



June 30, 2010

TO: Marilyn Tavenner
Acting Administrator and Chief Executive Officer
Centers for Medicare & Medicaid Services

FROM: /George M. Reeb/
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of American Recovery and Reinvestment Act of 2009 Medicaid
Eligibility Requirements in Texas (A-06-09-00099)

Attached, for your information, is an advance copy of our final report on American Recovery and Reinvestment Act of 2009 Medicaid eligibility requirements in Texas. We will issue this report to the Texas Health and Human Services Commission within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Robert A. Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Robert.Vito@oig.hhs.gov or Patricia Wheeler at (214) 767-6325 or through email at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-09-00099.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, TX 75242

July 8, 2010

Report Number: A-06-09-00099

Mr. Thomas M. Suehs
Executive Commissioner
Texas Health and Human Services Commission
P.O. Box 13247
Austin, Texas 78711

Dear Mr. Suehs:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of American Recovery and Reinvestment Act of 2009 Medicaid Eligibility Requirements in Texas*. We will forward a copy of this report to the HHS action official noted below.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please direct them to the HHS action official. Please refer to report number A-06-09-00099 in all correspondence.

Sincerely,

/Patricia Wheeler/
Regional Inspector General
for Audit Services

Enclosure

HHS Action Official:

Ms. Jackie Garner, Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF
AMERICAN RECOVERY AND
REINVESTMENT ACT OF 2009
MEDICAID ELIGIBILITY
REQUIREMENTS IN TEXAS**



Daniel R. Levinson
Inspector General

July 2010
A-06-09-00099

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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.

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to 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.

Pursuant to section 1905(b) of the Act, the Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. Although FMAPs are adjusted annually for economic changes in the States, Congress may increase FMAPs at any time.

Temporary Increases in Federal Medical Assistance Percentages

The American Recovery and Reinvestment Act of 2009 (the Recovery Act), P.L. No. 111-5, enacted February 17, 2009, provides fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act provides an estimated \$87 billion in additional Medicaid funding based on temporary increases in States' FMAPs. Section 5000 of the Recovery Act provides these increases to help avert cuts in health care provider payment rates, benefits, or services and to prevent changes in income eligibility requirements that would reduce the number of individuals eligible for Medicaid.

To qualify for the increased FMAP, States must meet various criteria. One of these addresses eligibility. Pursuant to section 5001(f)(1)(A) of the Recovery Act, a State is not eligible for an increase in its FMAP for quarters during the recession adjustment period in which its Medicaid eligibility standards, methodologies, or procedures are more restrictive than those in effect on July 1, 2008. Pursuant to section 5001(f)(1)(C), a State that applied restrictions after July 1, 2008, and before February 17, 2009, is not ineligible for the increased FMAP for quarters before July 1, 2009, if, by that date, it had reinstated eligibility standards, methodologies, or procedures that were no more restrictive than those in effect on July 1, 2008.

Texas's Temporary Increase in Federal Medical Assistance Percentage

In accordance with provisions in the Recovery Act, CMS made \$1.4 billion in additional Medicaid funding available to the Texas Health and Human Services Commission (the State agency) for the first three quarters of Federal fiscal year 2009 (October 2008 through June 2009). For that period, CMS increased the State agency's FMAP 9.32 percentage points, from 59.44 percent to 68.76 percent.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency's Medicaid eligibility standards, methodologies, and procedures during the first three quarters of Federal fiscal year 2009 were more restrictive than those in effect on July 1, 2008.

Scope

We reviewed the State agency's Medicaid eligibility standards, methodologies, and procedures that were in effect during the period October 1, 2008, through June 30, 2009, to determine whether they were more restrictive than those in effect on July 1, 2008. We did not review a sample of eligibility case files to validate that standards, methodologies, or procedures were consistently used in determining Medicaid eligibility. We did not determine if the State agency increased its Medicaid eligibility income standards (expressed as a percentage of the poverty line) or if it applied the increased FMAP to expenditures for individuals made eligible for Medicaid as a result of increased income standards. We did not review the State agency's overall internal control structure. We limited our review to obtaining an understanding of the procedures the State agency used for changing eligibility standards, methodologies, and procedures and for communicating procedures to the staff members who made eligibility determinations.

We performed our fieldwork at the State agency's office in Austin, Texas, and at four Medicaid offices in New Braunfels, McAllen, El Paso, and Amarillo, Texas, in July 2009.

Methodology

To accomplish our objective, we:

- reviewed the Recovery Act legislation and applicable CMS guidance;
- reviewed all Medicaid eligibility-related changes made to Texas's State plan after July 1, 2008;
- reviewed all changes made to Texas's Medicaid eligibility policies after July 1, 2008;
- interviewed CMS regional office officials;
- interviewed State agency management and Medicaid eligibility policy officials;
- interviewed county Medicaid office staff members who made eligibility determinations to determine how changes in eligibility standards, methodologies, and procedures were communicated to them and what changes they implemented after July 1, 2008; and
- compared all revised eligibility standards, methodologies, and procedures implemented after July 1, 2008, to those in effect on July 1, 2008.

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.

RESULTS OF REVIEW

The State agency made one policy change after July 1, 2008, that resulted in more restrictive eligibility standards, methodologies, and procedures during the first three quarters of Federal fiscal year 2009. However, in accordance with section 5001(f)(1)(C) of the Recovery Act, the State agency reinstated the less restrictive policy before July 1, 2009.

The State also made administrative policy changes that did not affect the eligibility process.

This report contains no recommendations.