident Definitions

An **accident** is an unexpected and unfortunate medical bodily event causing loss or injury to a person (e.g., automobile accident).

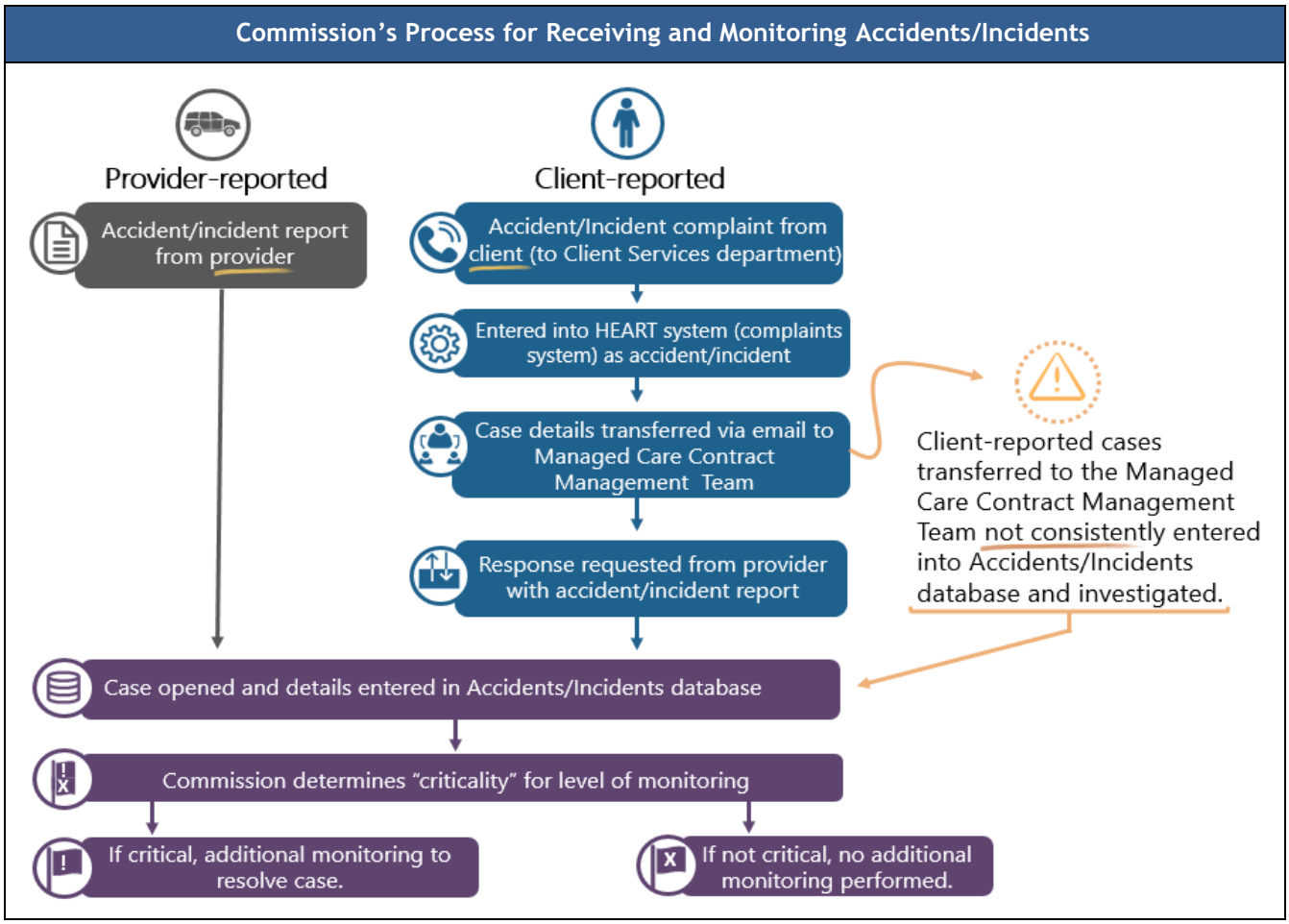
An **incident** is an occurrence, event, or public disturbance that interrupts the trip, causing the driver to stop the vehicle (e.g., vehicle breakdown or a passenger or driver becomes unruly or ill).

Source: Commission's *Accidents and Incidents Procedures*

[6] The risk related to the issues discussed in Chapter 3-A is rated as Medium because they present risks or effects that if not addressed 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 and reduce risks to a more desirable level.

The Commission adequately monitored provider-reported accidents/incidents but it did not ensure that providers investigated and resolved all client-reported accidents/incidents or that data in its Accidents/Incidents database was complete.

Figure 3



Sources: The Commission's *Medical Transportation Program Client Services Protocol for Complaint Management* and the Commission's *Accidents and Incidents Procedures*.

Provider-reported Accidents/Incidents

The Commission classifies each accident/incident case as either critical or non-critical in nature, which determines the level of monitoring for each case according to the Commission's *Accidents and Incidents Procedures*. For example, critical cases include serious injury or allegations of abuse. The Commission performs additional monitoring only for critical accidents/incidents.

Correct determinations of criticality and closing within a reasonable timeframe. The Commission correctly determined the criticality for all but one of the 25 provider-reported accidents/incidents with injury (cases) tested. For the remaining case tested, the Commission did not have adequate documentation (for example, a driver statement) to determine criticality. In addition, the Commission appropriately monitored the 15 critical cases (of the 25 cases tested[7]) to ensure that there was a sufficient resolution and that providers took appropriate corrective action.

In addition, the Commission properly closed out 14 (93 percent) of the 15 critical cases within 30 calendar days. The remaining case took 48 days to close after the provider sent the investigation documentation.

Unreliable data. The Commission did not have adequate controls to ensure that the information in its Accidents/Incidents database was accurate. The database is used to document and monitor the details for accidents/incidents to ensure that providers report accident/incidents in a timely manner (as noted in Chapter 2). Specifically:

- Twenty (80 percent) of 25 accident/incident records with injury tested had inaccurate dates in key date fields. For example, 14 critical cases had an inaccurate close date that did not reflect the actual date the cases were closed per closure letters. According to the Commission, it entered the date on which it manually entered final case details rather than the date in the closure letter. In addition, nine cases had an inaccurate accident/incident date and time that did not reflect the information in the final accident/incident report.

- Forty (14 percent) of 297 accident/incident records with injury reviewed had one or more of the following errors due to lack of edit checks for those fields: unreasonable dates; improper Medicaid numbers; and missing driver, subcontractor, and/or client information.

The Department of Information Resources' *Security Control Standards Catalog*, version 1.3, specifies the minimum security requirements, including ensuring that there are controls around data input into the system to prevent unexpected or incorrect results.

[7] The other 10 cases were not critical and therefore did not require the Commission to perform additional monitoring as noted in Figure 3.

Client-reported Accidents/Incidents

The Commission also receives notification of some accidents/incidents from clients in the form of complaints. The complaint staff refers these cases to the investigating department. All but one of the 25 client-reported accidents/incidents tested were properly transferred to the appropriate department.

However, the Commission's process was not adequately designed to ensure that client-reported accidents/incidents are entered into the Accidents/Incidents database when *initially* received, to facilitate monitoring and investigation processes. For 5 of 25 client-reported accidents/incidents tested, the Commission did not include those cases in the Accidents/Incidents database, as required by its *Accidents and Incidents Procedures*. As a result, the Commission did not investigate 4 (16 percent) of 25 accident/incident referrals tested. As of August 4, 2021, the 4 cases had remained open from 285 to 698 days.

Recommendations

Because the Commission plans to continue to monitor serious accidents/incidents, it should:

- Ensure that the Accidents/Incidents database is accurate and reflects the information in supporting documentation (such as closure letters and final accident/incident reports).
- Ensure that client-reported accidents/incidents are captured in the Accidents/Incidents database to facilitate monitoring and assure completeness of the database.

Management's Response

Statement of Agreement/Disagreement

HHSC agrees with the finding and offers the following response to the recommendations.

Action Plan

Since the conclusion of the audit, HHSC has aligned procedures for both the FFS and managed care delivery models related to Accident and Incident reporting. The Accident and Incident Report Form and the Accident/Incident database were updated to capture contractually required information for

accident/incident reports, including supporting documentation. The standard operating procedures related to Accident and Incident oversight were also updated to reflect these changes. The Transportation Oversight Workgroup (discussed in the resolution for Recommendation 1-B) will be tasked with ensuring the new processes fully capture program requirements.

HHSC is in the process of strengthening controls around Accident and Incident intake and tracking processes. In January 2023, HHSC anticipates the implementation of Accident and Incident tracking and reporting through HEART, the agency system application used to handle complaints. Pulling Accidents and Incidents into HEART will ensure client-reported Accidents and Incidents are captured completely and accurately to facilitate intake, tracking, and monitoring processes. The Transportation Oversight Workgroup (discussed in the resolution for Recommendation 1-B) will be tasked with evaluating options and implementing solutions for ensuring reporting for accidents and incidents is complete and accurate.

Responsible Manager

Deputy Executive Commissioner, Managed Care

Target Implementation Date

May 2022	*Transportation Oversight Workgroup discussion on accuracy and completeness of Accidents and Incidents reporting and oversight initiated*
July 2022	*Transportation Oversight Workgroup outlines options for interim process until HEART transition completed*
January 2023	*Accidents and Incidents tracking and reporting transitioned to HEART*

Chapter 3-B

The Commission Monitored Client Complaints, But It Should Strengthen Its Processes to Ensure That Complaints Are Closed Timely

Chapter 3-B Rating:

Medium [8]

The Commission monitored client complaints to ensure that there was sufficient resolution and corrective action (see text box for definition of a complaint). In addition, data entry for key fields in the HEART system was accurate and application controls were in place. However, the Commission should strengthen its processes to close complaints within established timeframes.

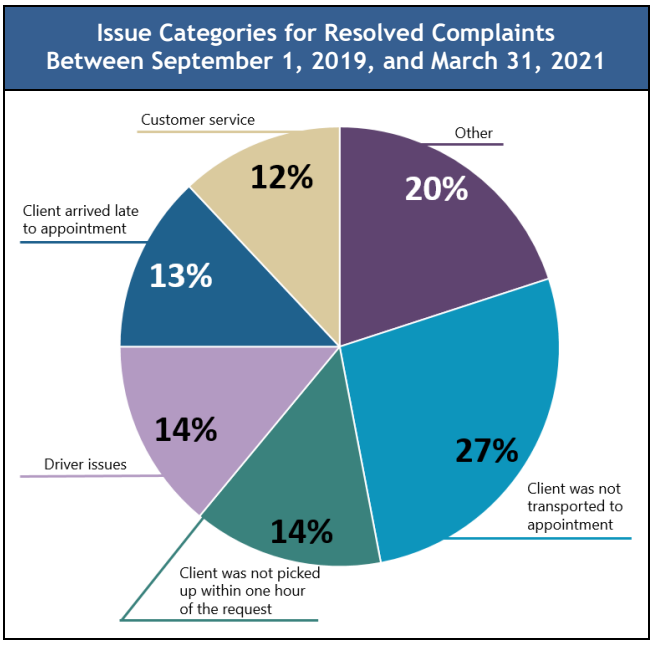
Complaint Definition

A **complaint** is any expression of dissatisfaction by a client or client's representative relating to medical transportation program services.

Sources: The Commission and the Commission's *Medical Transportation Program Client Services Protocol for Complaints Management*.

Figure 4 shows the issues related to resolved complaints for which the Commission verified there was a violation of policy or expectations.

Figure 4



Source: The Commission's complaint data from HEART.

Documenting and Resolving Complaints. The Commission had processes to ensure that it complied with its requirements for documenting and resolving complaints. Specifically, for 24 (96 percent) of the 25 resolved complaints

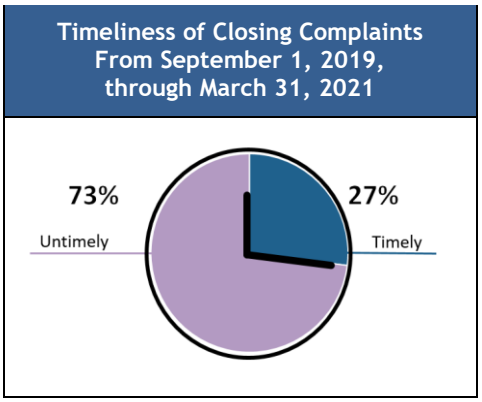
[8] The risk related to the issues discussed in Chapter 3-B is rated as Medium because they present risks or effects that if not addressed if not addressed could moderately affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Action is needed to address the noted concern and reduce risks to a more desirable level

tested, the Commission had sufficient documentation to close the case and ensure that resolution was appropriate and corrective action was effective.

Timeliness of Complaint Processing. The Commission did not follow up with the provider for 5 (83 percent) of the 6 resolved complaints tested in which the provider was more than 1 business day late providing a response within the contractually specified timeline. For one of those complaints, the response was received by the Commission 43 business days late. The Commission's *Medical Transportation Program Client Services Protocol for Complaint Management* (Protocol) requires staff to send deficiency notices when responses are late.

In addition, while the Protocol does not specify required timeframes for closing complaints, Commission management asserted that its goal is to comply with the timeframes in the prior complaint procedures[9]. However, the Commission did not close 20 (80 percent) of the 25 complaints tested within those established timeframes.

Figure 5



Source: The Commission's complaint data from HEART.

Data analysis of complaints closed between September 1, 2019, and March 31, 2021, showed that the Commission did not close 10,449 (73 percent) of 14,317 transportation program complaints within the established timeframes, taking an average of 42 business days to close complaints (see Figure 5).

The Commission attributed the lack of timeliness to delays caused by staff turnover. Without timely monitoring and resolution of complaints, the Commission may delay the identification of transportation providers' performance issues that affect clients.

Recommendation

Because the Commission will still be responsible for monitoring complaints, the Commission should:

- Evaluate and update its documented processes to ensure that complaints are effectively monitored and closed within established timeframes.
- Routinely monitor and communicate with transportation providers to verify that they are meeting the contractual requirement for reporting and resolving complaints.

[9] The Commission's prior procedures required that routine complaints should be closed in 15 business days and legislative complaints should be closed in 6 business days. According to the Commission, legislative complaints are inquiries and complaints received from congressional or state legislative offices.

Management's Response

Statement of Agreement/Disagreement

HHSC agrees with the finding and offers the following response to the recommendations.

Action Plan

HHSC is in the process of strengthening controls around complaint handling procedures. The Transportation Oversight Workgroup (discussed in the resolution for Recommendation 1-B) will be tasked with evaluating options and implementing solutions for ensuring complaints are effectively monitored and closed within established timeframes.

Responsible Manager

Deputy Executive Commissioner, Managed Care

Target Implementation Date

May 2022	*Transportation Oversight Workgroup discussion on oversight initiated*
September 2022	*Transportation Oversight Workgroup options for complaint monitoring evaluated*
December 2022	*Monitoring to ensure complaints are closed within required timeframes established*

Chapter 4

The Commission Effectively Transitioned the Transportation Program to a Managed Care Organization Model

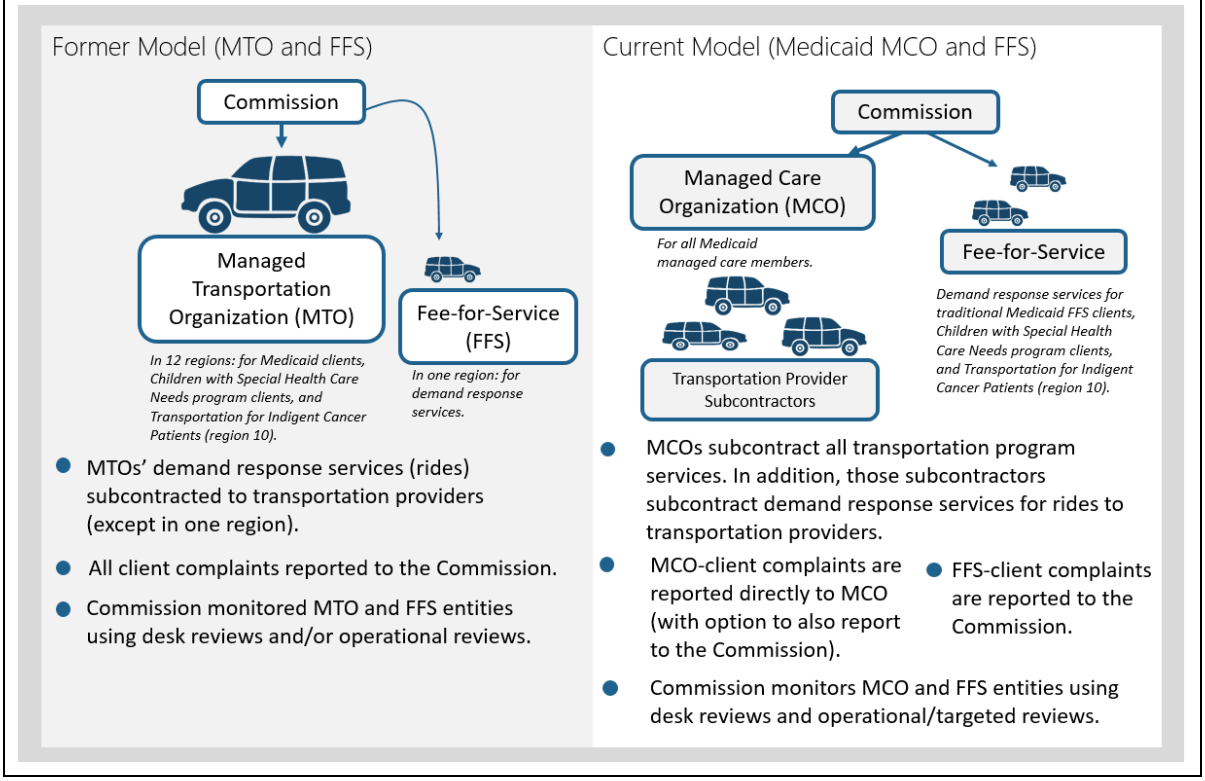
Chapter 4 Rating:

Low [10]

In fiscal year 2019, the 86th Legislature passed House Bill 1576 requiring the Commission to improve demand response for transportation services, add use of transportation network companies (for example, Uber Health), and move responsibility for nonemergency Medical Transportation Program services from MTOs to Medicaid MCOs for Medicaid managed care members. Figure 6 shows the differences between the former model (MTO and FFS) and the current model (MCO and FFS).

Figure 6

Overview of Differences Between Former Model (MTO) and Current Model (MCO)



Sources: The Commission and contracts with MTOs, FFS entities, and MCOs.

[10] The risk related to the issues discussed in Chapter 4 is rated as Low because 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.

The Commission effectively transitioned the transportation program to the MCO model as required. Specifically, the Commission:

- Ensured that all key requirements[11] from the prior model were included in the MCO contracts.
- Performed readiness reviews for all 17 MCOs and their 6 transportation subcontractors to provide transportation program services.
- Continued with the same monitoring frequency for five requirements reviewed; for the sixth requirement—call center operations—the monitoring will be more frequent, which was reasonable.

For the new model, the Commission will continue to use desk reviews to monitor provider compliance with contract requirements. However, the Commission had not updated all of its desk review procedures to reflect contract requirement changes. (See Figure 8 in Appendix 5 for a comparison of the prior and current contract requirements.) For example:

- The former model required that accidents/incidents be reported to the Commission within 1 hour if there was an injury or within 24 hours if there was no injury.
- The current model requires that accidents/incidents with serious injury or death be reported within 4 hours.

If desk review procedures are not redesigned and updated, there is a potential for (1) monitoring to be delayed and noncompliant providers continuing to operate without correcting issues timely and/or (2) reviews not producing relevant results to ensure that clients get to their healthcare appointments safely and on time. According to the Commission, it had not updated its procedures because it was focused on the transition.

Recommendation

The Commission should immediately redesign and update its desk review procedures to align with new MCO contract requirements to ensure that there is no delay in monitoring.

[11] These key requirements relate to (1) drivers/vehicles, (2) complaints, (3) accidents/incidents, (4) call center operations, (5) encounter data, and (6) transportation services.

Management's Response

Statement of Agreement/Disagreement

HHSC agrees with the finding and offers the following response to the recommendations.

Action Plan

HHSC has updated desk review procedures to align with new MCO contract requirements. The updated procedures became effective on January 20, 2022.

Responsible Manager

Deputy Executive Commissioner, Managed Care

Target Implementation Date

Implementation complete

Appendices

Appendix 1

Objectives, Scope, and Methodology

Objectives

The objectives of this audit were to determine whether the Health and Human Services Commission (Commission) administers select contract management processes related to the Medical Transportation Program (transportation program) in accordance with contract terms, applicable laws, regulations, and agency policies and procedures, including how the Commission ensures that:

- Required authorized services are provided to eligible clients.
- Providers meet key contract outcomes.

Scope

The scope of this audit covered the Commission's processes and controls related to transportation program claims data, transportation supporting documentation, transportation provider contracts, complaints, accident/incidents, and contract monitoring documentation between September 1, 2019, and March 31, 2021. The audit also covered the transition of the program to Medicaid Managed Care Organizations (MCOs), including transition supporting documentation, through August 31, 2021. The scope also included a review of significant internal control components related to the Commission's oversight of the transportation program (see Appendix 3 for more information about internal control components).

Methodology

The audit methodology included interviewing Commission staff; reviewing, analyzing, and testing transportation program claims, accidents/incidents, and complaints; reviewing transportation program contracts and amendments; testing selected contract monitoring documentation; reviewing readiness reports for transition; reviewing application controls for the Accidents/Incidents database and the HHS Enterprise Administrative Report and Tracking (HEART) system; and performing selected tests and other procedures.

Data Reliability and Completeness

Auditors assessed the reliability of the Commission's transportation program claims data for both the Medicaid Transportation Organization (MTO) regions and the Fee-for-Service (FFS) region, as well as complaints data (in the HEART system), by (1) reviewing data extract parameters, (2) analyzing key data elements fields for expected results, and (3) tracing samples of data to their source documents (see section below for sample details). Auditors determined that the data sets were sufficiently reliable for purposes of this report.

To assess the reliability and completeness of the data for accidents/incidents with injury (in the Accidents/Incidents database), auditors (1) reviewed data extraction parameters and tested application controls, (2) compared data to related source documentation, and (3) interviewed Commission staff about the data. The results of our electronic testing showed that data elements key to our review contained missing edit checks; sample testing to source documents contained invalid close date and data entry errors; and the Accidents/Incidents database was incomplete (missing records) as compared to HEART, a separate complaints system. As a result of these discrepancies, auditors concluded that the accident/incident with injury data was not sufficiently reliable for audit purposes. Auditors were unable to perform a data analysis procedure to determine whether the Commission closed cases within a reasonable time due to invalid close dates. Also, the data should not be used to reach conclusions due to its incompleteness.

Sampling Methodology

Auditors selected the following nonstatistical samples for tests of compliance and controls.

Table 2 on the next page identifies the sampling methodology used for each sample item. The items in the samples below were not necessarily representative of the populations; therefore, it would not be appropriate to project the test results to the populations.

Table 2

Total Populations and Samples Selected for Transportation Program Claims, Accidents/Incidents With Injury, Complaints (Including Accident/Incident Referrals), and Various Desk Reviews Between September 1, 2019, and March 31, 2021			
Description	**Population**	**Sample Size**	**Sample Methodology [a]**
Claims Data for MTO Regions (includes demand response, mass-transit, meals, lodging, airfare, or advanced funds for meals or lodging)	2,015,336 claims	65	60 random. 4 risk-based items for potential duplicate transactions. 1 directed item for largest cost for lodging (potential incorrect amount).
Mileage Claims for MTO Regions	296,531 claims	28	25 random. 1 risk-based item for risk of incorrect mileage rate paid. 2 directed items for largest distance traveled (potential incorrect amount).
Claims Data for FFS Region (includes demand response, mass-transit, meals, lodging, airfare, or advanced funds for meals and lodging)	42,678 claims	25	Random
Mileage Claims for FFS Region	5,106 claims	27	25 random. 2 risk-based for potential incorrect mileage rate paid.
Accidents/Incidents with Injury (from providers)	296 cases	25	Random
Accidents/Incidents (from clients)	282 cases	25	Random
Resolved Complaints	13,932	25	Random
Accidents/Incidents Desk Reviews	36 quarterly desk reviews	5	Random
Complaints Desk Reviews	18 semi-annual desk reviews (twice a year)	3	Random
Healthcare Claim Matching Desk Reviews	20 quarterly desk reviews	3	Random
Driver Credential and Screening Desk Reviews	18 semi-annual desk reviews	3	Random
Vehicle Registration Desk Reviews	18 semi-annual desk reviews	3	Random

Total Populations and Samples Selected for Transportation Program Claims, Accidents/Incidents With Injury, Complaints (Including Accident/Incident Referrals), and Various Desk Reviews Between September 1, 2019, and March 31, 2021			
Description	Population	Sample Size	Sample Methodology [a]

[a] **Random sample design** was chosen to ensure that the sample included a cross section of the claims, mileage claims, accident/incidents, resolved complaints, or the desk review area.

Directed sample design was chosen to ensure that the sample included items with specific characteristics.

Risk-based sample design was chosen to address specific risk factors identified in the population; the selected items had a high potential for error.

Information collected and reviewed included the following:

- The Commission's policies and procedures.
- Statutes related to the transportation program and the Office of the Comptroller of Public Accounts' state mileage rates.
- The Commission's transportation program claims data from Texas Medicaid & Healthcare Partnership (TMHP, the Commission's contractor) data warehouses and the Commission's Texas Medical Transportation System; related healthcare claims data from TMHP's data warehouse; transportation program client enrollment data from the Texas Integrated Eligibility Redesign System; accidents and incidents with injury data from the Commission's Accidents/Incidents database; and complaints data from the Commission's HEART system.
- The Commission's supporting documentation for transportation program claims, including transportation driver logs, lodging receipts, mileage claim forms, healthcare provider verification for out-of-county travel, and individual transportation participant enrollment support.
- Transportation program contracts, amendments, and monitoring documentation (Commission's desk review closure letters, Commission's readiness review reports for MCO transportation subcontractors, and other monitoring documentation).
- Resolved complaints and accidents/incidents with injury supporting documentation, including client and driver statements and required forms.
- Application controls over the Commission's Accidents/Incidents database and HEART system.

Procedures and tests conducted included the following:

- Interviewed Commission management and staff to understand the transportation program processes and monitoring related to transportation program claims, accidents/incidents, complaints, and transition to MCO model.

- Tested samples of transportation program claims for the MTO regions and the FFS region (including separate samples of mileage claims) to determine whether the transportation program claims were supported and allowable, had accurate amounts, had corresponding healthcare claims, and were for eligible clients, as required.

- Tested a sample of desk reviews to determine if the Commission adequately designed and monitored transportation providers' compliance with key contract outcomes in five areas: accident/ incident reporting, complaint reporting, matching transportation claims to corresponding healthcare claims, verifying vehicle registration, and verifying driver credential and screening.

- Tested a sample of (1) provider-reported accidents/incidents with injury and (2) resolved client complaints to ensure sufficient resolution, corrective action, and timely closing of cases. Also tested a sample of client-reported accident/incident complaint referrals to ensure that cases were properly transferred to and investigated by the department working accident/incident cases.

- Analyzed transportation program complaints to evaluate timeliness of monitoring and resolving cases as required.

- Compared the MTO contracts (and amendments) to the MCO contract amendment related to the inclusion of the transportation program for key areas selected and determined if the Commission included key requirements for those areas, if changes were reasonable, and if the Commission's monitoring frequency will be changed.

- Reviewed the Commission's readiness reviews of MCO transportation providers to determine whether the Commission adequately prepared for the transition from MTO providers to MCO providers.

Criteria used included the following:

- Texas Administrative Code, Chapter 380.
- Texas Government Code, Chapters 531 and 533.
- Transportation program contracts between the Commission and transportation providers.
- Commission's Accident and Incident Procedures.
- Commission's Medical Transportation Program Client Services Protocol for Complaint Management (effective June 2020) and the Commission's Medical Transportation Program Complaint Procedure (effective between March 2019 and June 2020).
- Commission's desk review procedures for (1) Accident Incident Reporting Review, (2) Complaint Management Review: Complaint Response and Resolution Time Frames, (3) Nonemergency Encounter Data Processing Procedures, (4) Vehicle Registration Review, and (5) Driver Credential Review.

Project Information

Audit fieldwork was conducted from February 2021 through October 2021. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective(s). Those standards also require independence in both fact and appearance. During the audit, legislative funding was vetoed. This condition could be seen as potentially affecting our independence in reporting results related to this agency. However, we proceeded with this audit as set forth by the annual state audit plan, operated under the Legislative Audit Committee. We believe this condition did not affect our audit conclusions.

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

- Kelley Ngaide, CIA, CFE (Project Manager)
- Arnton W. Gray, CPA, CIA (Assistant Project Manager)
- Steven Arnold, CFE
- Robert H. (Rob) Bollinger, CPA, CGMA, CFE

- Scott Labbe, CPA
- Jessica McGuire, MSA
- Anca Pinchas, CPA, CISA, CIDA
- Jessica I. Prieto, CPA
- Kiara White, CFE
- Robert G. Kiker, CFE, CGAP (Quality Control Reviewer)
- Courtney Ambres-Wade, CFE, CGAP (Audit Manager)

Appendix 2

Issue Rating Classifications and Descriptions

Auditors used professional judgment and rated the audit findings identified in this report. Those issue ratings are summarized in the report chapters/sub-chapters. The issue ratings were determined based on the degree of risk or effect of the findings in relation to the audit objective(s).

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.

Table 3 provides a description of the issue ratings presented in this report.

Table 3

Summary of Issue Ratings	
Issue Rating	**Description of Rating**
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.
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.
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.
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.

Appendix 3

Internal Control Components

Internal control is a process used by management to help an entity achieve its objectives. The U.S. Government Accountability Office's *Generally Accepted Government Auditing Standards* require auditors to assess internal control when internal control is significant to the audit objectives. The Committee of Sponsoring Organizations of the Treadway Commission (COSO) established a framework for 5 integrated components and 17 principles of internal control, which are listed in Table 4.

Table 4

Internal Control Components and Principles		
Component	**Component Description**	**Principles**
Control Environment	The control environment sets the tone of an organization, influencing the control consciousness of its people. It is the foundation for all other components of internal control, providing discipline and structure.	▪ The organization demonstrates a commitment to integrity and ethical values. ▪ The board of directors demonstrates independence from management and exercises oversight of the development and performance of internal control. ▪ Management establishes, with board oversight, structures, reporting lines, and appropriate authorities and responsibilities in the pursuit of objectives. ▪ The organization demonstrates a commitment to attract, develop, and retain competent individuals in alignment with objectives. ▪ The organization holds individuals accountable for their internal control responsibilities in the pursuit of objectives.
Risk Assessment	Risk assessment is the entity's identification and analysis of risks relevant to achievement of its objectives, forming a basis for determining how the risks should be managed.	▪ The organization specifies objectives with sufficient clarity to enable the identification and assessment of risks relating to objectives. ▪ The organization identifies risks to the achievement of its objectives across the entity and analyzes risks as a basis for determining how the risks should be managed. ▪ The organization considers the potential for fraud in assessing risks to the achievement of objectives. ▪ The organization identifies and assesses changes that could significantly impact the system of internal control.
Control Activities	Control activities are the policies and procedures that help ensure that management's directives are carried out.	▪ The organization selects and develops control activities that contribute to the mitigation of risks to the achievement of objectives to acceptable levels. ▪ The organization selects and develops general control activities over technology to support the achievement of objectives. ▪ The organization deploys control activities through policies that establish what is expected and procedures that put policies into action.

Internal Control Components and Principles		
Component	**Component Description**	**Principles**
Information and Communication	Information and communication are the identification, capture, and exchange of information in a form and time frame that enable people to carry out their responsibilities.	▪ The organization obtains or generates and uses relevant, quality information to support the functioning of internal control. ▪ The organization internally communicates information, including objectives and responsibilities for internal control, necessary to support the functioning of internal control. ▪ The organization communicates with external parties regarding matters affecting the functioning of internal control.
Monitoring Activities	Monitoring is a process that assesses the quality of internal control performance over time.	▪ The organization selects, develops, and performs ongoing and/or separate evaluations to ascertain whether the components of internal control are present and functioning. ▪ The organization evaluates and communicates internal control deficiencies in a timely manner to those parties responsible for taking corrective action, including senior management and the board of directors, as appropriate.

Source: Internal Control – Integrated Framework, Committee of Sponsoring Organizations of the Treadway Commission, May 2013.

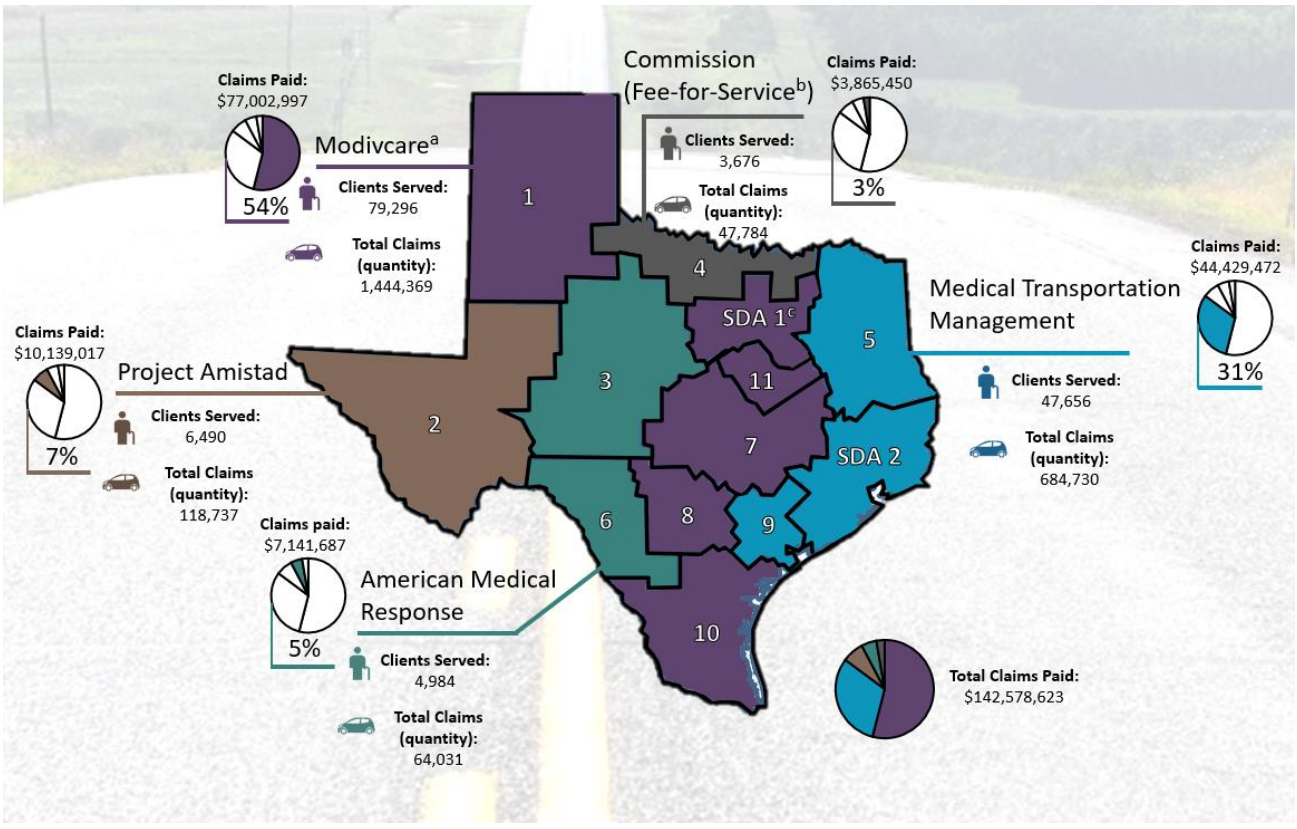
Appendix 4

Transportation Program Regions, Claims, and Clients Served by Transportation Provider

The Health and Human Services Commission's (Commission) Medical Transportation Program (transportation program) had 2.4 million claims related to 142,102 clients totaling $142.6 million[12] between September 1, 2019, and March 31, 2021. Prior to the transition of transportation program services to Medicaid Managed Care Organizations, 4 Managed Transportation Organizations (MTOs) were responsible for 12 regions, while the Commission was responsible for one Fee-for-Service region (Region 4). Figure 7 shows the total claim amounts paid, number of clients served, and total number of claims by transportation provider and region(s) served.

Figure 7

Transportation Program Claims and Clients Served by Provider
Between September 1, 2019, and March 31, 2021



[12] The Commission paid the 4 MTO providers responsible for 12 regions a set monthly amount per eligible member in each service area (known as the capitation rate). The $142.6 million in total claims are expenses incurred by transportation providers when providing services according to contract terms; that figure is not intended to represent that set monthly capitation amount.

Transportation Program Claims and Clients Served by Provider
Between September 1, 2019, and March 31, 2021

[a] Modivcare operated under the name LogistiCare prior to January 2021.

[b] Two Fee-for-Service providers in region 4, Real Time Transportation Corporation and Rolling Plains Management Corporation, provided demand response services to transportation program clients.

[c] SDA 1 and SDA 2 are Service Delivery Areas. These are the same as regions but the Commission refers to them as SDAs.

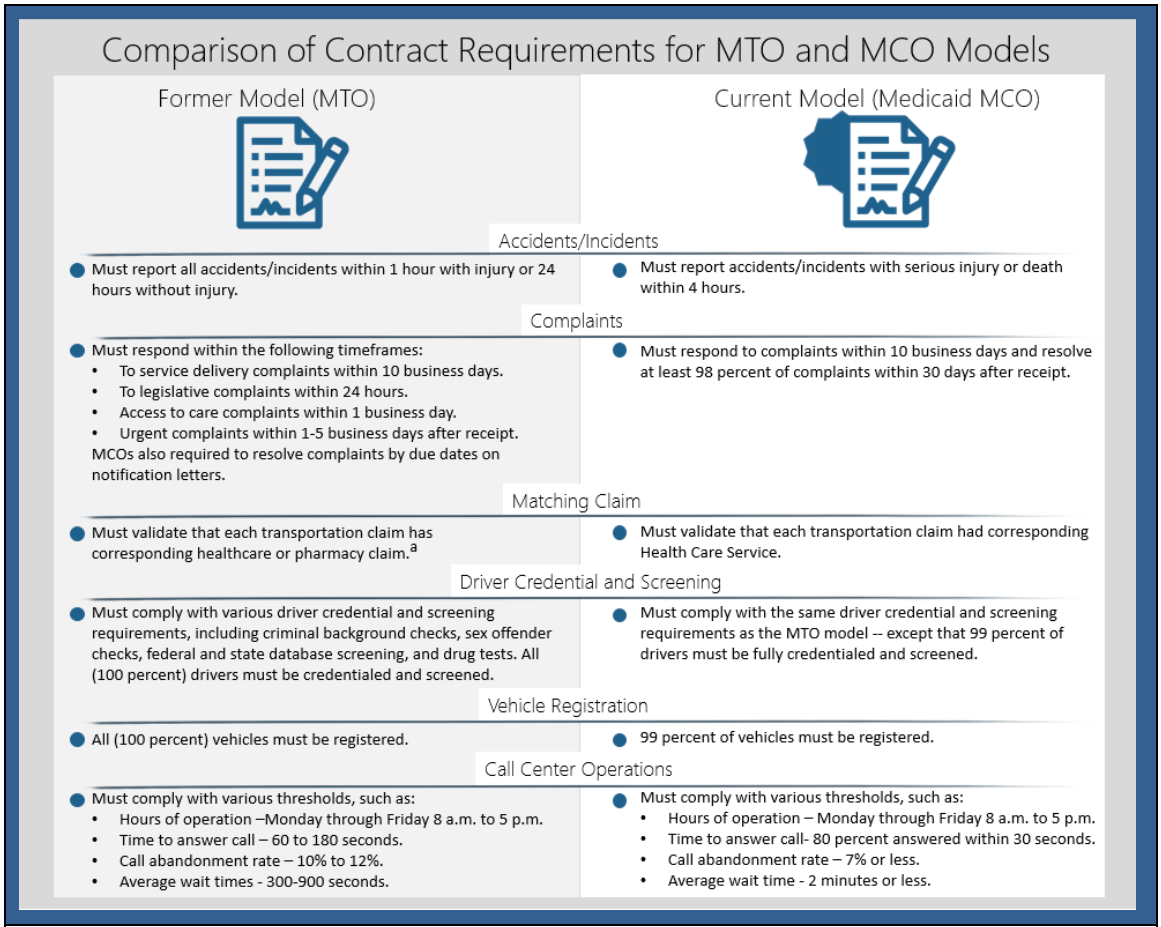
Sources: The Commission's transportation program claims data from the Texas Medicaid & Healthcare Partnership (the Commission's contractor) data warehouses and the Commission's Texas Medical Transportation System; and the Commission's contracts with transportation providers.

Appendix 5

Comparison of MTO and Medicaid MCO Contract Requirements

The Health and Human Services Commission (Commission) transitioned to the current Medicaid Managed Care Organization (MCO) model effective June 1, 2021. The Commission's transportation program was in transition during the audit, and auditors reviewed the Commission's processes for monitoring key contract requirements for the prior Managed Transportation Organization (MTO) model. While there were threshold changes to contract requirements, the key contract requirement areas are the same (see Chapter 4 for more information about the Commission's transition to the Medicaid MCO model). Figure 8 compares the contract requirements for the six key areas reviewed between the prior MTO contracts and current Medicaid MCO contracts.

Figure 8



[a] According to the Commission, it issued contract clarification to MTOs on September 22, 2021, (after audit scope) that required 1 percent of total unmatched transportation claims to receive validation from a healthcare provider per quarterly reporting period.

Sources: The Commission's contracts with MTO and Medicaid MCO entities.

Copies of this report have been distributed to the following:

Legislative Audit Committee

The Honorable Dan Patrick, Lieutenant Governor, Joint Chair
The Honorable Dade Phelan, 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. Cecile Erwin Young, Executive Commissioner