

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**TEXAS DID NOT MAKE INCREASED  
PRIMARY CARE PROVIDER PAYMENTS  
AND CLAIM REIMBURSEMENT IN  
ACCORDANCE WITH FEDERAL  
REQUIREMENTS**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



Gloria L. Jarmon  
Deputy Inspector General  
for Audit Services

April 2018  
A-06-15-00045

# *Office of Inspector General*

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The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

## Report in Brief

Date: April 2018

Report No. A-06-15-00045

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



### Why OIG Did This Review

To encourage primary care providers to participate in the Medicaid program, the Affordable Care Act required States to pay increased Medicaid payments to eligible providers for services in calendar years 2013 and 2014. The States received a 100-percent Federal matching rate for any increased payment over the Medicaid rate in effect on July 1, 2009.

Our objective was to determine whether Texas made the increased Medicaid payments to providers and claimed reimbursement in accordance with Federal requirements.

### How OIG Did This Review

Our review covered \$721 million in Federal funds that Texas received for increased provider payments. We reviewed the accuracy of rates Texas used to calculate the increased payments, obtained payment data supporting increased payments Texas claimed, and analyzed that data.

## Texas Did Not Make Increased Primary Care Provider Payments and Claim Reimbursement in Accordance With Federal Requirements

### What OIG Found

Texas did not always make the increased Medicaid payments to providers and claim reimbursement in accordance with Federal requirements. Of the \$721 million in Federal funds that it received, Texas inappropriately received \$20.7 million in Federal funds because (1) it incorrectly claimed the 100-percent matching rate for payments that were only eligible for the regular matching rate and (2) it made payments that were unallowable.

Additionally, we are setting aside \$1.1 million in Federal funds Texas received for payments that exceeded the providers' actual billed charges. Providers did not complete the billed charges field for some payment data with meaningful amounts, so we could not determine the correct payment amounts for the data.

### What OIG Recommends and Texas Comments

We recommend that Texas refund \$20.7 million to the Federal Government that it received for incorrectly claimed and unallowable payments.

We also recommend that Texas work with the Centers for Medicare & Medicaid Services to determine the portion of the \$1.1 million that it received for payments that exceeded providers' billed charges should be refunded to the Federal Government.

In written comments on our draft report, Texas did not indicate concurrence or nonconcurrence with our recommendations. Texas indicated that it would refund payments to the Federal Government that it confirms were incorrectly claimed and unallowable. Texas also indicated it will work with CMS to determine which portion of the \$1.1 million is unallowable and refund it to the Federal Government.

We maintain that our recommendations are valid.

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## INTRODUCTION

### WHY WE DID THIS REVIEW

To encourage primary care providers (providers) to participate in the Medicaid program, the Affordable Care Act (ACA)<sup>1</sup> required States to pay increased Medicaid payments to eligible providers for certain services in calendar years (CYs) 2013 and 2014. The States received a 100-percent Federal matching rate for any increased payment over the Medicaid rate in effect on July 1, 2009. The Texas Health and Human Services Commission (State agency) claimed more than \$718 million in increased payments to providers at the 100-percent matching rate.<sup>2</sup>

### OBJECTIVE

Our objective was to determine whether the State agency made the increased Medicaid payments to providers and claimed reimbursement in accordance with Federal requirements.

### BACKGROUND

#### Medicaid Program

The Medicaid program provides medical assistance to eligible low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

States use the standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), to report actual Medicaid expenditures for each quarter. CMS uses the information on the CMS-64 reports to calculate the reimbursement due to the States for the Federal share of Medicaid expenditures. The amount that the Federal Government reimburses to State Medicaid agencies, known as Federal share, is determined by the Federal medical assistance percentage (FMAP), which varies based on the State's relative per capita income. During our audit period, Texas' FMAP ranged from 58.05 percent to 58.69 percent.

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<sup>1</sup> The Patient Protection and Affordable Care Act (PPACA), P.L. No. 111-148 (March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), P.L. No. 111-152 (March 30, 2010), collectively referred to as "ACA."

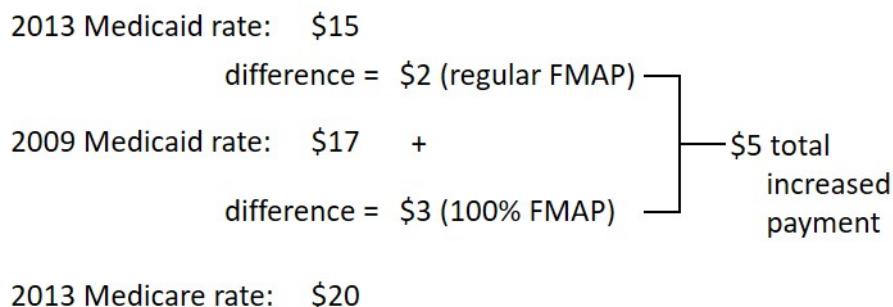
<sup>2</sup> We performed a similar review in Arkansas: *Arkansas Did Not Make Supplemental Payments in Accordance With Federal Requirements*, [A-06-15-00042](#) (Sept. 11, 2017).

## Federal Requirements Related to Increased Medicaid Payments

Section 1202 of the ACA amended the Social Security Act (the Act) to require State Medicaid agencies to make increased Medicaid payments for certain evaluation and management and vaccine administration services furnished by a provider specializing in family medicine, general internal medicine, or pediatric medicine.<sup>3</sup> The increased payment is the difference between the regular Medicaid payment and either the Medicare Part B rates in effect in CYs 2013 and 2014 or the rate that would be applicable using the CY 2009 Medicare conversion factor (CF), whichever is higher (Medicare rate).<sup>4</sup> For all services except for children's vaccine administration services, Federal regulations required States to limit payments to the lower of either the Medicare rate or the provider's actual billed charge for the service.<sup>5</sup>

The ACA established a 100-percent FMAP for the portion of the increased payment over the Medicaid rate in effect on July 1, 2009 (2009 Medicaid rate). To receive the increased FMAP, a State had to amend its State plan to reflect the increase in fee schedule payments in CYs 2013 and 2014. If a State decreased its Medicaid rates after July 1, 2009, the difference between the 2009 Medicaid rate and the Medicaid rate in effect on the date of service was only eligible for the regular FMAP. The following figure shows the FMAPs at which an increased payment should be claimed when a State decreased its Medicaid rates.

**Figure: Breakdown of an Increased Payment Between Federal Medical Assistance Percentages When a State Decreased Its Medicaid Rates**



To be eligible for the increased payments, first, a provider had to self-attest to specializing in family medicine, general internal medicine, or pediatric medicine, or a subspecialty recognized by the American Board of Medical Specialties, the American Board of Physician Specialties, or the American Osteopathic Association. Then, as part of that attestation, the provider had to

<sup>3</sup> Specifically, section 1202 of HCERA added new subsections 1902(a)(13)(C), 1902(jj), and 1905(dd) to the Act.

<sup>4</sup> The CF is part of the formula that calculates the Medicare payment rates in the Physician Fee Schedule. To determine the payment rate for a particular service, the sum of the geographically adjusted Relative Value Units is multiplied by a CF in dollars.

<sup>5</sup> 42 CFR §§ 447.405(a) and (b).

specify that he or she was board-certified by the appropriate professional association with such a specialty or subspecialty or that at least 60 percent of the Medicaid codes billed by the provider during the most recently completed CY were for eligible codes.<sup>6</sup>

### **Texas Medicaid Provider Increased Payments**

Effective January 1, 2013, the State agency amended its State plan to reflect the increase in fee schedule payments in CYs 2013 and 2014. The State plan identified all eligible codes for which the State agency would reimburse at the increased rates in CYs 2013 and 2014. The State agency's fiscal agent, the Texas Medicaid & Healthcare Partnership, calculated the increased payment amounts for providers that attested to their eligibility and made the payments.

Texas' Medicaid program is delivered through both the traditional fee-for-service (FFS) model and a managed care model. To determine the amount of increased payments to pay providers, the State agency used FFS claims data and managed care encounter data. The State agency calculated the 2009 Medicaid rates under FFS based on the physician fee schedule and, for the most part, the 2009 Medicaid managed care rates based on historical encounter data adjusted to 2009 levels. Texas decreased its Medicaid rates after July 1, 2009, so a portion of the increased payments was only eligible for the regular FMAP.

The State agency had two types of managed care encounter data—regular encounter data and capitated encounter data. Regular encounter data, the most common type, came from the managed care organizations (MCO) having FFS arrangements with providers, so the data usually included payment information. Capitated encounter data related to MCOs having subcapitated arrangements with providers, so the encounter data did not include payment information for the individual encounter. The State agency's methodology was to use the 2009 Medicaid rates under FFS as the payment amounts for capitated encounter data.

### **HOW WE CONDUCTED THIS REVIEW**

Our review covered \$721,034,637 in Federal funds that the State agency received for increased primary care provider payments. The State agency received these funds for \$723,154,652 in increased payments, consisting of \$718,053,951 that the State agency claimed at the 100-percent FMAP and \$5,100,701 that the State agency claimed at the regular FMAP.<sup>7</sup> We reviewed the accuracy of the rates that the State agency used to calculate the increased payments, obtained the FFS claims and encounter data supporting the increased payments the State agency claimed, and analyzed those data.

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<sup>6</sup> 42 CFR § 447.400(a).

<sup>7</sup> The payments claimed at the regular FMAP that we included in our scope related to unallowable payments that we identified.



We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

## FINDINGS

The State agency did not always make the increased Medicaid payments to providers and claim reimbursement in accordance with Federal requirements. Of the \$721,034,637 in Federal funds that the State agency received, the State agency inappropriately received \$20,714,957 in Federal funds because (1) it incorrectly claimed payments at the 100-percent FMAP that were only eligible for the regular FMAP (\$13,521,986) and (2) it made payments that were unallowable (\$7,192,971).

Additionally, we are setting aside \$1,051,629 in Federal funds the State agency received for payments that exceeded the providers' actual billed charges. Providers did not complete the billed charges field for capitated encounter data with meaningful amounts, so we could not determine the correct payment amounts for the data.

### **THE STATE AGENCY INCORRECTLY CLAIMED INCREASED PAYMENTS AT THE 100-PERCENT FEDERAL MEDICAL ASSISTANCE PERCENTAGE**

According to Federal regulations, Federal financial participation at the 100-percent FMAP was available for increased payments that exceeded the Medicaid payment that would have been made under the approved State plan in effect on July 1, 2009.<sup>8</sup> Because Texas decreased Medicaid rates after that date, the difference between the 2009 Medicaid rate and the Medicaid rate in effect on the date of service was only eligible for the regular FMAP. The State agency inappropriately received \$13,521,986 in Federal funds because it claimed payments at the 100-percent FMAP that were only eligible for regular FMAP, as follows:

- \$10,514,389 that resulted from the State agency miscalculating the 2009 Medicaid rates under the managed care program for the children's vaccine administration services procedure code,
- \$1,598,040 that resulted from the State agency misclassifying some initial increased payments under managed care that were made before the methodology for splitting such payments between the two FMAPs was finalized, and
- \$1,409,557 because the State agency's fiscal agent incorrectly programmed the

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<sup>8</sup> 42 CFR § 447.415(a).

payment processing system to claim all increased payments for the children's vaccine administration services procedure code at the 100-percent FMAP.<sup>9</sup>

### **Miscalculated 2009 Medicaid Managed Care Rates**

CMS instructed States to calculate the 2009 Medicaid managed care rates based on the same data originally used to develop the capitation rates in effect on July 1, 2009, if still available.<sup>10</sup> Also, States should make the same adjustments to the original data that they made when calculating the 2009 Medicaid managed care rates. CMS allowed States flexibility in determining the 2009 rates but also required that it review and approve States' methodologies for calculating the 2009 Medicaid rates under managed care.<sup>11</sup> Finally, Federal regulations stated that the enhanced 100-percent FMAP was available only if the State submitted its methodologies to CMS for review and approval.<sup>12</sup>

The State agency generally developed the capitation rates in effect on July 1, 2009, based on 2007 managed care encounter data adjusted to 2009 levels. On October 18, 2013, CMS approved the State agency's methodology for establishing those rates. That methodology adhered to CMS's instructions in the Technical Guidance and indicated that Texas would apply the methodology used to develop the capitation rates in effect on July 1, 2009.

The State agency decided the 2009 Medicaid rates under managed care for the children's vaccine administration services procedure code were unreasonable. As a result, the State agency recalculated the rates using unadjusted 2011 encounter data and arrived at Medicaid rates that were considerably different from those calculated using its approved methodology. For all other covered procedure codes, the State agency followed its approved methodology. The table on the next page compares the rates for children's vaccine administration services calculated using the State agency's CMS-approved methodology and the rates the State agency calculated after deviating from that methodology.

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<sup>9</sup> This amount is in addition to and not duplicated in the amount in this section's first bullet.

<sup>10</sup> CMS, *Medicaid Managed Care Payment for PCP [Primary Care Provider] Services in 2013 and 2014: Technical Guidance and Rate Setting Practices* (Technical Guidance) § 4.1.

<sup>11</sup> CMS, Technical Guidance § 3.

<sup>12</sup> 42 CFR § 438.804(a).

**Table: Comparison of the 2009 Medicaid Rates Using CMS Instructions and the Rates the State Agency Calculated**

<b>Managed Care Program<sup>13</sup></b>	<b>Rates Using CMS-Approved Methodology</b>	<b>State Agency Calculated Rates</b>	<b>Impact on Federal Claiming</b>
STAR	\$15.98	\$8.93	\$7.05
STAR+PLUS	\$6.86	\$8.08	(\$1.22)

The State agency’s understatement of the 2009 Medicaid rate under the STAR program, the managed care program for children, had the most impact on Federal financial participation. Specifically, the State agency claimed more than \$7 in increased payments per vaccine administration at the 100-percent FMAP, rather than the correct regular FMAP.

Because the State agency used rates that did not adhere to its approved methodology, it inappropriately claimed \$25,329,202 in increased payments at the 100-percent FMAP that were only eligible for the regular FMAP. The State agency would have only received \$14,814,813 in Federal funds for those payments at the regular FMAP, so the State agency inappropriately received the additional \$10,514,389 in Federal funds.

State agency officials believed it was appropriate to depart from its approved methodology for calculating the Medicaid managed care rates for children’s vaccine administration services in effect on July 1, 2009, because of the flexibility in CMS’s instructions. However, the State agency did not inform CMS of the State agency’s departure from its approved methodology.

**Misclassified Initial Increased Managed Care Payments**

Designing the increased payments methodology under managed care was complicated and took time. To get increased payments under managed care to providers, the State agency made initial increased payments before the methodology for splitting those payments between the two FMAPs was finalized. The State agency’s fiscal agent then checked those initial payments for accuracy.

The fiscal agent determined that the State agency, on the whole, had correctly made the payments. For example, if the State agency made a \$25 increased payment to a provider, the fiscal agent determined that that \$25 was accurate. However, the fiscal agent did not determine whether the State agency had correctly identified the split of the payments between the regular and 100-percent FMAPs.

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<sup>13</sup> STAR is Texas’ Medicaid managed care program for children, newborns, pregnant women, and some families. STAR+PLUS is Texas’ Medicaid managed care program for people who have disabilities or are aged 65 or older.

The State agency claimed \$3,868,410 in initial increased managed care payments at the 100-percent FMAP that was only eligible for the regular FMAP. The State agency would have only received \$2,270,370 in Federal funds for those payments at the regular FMAP. As a result, the State agency inappropriately received \$1,598,040 in additional Federal funds.

### **Incorrectly Programmed Payment Processing System**

Even though the 2013 and 2014 Medicaid rates for the children's vaccine administration services procedure code were lower than the 2009 Medicaid rates that the State agency calculated, the State agency claimed none of the increased payments for that code at the regular FMAP. This occurred because the State agency's fiscal agent incorrectly programmed the payment processing system to assign all such payments to the 100-percent FMAP under both FFS and managed care.

Because of the incorrect programming, the State agency claimed \$3,395,797 in payments for the children's vaccine administration services procedure code at the 100-percent FMAP that was only eligible for the regular FMAP. The State agency would have only received \$1,986,240 in Federal funds for those payments at the regular FMAP. As a result, the State agency inappropriately received \$1,409,557 in additional Federal funds.

### **THE STATE AGENCY MADE UNALLOWABLE INCREASED PAYMENTS**

The State agency inappropriately received \$7,192,971 in Federal funds because it made unallowable increased payments, as follows:

- \$6,719,623 for payments made based on inaccurate managed care encounter data,
- \$329,272 for payments made to providers that the State agency determined were ineligible,
- \$123,436 for payments that resulted from a Medicare rate that was incorrectly entered into the payment processing system,
- \$12,786 for payments that resulted from the fiscal agent incorrectly entering 2009 Medicaid FFS rates into the payment processing system for use as the capitated encounter data payment amounts, and
- \$7,854 for children's vaccine administration services provided to adults.

## **Payments for Inaccurate Managed Care Encounter Data**

According to Federal cost principles, to be allowable under Federal awards, costs must be adequately documented.<sup>14</sup> Additionally, the *CMS State Medicaid Manual* states that the amounts reported on the CMS-64 report and its attachments must represent actual expenditures. All supporting documentation must be in readily reviewable form and available at the time the claim is filed.<sup>15</sup> According to Federal regulations, MCO contracts must require MCOs to provide sufficient documentation to the State to enable it and CMS to ensure that payments were increased as required.<sup>16</sup>

Some regular managed care encounter data were marked as “paid” but did not include any payments, either from the MCO or other insurers. Therefore, the State agency should not have made increased payments based on the data because they were inaccurate. A State agency official that designed the increased payment system was not aware that some regular encounter data marked as “paid” would not actually include payment information. The State agency made \$8,825,887 in increased payments based on inaccurate encounter data and inappropriately received \$6,719,623 in Federal funds.

## **Payments Made to Ineligible Providers**

States were required to review a sample of providers who received increased payments to verify that they met the eligibility requirements.<sup>17</sup> The State agency’s fiscal agent performed the required provider reviews, which resulted in 23 providers that were deemed ineligible to receive the increased payments. However, the State agency did not recover any payments made to those providers. The State agency made increased payments totaling \$336,655 to ineligible providers and improperly received \$329,272 in Federal funds for those payments.

## **Payments for an Incorrectly Entered Medicare Rate**

For all services except for children’s vaccine administration services, Federal regulations limited payment to providers to the lower of the Medicare rate or the provider’s actual billed charge for the service.<sup>18</sup> The State agency’s fiscal agent incorrectly entered the 2014 Medicare rate for an adult’s vaccine administration services procedure code into the payment processing system. The correct rate for that code was \$23.64, but the rate entered into the system was \$26.34, or \$2.70 more than allowed. According to fiscal agent officials, the incorrect rate was

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<sup>14</sup> 2 CFR part 225, appendix A, subpart C (1)(j).

<sup>15</sup> *CMS State Medicaid Manual*, § 2500(A)(1).

<sup>16</sup> 42 CFR § 438.6(c)(5)(vi).

<sup>17</sup> 42 CFR § 447.400(b).

<sup>18</sup> 42 CFR §§ 447.405(a) and (b).

the result of a keying error. Because of that error, the State agency overpaid providers \$123,436, all of which the Federal Government funded.

### **Managed Care Payments That Resulted From Incorrectly Entered Medicaid Payment Rates**

Since capitated managed care encounter data did not include payment information, the State agency's methodology was to use the 2009 Medicaid rates under FFS as the payments for capitated encounters. The State agency's fiscal agent made errors when manually manipulating the 2009 Medicaid rates under FFS before loading them into the payment processing system. As a result, the State agency paid providers \$19,154 more than it would have if the FFS rates had been correctly entered and improperly received \$12,786 in Federal funds.

### **Children's Vaccine Administration Services Provided to Adults**

The American Medical Association defines the children's vaccine administration services procedure code as being for immunization services for children up to 18 years old. The State agency made increased payments of \$7,854 based on managed care encounter data for immunization services provided to adults over the age of 20, all of which was federally funded. The State agency did not ensure that MCO's payment systems included edits to avoid making these payments.

### **THE STATE AGENCY PAYMENTS EXCEEDED PROVIDERS' BILLED CHARGES**

For all services, except for children's vaccine administration services, Federal regulations required States to limit payments to the lower of the Medicare rate or the provider's actual billed charge for the service.<sup>19</sup> Based on capitated encounter data for services subject to the billed charges limit, the State agency made \$1,051,629 in increased payments that exceeded providers' billed charges, all of which was federally funded.

Providers did not complete the billed charges field for capitated encounter data with meaningful amounts because capitated encounter data are usually only used for utilization purposes.<sup>20</sup> After some providers complained that they were not getting increased payments for the services, the State agency removed the billed charges limit for affected encounter data. However, the State agency did not attempt to identify the accurate amounts for the billed charges field, so we could not determine the correct payment amounts for the data. As a result, we are setting aside the \$1,051,629 in Federal funds the State agency received for payments that exceeded the providers' actual billed charges.

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<sup>19</sup> 42 CFR §§ 447.405(a) and (b).

<sup>20</sup> Many providers completed the billed charges field with nominal amounts, such as a dollar or a penny.

## RECOMMENDATIONS

We recommend that the State agency:

- refund \$20,714,957 to the Federal Government that it received for incorrectly claimed and unallowable payments and
- work with CMS to determine the portion of the \$1,051,629 that the State agency received for payments that exceeded providers' billed charges that should be refunded to the Federal Government.

## STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with our recommendations.

Regarding our first recommendation, the State agency indicated that it would refund payments to the Federal Government that it confirms were incorrectly claimed and unallowable. Further, the State agency will review its methodology used to calculate the Medicaid rates under managed care for the children's vaccine administration services procedure code but believes that the rates it calculated were in compliance with CMS's instructions because of the flexibility in CMS's instructions. The State agency said it identified issues with the 2007 encounter data after it submitted its methodology to CMS for approval, so it was more appropriate to use the 2011 data in its calculations.

Regarding our second recommendation, the State agency said it will work with CMS to determine which portion of the \$1,051,629, if any, is unallowable and refund it to the Federal Government.

The State agency's comments are included in their entirety as Appendix B.

## OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our recommendations are valid. CMS required that it review and approve States' methodologies for calculating the 2009 Medicaid rates under managed care. The State agency did not inform CMS of the State agency's departure from its approved methodology.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our review covered \$721,034,637 in Federal funds that the State agency received for increased primary care provider payments. The State agency received these funds for \$723,154,652 in increased payments, consisting of \$718,053,951 that the State agency claimed at the 100-percent FMAP and \$5,100,701 that the State agency claimed at the regular FMAP.<sup>21</sup>

We limited our review of the State agency's internal controls to those related to the calculation of the increased payments because our objective did not require an understanding of the State agency's overall internal control structure.

We performed our audit work at the State agency's offices in Austin, Texas.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed the State agency's approved State plan;
- interviewed State agency officials to understand their policies and procedures related to the increased payments;
- evaluated the State agency's 2013 and 2014 provider eligibility reviews;
- reviewed the accuracy of the State agency's calculations for the 2009 Medicaid rates under FFS and managed care;
- verified that the State agency captured the correct 2013 and 2014 Medicare rates;
- determined whether all rates (Medicaid and Medicare) were correctly transferred into the payment processing system;
- obtained FFS claims and managed care encounter data support for increased payments and reconciled that data to the amounts claimed on the CMS-64 reports;

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<sup>21</sup> The payments claimed at the regular FMAP that we included in our scope related to unallowable payments we identified.



- analyzed the FFS and encounter data for accuracy and determined the effects of issues we identified; and
- discussed the results of our audit with the State agency.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## APPENDIX B: STATE AGENCY COMMENTS



Texas Health and Human Services Commission

Charles Smith  
Executive Commissioner

February 12, 2018

Ms. Patricia Wheeler  
Regional Inspector General for Audit Services  
Office of Inspector General, Office of Audit Services  
1100 Commerce, Room 632  
Dallas, Texas 75242

Reference Report Number A-06-15-00045

Dear Ms. Wheeler:

The Texas Health and Human Services Commission (HHSC) received a draft audit report entitled "*Texas Did Not Make Increased Primary Care Provider Payments and Claim Reimbursement in Accordance with Federal Requirements*" from the U.S. Department of Health and Human Services Office of Inspector General. The cover letter, dated December 13, 2017, requested that HHSC provide written comments, including the status of actions taken or planned in response to report recommendations.

I appreciate the opportunity to respond. Please find the attached HHSC management response which (a) includes comments related to the content of the findings and recommendations and (b) details actions HHSC has completed or planned.

If you have any questions or require additional information, please contact David M. Griffith, Deputy IG for Audit, HHSC Office of Inspector General. Mr. Griffith may be reached by telephone at (512) 491-2806 or by e-mail at David.Griffith@hhsc.state.tx.us.

Sincerely,

A black rectangular redaction box covering the signature of Charles Smith.

Charles Smith

P.O. Box 13247 • Austin, Texas 78711-3247 • 512-424-6500 • [hhs.texas.gov](http://hhs.texas.gov)

**Office of Inspector General Note**—The deleted text has been redacted because it is personally identifiable information.

Texas Health and Human Services Commission  
Management Response to the  
U.S. Department of Health and Human Services Office of Inspector General Report:  
**Texas Did Not Make Increased Primary Care Provider Payments and Claim  
Reimbursement in Accordance with Federal Requirements**

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**DHHS - OIG Recommendation #1:** *We recommend that the State agency refund \$20,714,957 to the Federal Government that it received for incorrectly claimed and unallowable payments.*

**HHSC Management Response:**

HHSC will conduct further research and analysis to verify incorrectly claimed and unallowable payments identified during the audit. Payments confirmed as incorrectly claimed or unallowable will be refunded to the Federal Government.

During this research and analysis HHSC will further review the methodology used for the Medicaid rates under the managed care program for the children's vaccine administration services procedure code (\$10,514,389 identified as unallowable due to methodology differences).

CMS technical guidance states that "The State has the flexibility in determining the 2009 baseline rate and the rate differential to comply with this rule, but the approach taken must be based on reasonable and documented data sources available to the state to accurately define these amounts to the fullest extent possible."

The rates used are in compliance with the technical directive. In calculating the STAR and STAR+PLUS 2009 baseline rates for the vaccination codes, HHSC identified issues in the 2007 managed care encounter data, after it had submitted the proposed methodology. HHSC proceeded to produce a more accurate estimate of the vaccination cost. Using the 2007 managed care data did not result in a reasonable nor appropriate 2009 baseline rate for the vaccination codes.

HHSC's position is that a more appropriate data source is the SFY 2011 data which was used in our calculations, because it provides a more accurate estimate of the vaccination cost per unit for determining the 2009 baseline rate. HHSC has performed validation of this position by comparing the SFY 2011 data results to the Fee for Service (FFS) rate for the same code, and noted that the results were similar.

**Estimated Completion Date:**

Within one year from the date of the final audit report.

**Title of Responsible Person:**

Deputy Executive Commissioner for Financial Services  
Deputy Associate Commissioner for Operations, Medicaid and CHIP Services

**DHHS - OIG Recommendation #2:** We recommend that the State agency work with the Centers for Medicare & Medicaid Services (CMS) to determine the portion of the \$1,051,629 that it received for payments that exceeded providers' billed charges should be refunded to the Federal Government.

**HHSC Management Response:**

HHSC will work with CMS to determine which portion of the \$1,051,629 in payments, if any, is unallowable. Payments confirmed as unallowable will be refunded to the Federal Government.

**Estimated Completion Date:**

Within one year of the date of the final audit report.

**Title of Responsible Person:**

Deputy Executive Commissioner for Financial Services  
Deputy Associate Commissioner for Operations, Medicaid and CHIP Services