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Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Texas Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare and Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Texas Medicaid Program. The onsite portion of the review was conducted in April 2008 at the offices of the Texas Health and Human Services Commission (HHSC). The MIG review team also visited the office of the Texas Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Health and Human Services Commission, Office of Inspector General (HHSC-OIG), which is responsible for Medicaid program integrity. This report describes five effective practices, four regulatory compliance issues, and three vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Texas improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Texas' Medicaid Program

The Medicaid/Children's Health Insurance Program Unit within HHSC's Health Services Division administers the Texas Medicaid program. As of the State fiscal year (SFY) ending August 31, 2007, the Medicaid program served nearly 2,832,000 recipients. Over 67 percent of the recipients are enrolled in Texas' 18 managed care organizations (MCO).

Medicaid expenditures in Texas for SFY 2007 totaled $21,057,733,379. HHSC processed an average of 68,566,323 claims per year over the period SFY 2005 through 2007. Approximately 90 percent of claims were submitted electronically. During Federal fiscal year 2007, the Federal medical assistance percentage was 60.78 percent.

As of April 15, 2008, there were 107,632 providers in Texas Medicaid. The Texas Medicaid Healthcare Partnership (TMHP), consisting of Affiliated Computer Services State Healthcare (ACS) and other subcontractors, serves as the Medicaid fiscal agent for claims processing and plays a primary role in provider enrollment. TMHP enrolls providers of acute care, long term care and mental health care in the Texas Medicaid program.

All MCO network providers are enrolled in Medicaid and TMHP as a precondition for participation in an MCO network. Transportation providers who participate in the State's Non-Emergency Medical Transportation (NEMT) program are enrolled by nine Transportation Service Area Providers (TSAP). Neither the NEMT providers nor the TSAPs are tracked in the

TMHP system. On May 1, 2008, the administration of the NEMT program was scheduled to move back into HHSC from the Texas Department of Transportation (TXDOT). During the review, HHSC was unable to provide the team with detailed information about how future monitoring and tracking would be handled after the changeover.

Program Integrity Section

The HHSC-OIG is the organizational component dedicated to the prevention and detection of provider fraud, abuse, and overpayments. At the time of the review, HHSC-OIG had approximately 530 full-time equivalent staff reporting to the Inspector General, excluding vacant positions. The Office of Inspector General is divided into four divisions: Divisions of Compliance, Enforcement, Operations, and Office of Chief Counsel.

The Compliance Division is responsible for identifying and reducing waste, abuse and fraud. The Enforcement Division is responsible for investigating allegations of waste, abuse and fraud. The Office of Chief Counsel is responsible for imposing administrative sanctions, damages or penalties and negotiating settlements. The Operations Division directs and guides the operation and planning of the Office of Inspector General. This division manages the Medicaid Fraud and Abuse Detection System and has responsibility for contractor oversight of the Surveillance and Utilization Review Subsystem (SURS) function and the third party liability program.

The table below presents the total number of provider investigations, administrative actions or sanctions, audits and identified overpayments in the past three SFYs as a result of program integrity activities. These numbers only reflect the activities of the HHSC-OIG; no managed care information is provided.

Table 1

SFY	Number of Preliminary & Full Provider Investigations	Number of State Administrative Actions or Sanctions (Approximation)	Number of Audits	Amount of Overpayments Identified
2005	557	8,628	5,377	$ 40,575,139
2006	863	9,848	3,086	$ 19,873,162
2007	652	8,717	6,214	$ 127,399,357

Methodology of the Review

In advance of the onsite visit, the review team requested that Texas complete a comprehensive review guide and supply documentation in support of its answers to the review guide. The review guide included such areas as provider enrollment, claims payment and post-payment review, managed care, SURS, and the MFCU. A five-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of April 15, 2008, the MIG review team met with numerous HHSC-OIG officials, the Medicaid Commissioner, and the Director of the MFCU. The review team conducted interviews with three MCOs and with State staff overseeing the NEMT and the NorthStar behavioral health waiver program. The review team also visited the TMHP offices.

Scope and Limitations of the Review

This review focused on the activities of the HHSC-OIG, but also considered the work of other State government units within the Texas Medicaid agency as well as contractors responsible for a range of complementary functions, including provider enrollment, data mining, contracting oversight, and legal support. Texas' State Children's Health Insurance Program is a stand-alone program and not included in this review.

Unless otherwise noted, HHSC provided the information on program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that HHSC provided.

RESULTS OF THE REVIEW

Effective Practices

The State has highlighted several practices that demonstrate its commitment to program integrity. These practices involve the establishment of an Office of Inspector General (OIG), the development of a protocol for providers to self-report fraud, waste and abuse, and a successful relationship between HHSC and the MFCU.

Establishment of the OIG

Texas established the OIG within HHSC. The OIG has 530 staff, excluding vacant positions. As one of the largest OIG offices in the country, all four divisions of the OIG contribute to the integrity of the Texas Medicaid program.

Cooperation with the MFCU

The HHSC's relationship with the MFCU is one of mutual cooperation that has worked extremely well for both agencies. The agencies' process for sharing of information is nearly seamless and ensures that administrative actions do not interfere with active MFCU investigations.

Provider self-reporting tool

The OIG developed a self-reporting protocol intended to encourage providers to voluntarily investigate and report inappropriate payments, as well as possible fraud, waste and abuse in State administered programs such as Medicaid. After following the protocol, the provider makes an initial report to the OIG. This early disclosure of non-compliance to the OIG generally allows for a better result for the provider than if the OIG discovered and investigated the matter independently.

Additionally, the MIG review team identified two practices that are particularly noteworthy. MIG recognizes the State's use of technology to assist in the evaluation of providers attempting to enter its Medicaid program, and the oversight of managed care networks.

Matching technology used in provider enrollment
TMHP recently purchased an innovative software package that automates the verification of licenses of potential Medicaid providers and ensures that Medicaid does not allow payments to non-qualified health care providers. The software allows TMHP to match a provider's information against the TMHP Master File, the Federal Provider Exclusion List, the Texas State Provider exclusion list, the Texas Medicaid Do Not Enroll List, and the Open Investigations list, so the user can easily determine if the provider is eligible to be enrolled. This has significantly reduced the risk that Medicaid recipients are receiving health care from excluded or restricted providers.

Oversight of MCO and network providers
HHSC requires managed care providers to be enrolled with Medicaid as a precondition for health plan credentialing. By requiring that all MCO providers be enrolled with HHSC via TMHP, the State is able to maintain centralized control over the credentialing process and standardize enrollment information disclosures and contractual obligations across all provider groups serving the Medicaid population.

Texas has a strong set of managed care regulations for MCOs. State regulation explicitly requires that MCOs participating in the Medicaid program implement program integrity strategies, such as creating investigative units dedicated to detection and identification of fraud and abuse, developing annual fraud and abuse compliance plans, and conducting program integrity-related enrollee education. Moreover, the HHSC-OIG has dedicated program integrity staff who review MCO compliance plans and quarterly reports, and interact with compliance officers on a monthly basis. These practices reflect a commendable commitment to the provision of ongoing MCO oversight.

Regulatory Compliance Issues
The State is not in compliance with Federal regulations related to required disclosure and notification activities.

Provider enrollment and credentialing packages do not capture ownership, control, and relationship information.
Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. Under 42 CFR § 455.104(c), the State agency may not contract with a fiscal agent that has not disclosed ownership and control information required under this section.

Provider information about individuals and entities disclosed on enrollment forms is captured in the Texas MMIS. However, not all provider enrollment forms capture the full range of disclosure information required by the regulation. For example, TMHP's enrollment forms do not capture information on the owners of a disclosing entity's related subcontractors. Therefore, any relationship to the entity's owners cannot be established. Similarly, TMHP does not collect information on owners, subcontractors and other disclosing entities related to TSAPs and their contracted drivers. Forms for managed care providers do not collect data on sibling relationships. In addition, most provider enrollment forms, with the exception of MCO contracts and long term care facility applications, do not require identification of related other disclosing entities. Lastly, it does not appear that the State requested or obtained the required ownership and control disclosures from TMHP's fiscal agent prior to contracting.

***Recommendations*:** Review all provider enrollment and credentialing packages and modify as necessary to request the information required under 42 CFR § 455.104(a). Obtain required ownership and control disclosures from the fiscal agent.

Provider enrollment agreements and contracts do not require providers to disclose certain business transactions.

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractors. All provider agreements processed by TMHP contain a global statement to "disclose information … related to business transactions … in accordance with 42 CFR Subpart B." However, TSAP contracts and agreements with NEMT drivers do not have a provision to provide this information.

***Recommendation*:** Review and modify the TSAP enrollment packages and contracts to incorporate the appropriate business transaction language. Review and modify all other enrollment packages and contracts to incorporate the appropriate language where needed.

Provider enrollment applications do not capture required criminal conviction information.

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made.

The majority of providers enrolled through TMHP disclose owners and managing employees through the Provider Information Forms (PIF) for providers [PIF-1] and for principals [PIF-2], defined by Texas as owners, corporate officers, directors, shareholders, managing employees, and agents. Both forms require disclosure of criminal convictions. However, providers who use a social security number (SSN) as an identifier are not required to disclose principals or their criminal convictions. Furthermore, TXDOT's enrollment procedures do not require owners and

managing employees of TSAPs and contracted NEMT drivers to disclose healthcare-related criminal convictions.

All criminal convictions disclosed through TMHP enrollment are reported to the HHS-OIG. However, as described above, not all criminal conviction disclosures are being captured so the State is not able to pass on the unreported information to the HHS-OIG. Accordingly, some managing employees who have excludable criminal backgrounds could participate or remain in the Medicaid program unchecked.

***Recommendation*:** Modify provider enrollment and managed care credentialing packages to request managing employee criminal conviction information for all provider types. Refer that information to the HHS-OIG as required.

HHSC does not report to the HHS-OIG actions it takes on provider applications for participation in the program

The regulation at 42 CFR § 1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. Texas does not report all adverse actions taken against a provider's application for participation to the HHS-OIG. HHSC only reports termination actions taken against managed care or fee-for-service (FFS) providers if they result from suspicions of fraud, waste, or abuse. Neither the MCOs nor FFS provider enrollment staff report denials of provider enrollment applications to HHSC-OIG so that the information can be passed on to HHS-OIG. Neither managed care nor FFS program integrity staff report actions taken to limit a provider's ability to participate in the Texas Medicaid program. Within the NEMT program, driver terminations are also not reported.

***Recommendation*:** Develop and implement policies and procedures to report to HHS-OIG adverse actions taken against FFS and managed care provider enrollment applications and actions taken to limit the ability of providers to participate in the Medicaid program.

Vulnerabilities

The review team identified three vulnerabilities in Texas' program integrity practices regarding exclusion search issues and the verification of managed care services.

Not capturing all current managing employee information or historical information on owners, officers and managing employees

As described above, providers who use their SSN as an identifier on Medicaid enrollment forms do not have to disclose information about principals with whom they may be affiliated. For practical purposes, this means that not all managing employees working for newly certified Medicaid providers become known to the system. In addition, the Texas MMIS only began to incorporate historical data on all owners, officers, and managing employees through the TMHP systems enhancements of March 2008. Therefore, TMHP cannot routinely check previously reported owners, officers and managing employees for exclusions after the affiliated provider is enrolled. The HHSC-OIG Chief Counsel told the review team that the historical database of

disclosure information, which the State is building to conduct criminal background checks, can also be used to check previously reported principals for exclusions.

Recommendations**:** Include managing employee questions on all enrollment forms. This information should also be captured in MMIS and used to search for exclusions upon enrollment and periodically thereafter. Continue to build the database of disclosures from providers enrolled prior to the implementation of the system upgrades at TMHP. Compare the historical database against the appropriate listings to identify persons with Federal exclusions and criminal backgrounds.

Not conducting complete searches for individuals and entities excluded from participating in Medicaid

Because of the incomplete information on owners, officers and managing employees in the MMIS, HHSC-OIG is not able to conduct a comprehensive search for Federal exclusions before or after provider enrollment occurs or MCO contracts are approved.

The review team identified additional vulnerabilities relating to the exclusion search process at the time of enrollment. HHSC relies on the Texas Department of Insurance (DOI) to conduct background checks of MCOs. The review team was told by Medicaid management that DOI does not conduct exclusion searches against the Federal exclusion databases.

TXDOT enrolls the TSAPs and does not search for exclusions of owners and managing employees who may hold strategic positions such as billing managers and department heads. Some TSAPs are direct providers while others contract with drivers. Neither TXDOT nor TSAP search drivers for exclusions.

Fiscal agent owners and managing employee disclosures are not captured and searched for exclusions.

The review team also observed that automated post-enrollment exclusion searches are not routinely performed. Neither TMHP, HHSC-OIG nor the MCOs use Medicare Exclusion Database files or other sources to search for exclusions on a routine or ongoing basis. HHSC-OIG relies on the paper notices sent each month by the HHS-OIG to identify excluded individuals and entities in the State. However, HHSC-OIG cannot check exclusions for out-of-state providers or for owners and managing employees affiliated with providers enrolled prior to March 2008.

Only changes in ownership for facilities subject to the survey process trigger an automatic exclusion search. MCOs re-credential their providers every three years and check the National Practitioner database for adverse actions and exclusions. However, MCO providers are not subject to exclusion searches in the period between credentialing actions, and affiliated owners or managing employees are not subject to subsequent exclusion searches at all.

Recommendation**:** Develop policies and procedures for systematic collection of information on the owners, officers, and managing employees of providers and disclosing entities and to check such individuals and entities and their affiliated providers for Federal exclusions at the time of enrollment or contracting and periodically thereafter.

Not conducting recipient verification of services in the managed care programs
While Texas uses Explanations of Medical Benefits (EOMB) to verify with recipients whether services billed FFS were rendered, Texas' MCOs do not verify through issuance of EOMBs or other methods whether managed care enrollees received Medicaid managed care services. MCOs rely on sampling medical records or matching financial records to encounter data to verify that services were rendered.

Recommendation**:** Modify the MCO contract to require MCOs to perform recipient verification that includes direct contact with recipients.

CONCLUSION

The State of Texas applies some effective practices that demonstrate program integrity strengths and the State's commitment to program integrity. These effective practices include:

- the establishment of the Texas OIG in HHSC with staff dedicated to Medicaid program integrity,
- an excellent relationship between HHSC and the MFCU,
- HHSC-OIG's development of a self-reporting protocol for providers,
- the use of innovative software which automates the verification of provider licenses, and
- strong oversight of MCOs.

CMS supports the State's efforts and encourages the State to look for additional opportunities to improve overall program integrity.

However, the identification of four areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, three areas of vulnerability were identified. CMS encourages HHSC to closely examine each of the three areas of vulnerability.

It is important that these issues be rectified as soon as possible. To that end, we will require HHSC to provide a corrective action plan for each area of non-compliance within 30 calendar days of the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Texas will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the areas of non-

compliance or vulnerability will take more than 90 calendar days from the date of the letter. If HHSC has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Texas on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its noteworthy practices.