Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

TEXAS MADE CAPITATION PAYMENTS FOR ENROLLEES WHO WERE CONCURRENTLY ENROLLED IN A MEDICAID MANAGED CARE PROGRAM IN ANOTHER STATE

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Report in Brief
Date: September 2023
Report No. A-05-22-00018

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

Texas Made Capitation Payments for Enrollees Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Another State

Why OIG Did This Audit

Texas pays managed care organizations to make services available to eligible Medicaid enrollees in return for a monthly fixed payment (capitation payment) for each enrollee. Previous OIG audits found that State Medicaid agencies made capitation payments on behalf of enrollees who were residing and enrolled in Medicaid in another State. We are concerned that the concurrent Medicaid enrollment identified in our previous audits could be an issue that negatively impacts Texas' Medicaid program.

Our objective was to determine whether Texas made capitation payments on behalf of Medicaid enrollees who were concurrently enrolled in a Medicaid managed care program in another State.

How OIG Did This Audit

Our audit covered $30.9 million in Medicaid managed care capitation payments for August 2021 made by Texas on behalf of 61,065 Texas enrollees who were concurrently enrolled in a managed care program in another State during the period of July 1 through September 30, 2021 (audit period).

To identify our population of enrollees who had concurrent enrollment during our audit period, we compared CMS's Transformed Medicaid Statistical Information System (T-MSIS) data from 48 States, the District of Columbia, and Puerto Rico. We then identified all associated August 2021 capitation payments that Texas made.

What OIG Found

Texas made August 2021 Medicaid managed care capitation payments totaling $30.9 million on behalf of 61,065 enrollees who were concurrently enrolled for Medicaid benefits in Texas and another State. Of the 100 enrollees in our stratified random sample, we determined that 62 enrollees were residing and enrolled for Medicaid benefits in Texas. However, Texas made August 2021 capitation payments totaling $31,939 ($21,744 Federal share) on behalf of 38 Texas Medicaid managed care enrollees who were residing and concurrently enrolled for Medicaid in another State. On the basis of our sample results, we estimated that Texas incurred costs of $12.8 million ($8.7 million Federal share) for August 2021 capitation payments made on behalf of enrollees who were residing and concurrently enrolled in another State.

What OIG Recommends and Texas Comments

We recommend that Texas resume and enhance procedures that are in accordance with Federal requirements and the State's unwinding process to identify and disenroll enrollees who are residing and enrolled in Medicaid managed care in another State, and work with CMS to consider the potential use of T-MSIS data to identify potential cases of concurrent enrollment.

In written comments on our draft report, Texas concurred with our recommendations and described the actions that it plans to take to address them. Texas' actions include: (1) resuming procedures during the unwinding process to identify and disenroll clients who are no longer eligible for Medicaid, including those who have moved to another State and (2) meeting with CMS to discuss the benefit of using T-MSIS data to assist in identifying potential cases of concurrent enrollment.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Texas Health and Human Services Commission (State agency) pays managed care organizations (MCOs) to make services available to eligible Medicaid enrollees in return for a monthly fixed payment (capitation payment) for each enrollee.[1] Previous Office of Inspector General (OIG) audits found that State Medicaid agencies made capitation payments on behalf of enrollees who were residing and enrolled in Medicaid in another State.[2] We determined that these States did not always identify and terminate enrollment for enrollees with concurrent Medicaid enrollment. We are concerned that the concurrent Medicaid enrollment identified in our previous audits could be an issue that negatively impacts Texas' Medicaid program.

OBJECTIVE

Our objective was to determine whether the State agency made capitation payments on behalf of Medicaid enrollees who were concurrently enrolled in a Medicaid managed care program in another State.

BACKGROUND

The Medicaid Program

The Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). 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 each State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

States may offer Medicaid benefits on a fee-for-service (FFS) basis, through managed care plans, or both.[3] Under the FFS model, the State pays providers directly for each covered service received by a Medicaid enrollee. Under managed care, the State pays a fee to a managed care

[1] A capitation payment is "a payment the State makes periodically to a contractor on behalf of each beneficiary enrolled under a contract . . . for the provision of services under the State plan. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment" (42 CFR § 438.2).

[2] These audits were conducted in Florida, Illinois, Minnesota, and Ohio. See Appendix B for related report information.

[3] We limited our audit to managed care capitation payments.

plan for each person enrolled in the plan. State Medicaid managed care programs are intended to increase access to and improve the quality of health care for Medicaid enrollees. More than two-thirds of Medicaid enrollees are enrolled in managed care nationally.

States contract with MCOs to make services available to Medicaid enrollees, usually in return for a periodic payment, known as a capitation payment. In turn, the MCO pays providers for all the Medicaid services an enrollee may require that are included in the MCO's contract with the State. States make the capitation payments regardless of whether the enrollees receive services during the period covered by the payment. If an enrollee's enrollment is not terminated when appropriate, capitation payments may continue automatically. States report these capitation payments on the States' Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). 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 as calculated by a defined formula (42 CFR § 433.10).

Federal Requirements

States are required to provide Medicaid services to eligible residents, including residents who are absent from the State, unless another State determines that an enrollee has established residency there for purposes of Medicaid eligibility (42 CFR §§ 435.403(a) and (j)(3)).

Ordinarily, States must redetermine the eligibility of Medicaid enrollees whose eligibility is determined using methodologies based on modified adjusted gross income (MAGI), a measure of income based on Internal Revenue Service rules, once every 12 months and no more frequently than once every 12 months (42 CFR § 435.916(a)). For Medicaid enrollees whose eligibility is not determined using MAGI-based financial methodologies, States must redetermine eligibility at least once every 12 months (42 CFR § 435.916(b)).[4] States must also have procedures designed to ensure that enrollees make timely and accurate reports of any change in circumstances that may affect their eligibility. States must promptly redetermine eligibility when they receive information about changes in enrollee circumstances that may affect eligibility (42 CFR §§ 435.916(c) and (d)). States may not deny or terminate eligibility or reduce benefits for any individual based on information received unless the State has sought additional information from the individual and provided the individual a reasonable period to respond and proper notice and hearing rights (42 CFR §§ 435.952(c) and (d)). Receiving Medicaid in another State typically represents a potential change in an enrollee's circumstances, which requires the State to contact the enrollee and attempt to verify State residency prior to termination.

However, during the public health emergency (PHE) for coronavirus disease 2019 (COVID-19), which occurred during our audit period of July 1 through September 30, 2021 (audit period),

[4] For example, MAGI-based methods do not apply to individuals receiving Supplemental Security Income (42 CFR § 435.603(j)).

States made changes to their eligibility and enrollment operations to comply with the Families First Coronavirus Response Act (FFCRA). To qualify for the temporary 6.2-percentage-point FMAP increase provided under the FFCRA during the PHE, States had to satisfy certain conditions, such as maintaining eligibility standards, methodologies, or procedures that are no more restrictive than what the State had in place as of January 1, 2020, and ensuring that most individuals who were enrolled for Medicaid benefits as of or after March 18, 2020, were continuously enrolled through the end of the month in which the PHE ends. However, the FFCRA has exceptions that allowed States that received the temporary 6.2-percentage-point FMAP increase to still disenroll individuals who requested a voluntary termination of eligibility or ceased to be a resident of the State (§ 6008 of the FFCRA). Federal regulations also provide an exception in meeting the States' timeliness standards for processing Medicaid eligibility redeterminations and changes in an enrollee's circumstances for Medicaid eligibility during an emergency, such as the PHE (42 CFR § 435.912(e)(2)). During our audit period, the FMAP in Texas was 68.01 percent, which includes the 6.2-percentage-point increase provided under the FFCRA.

On December 29, 2022, the Consolidated Appropriations Act, 2023 (CAA) was enacted. This law included various Medicaid provisions, including significant changes to the FFCRA's continuous enrollment condition. States have up to 12 months to initiate, and 14 months to complete, a renewal for all individuals enrolled in Medicaid following the end of the continuous enrollment condition (this process has commonly been referred to as "unwinding"). The CAA does not address the end date of the PHE; however, it does address the end of the continuous enrollment condition, the temporary FMAP increase, and the unwinding process. Under the CAA, expiration of the continuous enrollment condition and receipt of the temporary FMAP increase is no longer linked to the end of the PHE.[5] The continuous enrollment condition ended on March 31, 2023, and the FFCRA's temporary FMAP increase will gradually be phased down beginning April 1, 2023, and will end on December 31, 2023. Beginning April 1, 2023, States were able to terminate Medicaid enrollment for all individuals who are no longer eligible.

States must generally provide advance notice when the State agency terminates a Medicaid enrollee's covered benefits or eligibility at least 10 days before the date of action (42 CFR § 431.211). However, if a State establishes that the enrollee has been accepted for Medicaid services by another State, the original State may send notice of the termination of the enrollee's benefits or eligibility no later than the date of the termination (42 CFR § 431.213(e)).

State Requirements

During our audit period, the State agency implemented temporary policies and procedures that incorporated the continuous enrollment provisions of the FFCRA. Specifically, the State agency suspended the closing of Medicaid coverage for enrollees who failed to renew their eligibility during annual redeterminations, extended all Medicaid recertifications, and generally suspended the closure of enrollees' Medicaid coverage. Under the State's temporary policies

[5] The COVID-19 PHE ended on May 11, 2023.

and procedures, Medicaid coverage could not be denied to most enrollees receiving Medicaid as of March 18, 2020. However, while not required, the State agency staff could deny coverage if the enrollee requested a voluntary termination of eligibility, moved out of State, or died.

Texas' Medicaid Managed Care Program

The State agency is the single State agency responsible for administering Medicaid in Texas. The State agency is responsible for the management and oversight of various public assistance programs that help families with food, health care, safety, and disaster services including Medicaid, Supplemental Nutritional Assistance (SNAP), Temporary Assistance for Needy Families, and the Women, Infants, and Children programs. The State agency provides administrative support and community access to local resources and services. The State agency's responsibilities include performing Medicaid eligibility determinations for individuals.

Under Texas' Medicaid managed care contract provisions, the State agency, or its designee, generally makes eligibility determinations for individuals to enroll and disenroll in the MCO programs. If the MCO becomes aware that the individual has moved outside of the MCO's service area, for example when the enrollee moved outside of the State, the MCO must inform the State agency within 10 business days. During our audit period, approximately 96 percent of Texas' Medicaid population (over 4 million individuals) received benefits through MCOs under contract with the State agency.

Texas' State Medicaid plan requires that Medicaid be granted to eligible applicants who, among other requirements, are residents of the State, whether or not the individuals maintain their residency at a fixed address. An individual may be temporarily absent from the State and maintain Texas residency if the individual intends to return when the purpose of the absence has been accomplished, unless another State has determined that the individual is a resident there for purposes of Medicaid.

Transformed Medicaid Statistical Information System

CMS maintains the Transformed Medicaid Statistical Information System (T-MSIS). Its primary purpose is to establish an accurate, current, and comprehensive database of standardized enrollment, eligibility, and paid claim data about Medicaid recipients that is used for administering Medicaid federally and assisting in detecting fraud, waste, and abuse in Medicaid.

T-MSIS contains enhanced information about enrollee eligibility, enrollee and provider enrollment data, service utilization data, claim and managed care data, and expenditure data. Timeliness issues have prompted CMS to move towards a streamlined data submission process, along with an enhanced data repository. The T-MSIS data is expected to further CMS's goals with improved timeliness, reliability, and robustness, with an increase in the amount of data requested. States submit their T-MSIS data to CMS monthly.

OIG has full access to T-MSIS data for all States. However, CMS limits States' access to other States' T-MSIS data, with the exception of the T-MSIS Analytic Files (TAF).[6]

Public Assistance Reporting Information System

The Public Assistance Reporting Information System (PARIS), managed by the Administration for Children and Families (ACF),[7] matches State and Federal public assistance eligibility data, including Medicaid data, quarterly to provide States with enrollee information that they can use to identify possible concurrent enrollment and erroneous payments. The Veterans Administration Match, Department of Defense/Office of Personnel Management Match, and the Interstate Match are the three parts of PARIS. The programs that use PARIS include Medicaid, Temporary Assistance for Needy Families, Workers' Compensation, Child Care, and the Supplemental Nutrition Assistance Program.

As a condition of receiving Medicaid funding for their automated data systems, States are required to have an eligibility determination system that provides for data matching through PARIS (Social Security Act § 1903(r)(3) and 42 CFR § 435.945(d)). The PARIS Interstate Match alerts States when they may be making payments on behalf of Medicaid enrollees with concurrent enrollment in another State. States are ordinarily expected to determine whether such enrollees should continue to be eligible for benefits in their State and take whatever case action is appropriate.[8] States may use local benefit office staff, fraud investigators, or both to review PARIS Interstate Match alerts. However, PARIS data are only collected and matched on a quarterly basis by a non-Medicaid agency, and data matching agreements do not prescribe which of the three PARIS matches State Medicaid agencies must conduct, nor the frequency with which any match must be conducted.

According to the State agency's Medicaid eligibility verification plan, the Texas Office of Inspector General (TX-OIG) administers the quarterly PARIS Interstate Match and periodically reviews certain PARIS matches as an investigative tool to identify individuals who may be concurrently receiving public assistance in two or more States in attempt to identify improper payments. Each quarter, TX-OIG attempts to verify residency for a limited number of enrollees who had a PARIS Interstate Match based on TX-OIG's priorities and workload. If Texas residency cannot be verified or if the individual confirms residency in another State, the TX-OIG provides the State agency the PARIS Interstate Match information for the limited number of

[6] The TAF is available to all States upon request and approval from CMS but does not contain personally identifiable information that is needed to identify enrollees with concurrent Medicaid enrollment. The TAF is a research-optimized version of T-MSIS data and serves as a data source tailored to meet the broad research needs of the Medicaid and Children's Health Insurance Program (CHIP) data user community. These files include data on Medicaid and CHIP enrollment, demographics, service utilization, and payments.

[7] ACF is a division of HHS that promotes the economic and social well-being of families, children, youth, individuals and communities with funding, strategic partnerships, guidance, training, and technical assistance.

[8] 42 CFR §§ 435.952(a) and 435.916(d)(1).

enrollees. The State agency is required to contact the enrollees before eligibility may be terminated.[9]

On November 2, 2020, 42 CFR § 433.400(d)(3)(ii) went into effect. This regulation states that an enrollee may be treated as not being a State resident under § 6008(b)(3) of the FFCRA when there is a PARIS match indicating concurrent enrollment in two or more States, and the enrollee fails to respond to a request to verify State residency, provided that the State takes all reasonably available measures to attempt to verify the enrollee's residency, and the State's alternative efforts cannot verify the enrollee's continued residency in the State through other sources.

HOW WE CONDUCTED THIS AUDIT

Our audit covered $30.9 million in Medicaid managed care capitation payments for August 2021 made by the State agency on behalf of 61,065 Texas enrollees who were concurrently enrolled in a managed care program in another State during our audit period. We selected the middle month of our audit period to ensure that enrollees were eligible in the month before, during, and after the August 2021 capitation payments. This helped to identify enrollees who did not move to or from another State during August 2021. To identify our population of enrollees who had concurrent enrollment during our audit period, we compared CMS's T-MSIS data from 48 States, the District of Columbia, and Puerto Rico[10] using the enrollees' Social Security numbers (SSNs), dates of birth (DOB), names, and sex (personally identifiable information (PII)). We then identified all associated August 2021 capitation payments that the State agency made.

We selected a stratified random sample of 100 Texas Medicaid managed care enrollees with August 2021 capitation payments, totaling $102,554 ($70,148 Federal share), to determine whether the enrollees were residing and receiving Medicaid benefits in Texas during the audit period. Using the results of our sample, we estimated the total value and Federal share of capitation payments that the State agency paid on behalf of enrollees who were residing and enrolled for Medicaid benefits in another State.

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.

[9] According to 42 CFR § 435.952(d), a State Medicaid agency may not terminate an enrollee's Medicaid eligibility based on information received through sources such as PARIS unless the State agency has sought additional information from the enrollee.

[10] At the time of our request, two States (Alaska and Vermont) did not have complete T-MSIS Medicaid managed care enrollment and payment data available.

Appendix A contains the details of audit scope and methodology, Appendix C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

FINDINGS

The State agency made August 2021 Medicaid managed care capitation payments totaling $30.9 million on behalf of 61,065 enrollees who were concurrently enrolled for Medicaid benefits in Texas and another State. Of the 100 enrollees in our stratified random sample, we determined that 62 enrollees were residing and enrolled for Medicaid benefits in Texas. However, the State agency made August 2021 capitation payments totaling $31,939 ($21,744 Federal share) on behalf of 38 Texas Medicaid managed care enrollees who were residing and concurrently enrolled for Medicaid in another State. On the basis of our sample results, we estimated that the State agency incurred costs of $12.8 million ($8.7 million Federal share)[11] for August 2021 capitation payments made on behalf of enrollees who were residing and concurrently enrolled in another State.

The State agency made August 2021 capitation payments on behalf of Medicaid enrollees who established residency and Medicaid enrollment in another State but remained enrolled in Texas' Medicaid managed care program. We determined that the State agency did not always receive notification when enrollees in our sample had moved and enrolled in Medicaid in another State. When the State agency received notification from some of the sampled enrollees that they were no longer residing in Texas, the State agency did not terminate their Medicaid enrollment, as permitted under the FFCRA and its policies and procedures.

THE STATE AGENCY MADE PAYMENTS TO MANAGED CARE ORGANIZATIONS FOR MEDICAID ENROLLEES WITH CONCURRENT ENROLLMENT IN ANOTHER STATE

Under Federal regulations, State agencies must provide Medicaid to eligible residents of the State, including those who are temporarily absent, unless a person has established residency and enrolled in Medicaid in another State.[12]

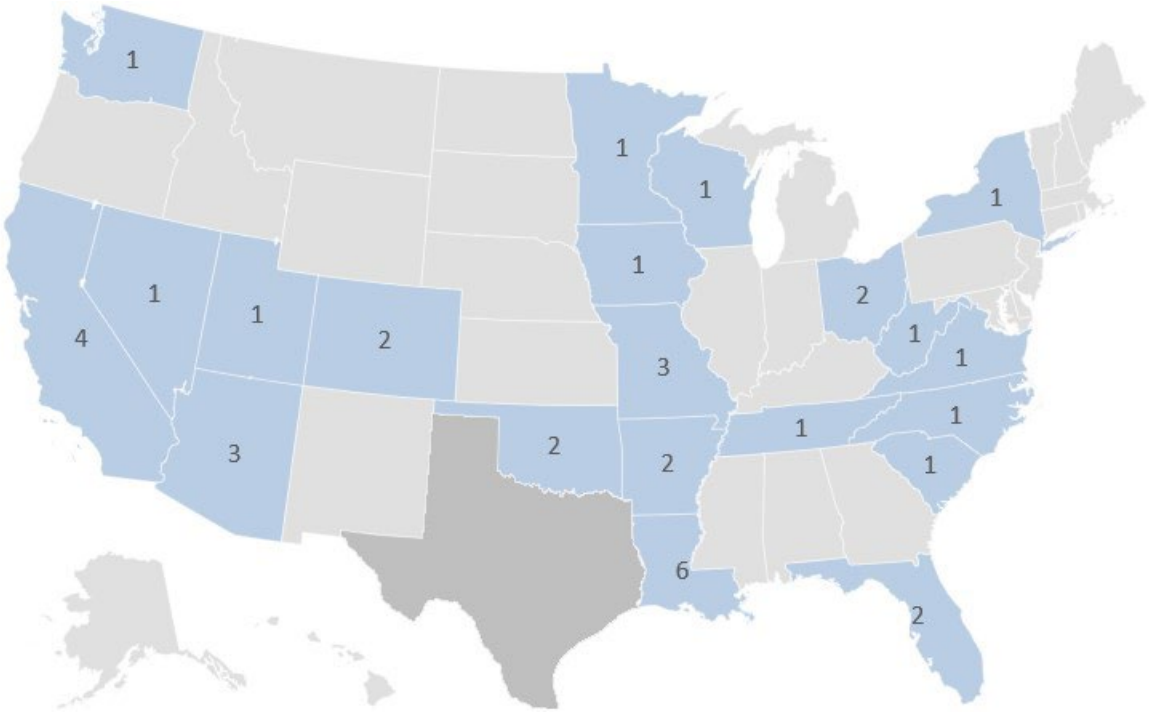
For our sample, we found that the State agency made August 2021 capitation payments totaling $31,939 ($21,744 Federal share) on behalf of 38 Texas Medicaid managed care enrollees who were residing and concurrently enrolled for Medicaid managed care in another State (Figure on the next page).[13]

[11] Rounding to the nearest dollar, the amounts equaled $12,800,913 and $8,730,057, respectively.

[12] 42 CFR §§ 435.403(a) and (j)(3).

[13] We confirmed the enrollees' Medicaid enrollment status using State and county case files, SNAP transactions, a national investigative database, and by contacting the other State Medicaid agencies when necessary. We also reviewed encounter claims that identify the date and location the enrollees had an interaction with a health care provider.

Figure: August 2021 Capitation Payments Made for Enrollees Who Were Residing and Concurrently Enrolled for Medicaid Managed Care in Another State



On the basis of our sample results, we estimated that the State agency incurred costs of $12.8 million ($8.7 million Federal share) for August 2021 capitation payments made on behalf of enrollees who were residing and concurrently enrolled in Medicaid in another State.

The State Agency Did Not Receive Notification That Enrollees Moved Out of State or Did Not Terminate Enrollees Who Provided Notification They Moved Out of State

The State agency made the August 2021 capitation payments on behalf of 38 concurrently enrolled Medicaid enrollees for two reasons. The State agency did not receive notification that 31 of the 38 enrollees were no longer residing in Texas during our audit period. For the remaining seven enrollees, the State agency received notification from the enrollees that they were no longer residing in Texas, but the State agency did not terminate their Medicaid enrollment.

The State agency did not receive notification that 31 sampled enrollees were residing and had concurrent enrollment in another State. During our audit period, the State agency processed Medicaid renewals in accordance with the flexibilities provided to States during the PHE, which included automatically extending Medicaid benefits for enrollees who failed to return requested information and for those who would otherwise be ineligible. TX-OIG obtained and reviewed PARIS Interstate Matches from ACF during our audit period but only verified residency for a limited number of enrollees who had a PARIS Interstate Match. If Texas residency cannot

be verified or if the individual confirms residency in another State, TX-OIG provides the State agency the PARIS Interstate Match information for the enrollee. However, TX-OIG did not notify the State agency that any of our sampled enrollees were on the PARIS Interstate Match during our audit period.[14]

The FFCRA allows the State agency to terminate Medicaid enrollment when the enrollee ceases to be a resident of the State or requests a voluntary termination of enrollment. However, the State agency did not terminate Medicaid enrollment for seven enrollees when the enrollee informed the State agency of a change in residency to another State.[15] The State agency revised and implemented temporary policies and procedures that included these exceptions under the FFCRA, but the State agency did not always choose to use these exceptions.

The following examples describe some of the issues we found:

- **Texas Was Not Notified That the Enrollee Resided and Received Medicaid in Another State**
  One sampled enrollee had concurrent Medicaid enrollment in Texas and Arizona during our audit period. The enrollee's managed care in Texas and Arizona started in January 2021 and June 2021, respectively, and was still active as of July 2022 in both States. Texas and Arizona made August 2021 capitation payments to a managed care organization in their State on behalf of the same enrollee, totaling $852 and $635, respectively. OIG contacted Arizona's Medicaid agency and received confirmation that the enrollee resided and received Medicaid in Arizona during our audit period. However, the State agency did not receive notification that the enrollee resided and was enrolled for Medicaid in Arizona during our audit period. The State agency sent the enrollee several correspondence letters in 2021 but received multiple pieces of returned mail and was unable to locate the enrollee. Prior to the PHE, the State agency may have terminated enrollment when the enrollee failed to return requested information or could not be located. However, in accordance with the FFCRA's continuous enrollment requirement as a condition of receiving the temporary FMAP increase, the State agency was unable to terminate the individual's enrollment during the PHE.

- **The Enrollee Notified Texas of Moving to Another State**
  One sampled enrollee had concurrent Medicaid enrollment in Texas and Louisiana during our audit period. The enrollee notified the State agency that they moved to Louisiana in June 2021. However, the enrollee's enrollment was not terminated. The enrollee's managed care in Texas and Louisiana started in June 2019 and June 2021, respectively, and was still active as of March 2022 in both States. Texas and Louisiana made August 2021 capitation payments to a managed care organization in their State on

[14] Of the 31 sampled enrollees who were determined to be residing in another State, 23 had a PARIS Interstate Match.

[15] Six of the seven sampled enrollees who informed the State agency of a change in residency to another State had a PARIS Interstate Match, but TX-OIG did not notify the State agency.

behalf of the same enrollee, totaling $1,109 and $459, respectively. The capitation payments that occurred after the enrollee informed the State agency of the move to Louisiana could have been prevented if the State agency terminated the enrollee's enrollment for ceasing to be a resident of Texas, as permitted under its own policies and procedures.

CONCLUSION

We estimated that the State agency incurred costs of $12.8 million ($8.7 million Federal share) for August 2021 capitation payments made on behalf of enrollees who were residing and concurrently enrolled for Medicaid in another State. This amount represents potential monthly savings to Texas' Medicaid program that, if annualized, would amount to approximately $153.6 million ($104.4 million Federal share) in program savings.

For Texas and other States that accepted the temporary 6.2-percent FMAP increase during the PHE, section 6008 of the FFCRA added new restrictions for States related to Medicaid eligibility. In addition to other requirements, States were restricted from terminating an enrollee's Medicaid eligibility during the PHE for most situations unless the enrollee requests a voluntary termination of eligibility or ceases to be a State resident. However, on March 31, 2023, the continuous enrollment condition ended under the CAA, and States must return to normal eligibility and enrollment operations over time. States have up to 12 months to initiate, and 14 months to complete, a renewal for all Medicaid enrollees. Beginning April 1, 2023, States were able to terminate Medicaid enrollment for all enrollees who are no longer eligible.

Although the FFCRA restrictions may have increased concurrent enrollment across two States during the PHE, previous audits have shown that concurrent Medicaid enrollment was an issue in nearly all States prior to the PHE.[16] Going forward, we maintain that the number of capitation payments made on behalf of enrollees with concurrent Medicaid enrollment in another State can be reduced with the use of timelier T-MSIS data and improved policies and procedures to confirm the concurrent enrollment and disenroll these enrollees.

RECOMMENDATIONS

We recommend that the Texas Health and Human Services Commission:

- resume and enhance procedures that are in accordance with Federal requirements and the State's unwinding process to identify and disenroll enrollees who are residing and enrolled in Medicaid managed care in another State and

- work with CMS to consider the potential use of T-MSIS data to identify potential cases of concurrent enrollment.

[16] See Appendix B, OIG report number A-05-20-00025.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency concurred with our recommendations and described the actions that it plans to take to address them. The State agency's actions include: (1) resuming procedures during the unwinding process to identify and disenroll clients who are no longer eligible for Medicaid, including those who have moved to another State and (2) meeting with CMS to discuss the benefit of using T-MSIS data to assist in identifying potential cases of concurrent enrollment. The State agency's comments are included in their entirety as Appendix E.

We recognize the corrective actions the State agency plans to implement to address our recommendations. These corrective actions should assist the State agency with identifying and correcting concurrent enrollment.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $30.9 million in Medicaid managed care capitation payments for August 2021 made by the State agency on behalf of 61,065 Texas enrollees who were concurrently enrolled in a managed care program in another State during the period of July 1 through September 30, 2021 (audit period). We selected and reviewed a stratified random sample of 100 enrollees with capitation payments totaling $102,554 ($70,148 Federal share), to determine whether the enrollees were residing and enrolled for Medicaid benefits in Texas during the audit period.

To identify our population of enrollees who had concurrent enrollment during our audit period, we compared CMS's T-MSIS data from 48 States, the District of Columbia, and Puerto Rico[17] using the enrollees' PII. We then identified all associated August 2021 capitation payments that the State agency made.

We assessed internal controls and compliance with laws and regulations necessary to satisfy the audit objective. In particular, we assessed the design, implementation, and operating effectiveness of the State agency's internal controls related to control activities and monitoring of capitation payments made on behalf of enrollees with concurrent enrollment in a Medicaid managed care program in another State. As part of our internal control review, we reviewed the State agency's policies and procedures for identifying and terminating the enrollment of Medicaid enrollees who were not residents of Texas. However, because our review was limited to these aspects of internal control, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit. Any internal control deficiencies we found are discussed in this report.

We conducted our audit work from July 2022 through July 2023.

METHODOLOGY

To accomplish our objective, we:

- reviewed the State agency contracts with the MCOs that were in effect during the audit period;

- reviewed Federal and State laws, regulations, and guidance;

[17] At the time of our request, two States (Alaska and Vermont) did not have complete T-MSIS Medicaid managed care enrollment and payment data available.

- gained an understanding of the State agency's internal controls over preventing, identifying, and correcting payments that were made on behalf of enrollees with concurrent enrollment in another State;

- identified sources that the State agency used to identify enrollees who were receiving Medicaid in another State;

- obtained T-MSIS data that identified 61,065 Texas enrollees with concurrent Medicaid managed care enrollment in another State during our audit period July through September 2021 and obtained Texas' Medicaid Management Information System August 2021 capitation payment data associated with these enrollees that were made by the State agency, totaling $30,937,263;

- selected for review a stratified random sample of 100 enrollees with August 2021 capitation payments, totaling $102,554 ($70,148 Federal share);

- validated the T-MSIS data for each sampled enrollee by comparing current enrollee data from the State agency to determine whether the enrollees' Medicaid managed care enrollment and PII information was accurate;

- reviewed the following supporting documentation to determine in which State the enrollee resided and was receiving Medicaid benefits during the audit period:

    - PARIS Interstate Matches, used to determine whether the State agency was made aware of an enrollee's potential concurrent enrollment in another State;

    - SNAP transactions, which contained a record of the dates and locations the enrollees used their food assistance benefits (i.e., grocery store and gas station purchases, etc.);

    - encounter claims, which contained a record of Medicaid services that were provided and were used to identify the date and location that enrollees had an interaction with a health care provider;

    - eligibility case files, which contained detailed eligibility and residency information, such as utility bills, lease agreements, and detailed notes of interactions between the enrollees and county caseworkers, to help determine where the enrollees resided and whether they were eligible for Medicaid benefits during the audit period;

- Accurint, which is a LexisNexis national investigative data depository that contains more than 80 billion records, e.g., addresses, motor vehicle records, and driver's license records, that we used to help determine where the enrollees resided during the audit period; and

- information from other States, i.e., eligibility case file information from the matched State, to help determine whether the enrollees resided and received Medicaid benefits in the other State during the audit period;

- estimated, based on the sample results, the total value and Federal share of capitation payments made that the State agency paid on behalf of enrollees who were residing and enrolled for Medicaid benefits in another State by using the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software; and

- discussed the results of our audit with State agency officials.

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: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Issue Date
Florida Made Capitation Payments for Enrollees Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Another State	A-05-21-00028	2/16/2023
Nearly All States Made Capitation Payments for Beneficiaries Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Two States	A-05-20-00025	9/19/2022
Minnesota Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries With Concurrent Eligibility in Another State	A-05-19-00032	5/6/2021
Illinois Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries With Concurrent Eligibility in Another State	A-05-19-00031	2/3/2021
Ohio Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries With Concurrent Eligibility in Another State	A-05-19-00023	11/12/2020

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame was an Access database containing 61,065 Texas Medicaid enrollees with August 2021 capitation payments and concurrent Medicaid managed care enrollment in another State during the period of July 1 through September 30, 2021, totaling $30,937,263.

SAMPLE UNIT

The sample unit was a Texas Medicaid managed care enrollee.[18]

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample outlined in Table 1.

Table 1: Sample Design Summary

Stratum	Frame Information			
	Stratum Dollar Boundaries	Number of Enrollees	Dollar Amount of August 2021 Capitation Payments	Sample Size
1	$12.56 – $778.25	50,472	$14,892,753	46
2	$778.38 – $17,993.16	10,593	16,044,510	54
	Totals	**61,065**	**$30,937,263**	**100**

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG/OAS statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We sorted each stratum using the enrollees' SSN and consecutively numbered the items in each stratum in the sampling frame. A statistical specialist generated random numbers for each stratum, and we selected the corresponding sample frame items for review given the sample sizes defined in Table 1.

[18] Texas made more than one August 2021 capitation payment for some enrollees. We grouped those payments into one August 2021 capitation payment record.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total value and Federal share of capitation payments that the State agency paid on behalf of Texas Medicaid enrollees who were residing and enrolled for Medicaid benefits in another State during our audit period.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

						Texas Medicaid Enrollees in the Sample Who Were Residing and Enrolled for Medicaid Benefits in Another State		
Stratum	**Frame Size**	**Value of Frame**	**Sample Size**	**Total Value of Sample**	**Federal Share of Sample**	**Number in Sample**	**Total Value of August 2021 Capitation Payments**	**Federal Share of August 2021 Capitation Payments**
1	50,472	$14,892,753	46	$14,356	$9,809	20	$7,253	$4,955
2	10,593	16,044,510	54	88,199	60,339	18	24,686	16,789
Total	**61,065**	**$30,937,263**	**100**	**$102,554**[19]	**$70,148**	**38**	**$31,939**	**$21,744**

Table 3: Estimated August 2021 Capitation Payments in the Sampling Frame That the State Agency Paid on Behalf of Texas Medicaid Enrollees Who Were Residing and Enrolled for Medicaid Benefits in Another State

(Limits Calculated at the 90-Percent Confidence Level)

	Total Amount	**Federal Share**
Point estimate	$12,800,913	$8,730,057
Lower limit	9,521,539	6,497,802
Upper limit	16,080,286	10,962,312

[19] The stratum amounts do not sum to the total amount due to rounding.

APPENDIX E: STATE AGENCY COMMENTS

Texas Health and Human Services Commission (HHSC)
Management Response to the
U.S. Department of Health and Human Services Office of Inspector General
Draft Report dated July 6, 2023 - A-05-22-00018

"Texas Made Capitation Payments for Enrollees Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Another State"

Management Response Recommendation 1

Recommendation 1: *We recommend that the Texas Health and Human Services Commission resume and enhance procedures that are in accordance with Federal requirements and the State's unwinding process to identify and disenroll enrollees who are residing and enrolled in Medicaid managed care in another State.*

Statement of Concurrence or Nonconcurrence and Actions Taken and/or Planned

The Texas Health and Human Services Commission (HHSC) concurs with the issues reported and plans to resume procedures to identify and disenroll clients who are no longer eligible for Medicaid, including those who have moved to another state.

Effective March 31, 2023, H.R. 2617, the Consolidated Appropriations Act, 2023, ended the Families First Coronavirus Response Act (FFCRA) requirement to maintain Medicaid coverage. In Texas, a redetermination of eligibility must be initiated for all Medicaid recipients within the 12-month unwinding period, beginning April 1, 2023, through March 31, 2024. All redeterminations must be processed by May 31, 2024.

Access and Eligibility Services (AES) continued to terminate eligibility for individuals who moved out of state and continued to process the Public Assistance Reporting Information System (PARIS) matches received from HHSC Office of Inspector General (HHSC-OIG) while the continuous enrollment requirement was in effect. As indicated on page 8 of the draft report, for 31 out of the 38 of the sample cases for which capitation was paid in Texas and another state, AES was unable to terminate eligibility because AES did not receive notification from the beneficiary or HHSC-OIG that they had moved out of state.

After reviewing the seven cases where AES was aware of the move out of state, AES determined that the cases where AES did not act were due to inability to act on Department of Family and Protective Services (DFPS) or Social Security Administration (SSA)-related types of assistance, deficiencies related to temporary system changes made to maintain eligibility during the COVID-19 public health emergency (PHE), or delayed processing timeframes due to the COVID-19 PHE. AES did not identify any processes to enhance as part of this audit because the

issues identified will be resolved as part of the unwinding of continuous Medicaid. AES is resuming normal eligibility determination processes during the unwinding of continuous Medicaid and will fully resume normal processes by May 31, 2024.

The process of removing clients from the Medicaid capitation roles is automated. When AES closes the eligibility and the client is disenrolled in the Texas Integrated Eligibility Redesign System (TIERS), the information is sent to the Premiums Payable System (PPS) monthly, at cutoff, and PPS no longer provides capitation on that client for the next month.

Responsible Manager

Deputy Associate Commissioner for AES Program Policy

Target Implementation Date

May 31, 2024

Management Response to Recommendation 2

Recommendation 2: *We recommend that the Texas Health and Human Services Commission work with CMS to consider the potential use of T-MSIS data to identify potential cases of concurrent enrollment.*

Statement of Concurrence or Nonconcurrence and Actions Taken and/or Planned

The Texas Health and Human Services Commission (HHSC) concurs with the recommendation. HHSC, in conjunction with HHSC Office of Inspector General (HHSC-OIG), requested a meeting with the Centers for Medicare & Medicaid Services (CMS) to discuss the benefit of using the Transformed Medicaid Statistical Information System (T-MSIS) data to assist in identifying potential cases of concurrent enrollment. CMS indicated it is currently conducting an exploratory analysis to support sharing T-MSIS information with the states and the states will hear from CMS once it is completed.

Responsible Manager

Deputy Associate Commissioner of Program Enrollment and Support, Medicaid and CHIP Services

Chief of Investigations and Utilization Review, HHSC-OIG

Target Implementation Date

December 31, 2023