

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**TEXAS MADE UNALLOWABLE MEDICAID  
MANAGED CARE PAYMENTS FOR  
BENEFICIARIES ASSIGNED MORE THAN  
ONE MEDICAID IDENTIFICATION  
NUMBER**

*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

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# ***Office of Inspector General***

<https://oig.hhs.gov>

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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.

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## ***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.

***Texas incorrectly claimed \$3.8 million over a 2-year period in Federal Medicaid reimbursement for managed care payments for beneficiaries assigned more than one Medicaid identification number.***

## **INTRODUCTION**

### **WHY WE DID THIS REVIEW**

Previous Office of Inspector General work identified Federal Medicaid reimbursement for managed care payments that were not claimed in compliance with Federal requirements. Specifically, some beneficiaries enrolled in Medicaid managed care had more than one Medicaid identification number. As a result, Medicaid managed care organizations (MCOs) received unallowable monthly Medicaid payments for these beneficiaries.

### **OBJECTIVE**

Our objective was to determine whether the Texas Health and Human Services Commission (the State agency) claimed Federal Medicaid reimbursement for managed care payments in compliance with Federal requirements.

### **BACKGROUND**

#### **The Medicaid Program**

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 programs. Each State administers its Medicaid program in accordance with a CMS-approved State plan. The State plan establishes which services the Medicaid program will cover. Although a State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements.

#### **Texas' Medicaid Managed Care Program**

In Texas, the State agency administers the Medicaid program. The State agency's Office of Social Services, Eligibility Operations, is responsible for determining whether individuals applying for Medicaid (applicants) meet eligibility requirements and for ensuring that the applicants have only one active Medicaid identification number.

Under its Medicaid managed care program, the State agency pays MCOs a monthly fee to ensure that beneficiaries have access to a comprehensive range of medical services.<sup>1</sup>

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<sup>1</sup> For those beneficiaries not enrolled in the Medicaid managed care program, the State agency pays Medicaid providers on a fee-for-service basis for every Medicaid-eligible service provided to a beneficiary.

## *Beneficiary Enrollment*

The State agency electronically maintains eligibility information, including beneficiaries' Medicaid identification numbers, in its Texas Integrated Eligibility Redesign System (TIERS).<sup>2</sup> The State agency guidance states that during the application process, the eligibility staff are to check the TIERS to determine whether an applicant is receiving medical or public assistance benefits and whether the applicant already has a Medicaid identification number.<sup>3</sup>

## *Federal Eligibility Requirements*

Federal law prohibits payments to MCOs for a beneficiary whose eligibility was not properly determined.<sup>4</sup> Federal law also requires an applicant to provide his or her SSN to the State (42 CFR § 435.910(a)).<sup>5</sup> The State must then verify that the Social Security Administration furnished the SSN to the applicant and determine whether it furnished any other SSNs to that individual (42 CFR § 435.910(g)). In addition, each State must include in each applicant's case file facts to support the Medicaid eligibility determination (42 CFR § 435.913(a)).

## **HOW WE CONDUCTED THIS REVIEW**

Our review included Medicaid managed care payments the State agency made to MCOs for the same beneficiary under different Medicaid identification numbers. We identified 3,170 beneficiary matches with payments totaling \$18,823,807 (\$11,081,984 Federal share) that the State agency claimed for the period January 1, 2013, through December 31, 2014. For this review, we defined a beneficiary match to be either (1) a beneficiary with more than one Medicaid identification number associated with the same SSN or (2) a beneficiary who did not provide, or was not required to provide, an SSN but whose selected personal information (i.e., the first five characters of the first name, the last name, the date of birth, and the sex) was identical for more than one Medicaid identification number.

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

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<sup>2</sup> The TIERS maintains and processes information about individuals who are eligible for benefits under all assistance programs, including Medicaid.

<sup>3</sup> The TIERS compares the applicant's name, date of birth, and Social Security number (SSN) entered by the eligibility staff with all other beneficiary information in the State agency's eligibility system and produces a list of individuals who have a similar, or the same, SSN, last name, and/or first name as the applicant. According to the State agency guidance, eligibility staff are expected to determine whether an individual applying for Medicaid is the same as another individual on the list with an existing Medicaid identification number.

<sup>4</sup> The Social Security Act, § 1903(m)(2)(A)(iii).

<sup>5</sup> States are required to provide mandatory coverage to pregnant women, newborns of women receiving Medicaid, and individuals who qualify for emergency medical assistance. These applicants are excluded from this requirement (42 CFR part 435).

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 claim Federal Medicaid reimbursement for managed care payments in compliance with Federal requirements. Of the 3,170 beneficiary matches, the State agency complied with Federal requirements for 125. For the remaining 3,045 beneficiary matches, the associated beneficiary was assigned more than one Medicaid identification number. As a result, MCOs received improper monthly Medicaid payments for those beneficiaries.

Sections 2(f)(2)(A) and (B) of the Improper Payments Elimination and Recovery Act of 2010 defined an improper payment as any payment that should not have been made, including any duplicate payment.<sup>6</sup> The State agency made duplicate managed care payments totaling \$3,005,573<sup>7</sup> to MCOs for the same beneficiary under different Medicaid identification numbers for the same month. In addition, the State agency paid MCOs \$3,509,450 for beneficiaries under an inactive Medicaid identification number rather than the beneficiaries' active numbers.<sup>8</sup> In total, the State agency improperly claimed \$6,515,023 (\$3,843,339 Federal share) for managed care payments that did not comply with Federal requirements.

The improper payments occurred because the State agency did not ensure that beneficiaries were assigned only one Medicaid identification number. Specifically, the State agency stated that its eligibility staff failed to appropriately research potential beneficiary matches identified during the application process before assigning a Medicaid identification number. In other instances, the State agency explained that it did not identify potential beneficiary matches because insufficient applicant information was available during the application process<sup>9</sup> or that the applicant provided incorrect information. In addition, the State agency stated that eligibility staff made data entry errors that prevented potential beneficiary matches from being identified.

## RECOMMENDATIONS

We recommend that the State agency:

- refund \$3,843,339 to the Federal Government,

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<sup>6</sup> The Improper Payments Elimination and Recovery Act is codified at 31 U.S.C. § 3301.

<sup>7</sup> This amount represents the managed care payments made to MCOs under duplicate beneficiary identification numbers the State agency inactivated following our audit.

<sup>8</sup> The State agency may refund those improper payments and reclaim Federal reimbursement for those managed care payments under the beneficiaries' active Medicaid identification number.

<sup>9</sup> For example, the SSN of a newborn or a child entering foster care was not available at the time of the application.

- identify additional unallowable monthly Medicaid managed care payments made before and after our audit period for the 3,045 beneficiary matches,
- identify any other beneficiaries who are assigned more than one Medicaid identification number and refund any unallowable payments associated with those beneficiaries, and
- strengthen its procedures to determine whether applicants are enrolled in any medical or public assistance benefits throughout the State and ensure that no beneficiary is issued more than one Medicaid identification number.

### **STATE AGENCY COMMENTS**

In its written comments on our draft report, regarding the first and second recommendations, the State agency stated that it would research our findings and refund any unallowable payments. Regarding our third recommendation, the State agency said that it would identify any additional beneficiaries assigned more than one Medicaid identification number and refund any unallowable payments associated with those beneficiaries. Regarding our last recommendation, the State agency stated that it had implemented several strategies to mitigate the creation of more than one Medicaid identification number for a beneficiary, including improved automation and training. In addition, the State agency explained that it has established an eligibility and enrollment workgroup actively engaged in addressing eligibility and enrollment issues, including the proactive analysis and resolution of payment discrepancies stemming from the assignment of more than one Medicaid identification number to a beneficiary. The State agency's comments appear in their entirety as Appendix B.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our review included Medicaid managed care payments the State agency made to MCOs for 3,170 beneficiary matches totaling \$18,823,807 (\$11,081,984 Federal share) during the period January 1, 2013, through December 31, 2014.

We limited our review of the State agency's internal controls to those applicable to our objective. Specifically, we obtained an understanding of the State agency's procedures for assigning Medicaid identification numbers to eligible beneficiaries.

We performed our audit work from December 2015 through September 2016.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations and State guidance;
- met with State agency officials to gain an understanding of the procedures for assigning Medicaid identification numbers and preventing the assignment of more than one Medicaid identification number;
- identified 3,170 beneficiary matches from the Texas Medicaid eligibility file;
- obtained the details of Medicaid managed care payments made to MCOs for those beneficiary matches during the period January 1, 2013, through December 31, 2014;
- requested that State agency officials conduct their own review of the identified beneficiary matches to determine whether the individuals were the same person and assigned more than one Medicaid identification number;
- evaluated the documentation obtained from the State agency for the beneficiary matches that it determined were not the same individual; and
- determined the unallowable payments the State agency made to MCOs and calculated the Federal reimbursement claimed for those unallowable payments.

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

December 9, 2016

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-06-15-00024

Dear Ms. Wheeler:

The Texas Health and Human Services Commission (HHSC) received a draft audit report entitled "Texas Made Unallowable Medicaid Managed Care Payments for Beneficiaries Assigned More Than One Medicaid Identification Number" from the Department of Health and Human Services Office of Inspector General. The cover letter, dated October 26, 2016, 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 on 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 Inspector General. Mr. Griffith may be reached by telephone at (512) 491-2806 or by e-mail at [David.Griffith@hhsc.state.tx.us](mailto:David.Griffith@hhsc.state.tx.us).

Sincerely,

A handwritten signature in black ink, appearing to read "Charles Smith".

Charles Smith

Attachment

P. O. Box 13247 • Austin, Texas 78711 • 4900 North Lamar, Austin, Texas 78751 • (512) 424-6500

Texas Health and Human Services Commission  
Management Response to the  
U.S. Department of Health and Human Services Office of Inspector General Report:

**Texas Made Unallowable Medicaid Managed Care Payments for Beneficiaries Assigned  
More Than One Medicaid Identification Number**

**DHHS - OIG Recommendation:** *We recommend that the State agency refund \$3,843,339 to the Federal Government.*

**HHSC Management Response:**

**Actions Planned:**

HHSC will conduct further research and analysis of its member records and managed care capitation files to verify unallowable payments made during the audit period. Managed care payment amounts confirmed as unallowable will be refunded to the Federal Government.

**Estimated Completion Date:** One year from date of final audit report

**Title of Responsible Person:** Deputy Associate Commissioner for Program Enrollment and Support

**DHHS - OIG Recommendation:** *We recommend that the State agency identify additional unallowable monthly Medicaid managed care payments made before and after our audit period for the 3,045 beneficiary matches.*

**HHSC Management Response:**

**Actions Planned:**

HHSC will evaluate member records and managed care capitation files outside the audit period to determine any additional unallowable payments associated with the beneficiary matches confirmed by HHSC.

**Estimated Completion Date:** One year from date of final audit report

**Title of Responsible Person:** Deputy Associate Commissioner for Program Enrollment and Support

**DHHS - OIG Recommendation:** *We recommend that the State agency identify any other beneficiaries who are assigned more than one Medicaid identification number and refund any unallowable payments associated with those beneficiaries.*

**HHSC Management Response:**

**Actions Planned:**

HHSC will evaluate member records and managed care capitation files to identify duplicate individuals. After identification of duplicate individuals, HHSC will refund confirmed unallowable payments associated with the beneficiaries.

**Estimated Completion Date:** Two years from date of final audit report

**Title of Responsible Person:** Deputy Associate Commissioner for Eligibility Operations and Deputy Associate Commissioner for Program Enrollment and Support

**DHHS - OIG Recommendation:** *We recommend that the State agency strengthen its procedures to determine whether applicants are enrolled in any medical or public assistance benefits throughout the State and ensure that no beneficiary is issued more than one Medicaid identification number.*

**HHSC Management Response:**

In response to the preliminary audit findings, HHSC implemented several strategies to mitigate creation of duplicate identification numbers, including improved automation and training. New automation enhancements were deployed to validate Social Security Numbers (SSNs) in real time when compared to Social Security Administration data. In addition, HHSC will continue its existing monthly process of identifying any unverified SSNs and validating with the Social Security Administration.

HHSC also issued mandatory refresher training for existing staff and improved training for new hires further emphasizing the importance of identifying distinct individuals when creating identification numbers.

Furthermore, HHSC has established an eligibility and enrollment workgroup, involving the participation of its contracted managed care organizations. This workgroup is actively engaged in addressing eligibility and enrollment issues, including the proactive analysis and resolution of payment discrepancies stemming from the assignment of duplicate Medicaid identification numbers and the corresponding enrollment of beneficiaries into more than one managed care organization. This recommendation is fully implemented.