

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**TEXAS MADE INCREASED  
PAYMENTS FOR SERVICES  
RENDERED BY ELIGIBLE  
PRIMARY CARE PROVIDERS  
UNDER FEDERAL REQUIREMENTS**

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# *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: May 2018

Report No. A-06-17-09003

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 increased payments for services rendered by providers eligible as primary care providers under Federal requirements.

### How OIG Did This Review

Our review covered \$141.6 million in increased payments for services rendered by 120 selected providers. Texas received \$136.3 million in Federal funds for those increased payments.

We verified that the selected providers were eligible under Federal requirements.

## Texas Made Increased Payments for Services Rendered by Eligible Primary Care Providers under Federal Requirements

### What OIG Found

The 120 selected providers were eligible as primary care providers under Federal requirements. Therefore, Texas appropriately made the \$141.6 million in increased payments for services rendered by the selected providers and received the \$136.3 million Federal funds.

### What OIG Recommends

This report contains no recommendations.

**TABLE OF CONTENTS**

INTRODUCTION ..... 1

    Why We Did This Review ..... 1

    Objective ..... 1

    Background ..... 1

        Medicaid Program..... 1

        Increased Primary Care Provider Payments ..... 2

    How We Conducted This Review ..... 3

RESULTS OF REVIEW ..... 3

APPENDIX

    Audit Scope and Methodology ..... 4

## 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 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.<sup>2</sup>

### OBJECTIVE

Our objective was to determine whether the State agency made increased payments for services rendered by providers eligible as primary care providers under Federal requirements.

### BACKGROUND

#### 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 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 CMS-64 reports to reimburse States for the Federal share of Medicaid expenditures. The amount that the Federal Government reimburses to State Medicaid agencies, known as Federal financial participation, or 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), Pub. L. No. 111-148 (March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152 (March 30, 2010), collectively referred to as "ACA."

<sup>2</sup> We performed related reviews in Arkansas under report number [A-06-15-00042](#), September 2017, and in Texas under report number [A-06-15-00045](#), April 2018.

## Increased Primary Care Provider 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.<sup>4</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. 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, which Texas did, 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.

To be eligible for the increased payments, first, a provider had to self-attest to specializing in family medicine, general internal medicine, 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 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>5</sup> CMS allowed States to pay providers based on their self-attestation alone.

Effective January 1, 2013, the State agency amended its State plan to reflect the increase in fee schedule payments in CYs 2013 and 2014. 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's fiscal agent, the Texas Medicaid & Healthcare Partnership, calculated the increased payment amounts for providers that attested to their eligibility and made the payments, of which almost 75 percent were made based on managed care encounter data.

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<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 § 447.400(a).

## **HOW WE CONDUCTED THIS REVIEW**

We judgmentally selected 120 providers who rendered the services associated with more than 25 percent of increased payments made based on encounter data that the State agency claimed at the 100-percent FMAP. Our review covered \$141,580,918 in increased payments for services rendered by the selected providers.<sup>6</sup> The State agency received \$136,257,163 in Federal funds for those increased payments. We verified the accuracy of each selected provider's attestations related to board certification, the 60-percent of Medicaid billings requirement, or both.

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.

The Appendix contains the details of our audit scope and methodology

## **RESULTS OF REVIEW**

The 120 selected providers were eligible as primary care providers under Federal requirements. Therefore, the State agency appropriately made the \$141,580,918 in increased payments for services rendered by the selected providers and received the \$136,257,163 in Federal funds. Accordingly, this report contains no recommendations.

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<sup>6</sup> The State agency claimed \$12,852,079 of the increased payments that we reviewed at regular FMAPs.

## APPENDIX: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our review covered \$141,580,918 in increased payments for services rendered by 120 selected providers.<sup>7</sup> The State agency received \$136,257,163 in Federal funds for those increased payments.<sup>8</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 in Austin, Texas from July 2017 through March 2018.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed the State agency's approved State plan amendment;
- analyzed the managed care encounter data and selected 120 providers who rendered the services associated with more than 25 percent of increased payments made based on encounter data that the State agency claimed at the 100-percent FMAP;
- verified the accuracy of each selected provider's attestations related to board certification, the 60-percent of Medicaid billings requirement, or both; 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.

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<sup>7</sup> The State agency claimed \$12,852,079 of the increased payments that we reviewed at regular FMAPs.

<sup>8</sup> We adjusted our scope amounts for findings identified in audit report A-06-15-00045.