

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**TEXAS DID NOT ALWAYS
CALCULATE PHYSICIAN
SUPPLEMENTAL PAYMENTS
MADE TO THE UNIVERSITY OF
TEXAS HEALTH INSTITUTIONS IN
ACCORDANCE WITH FEDERAL
AND STATE REQUIREMENTS**

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Office of Inspector General

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EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security 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. In Texas, the Health and Human Services Commission (State agency) administers the program.

Texas State plan amendment 04-010 (SPA) provided for quarterly physician supplemental payments (supplemental payments) for services provided by physicians who were employed by group practices owned or operated by one of three State academic health systems. The State agency provides supplemental payments to encourage physicians to provide health care to more Medicaid patients. The SPA was codified in the Texas Administrative Code. This is the second in a series of reports on the Texas physician supplemental payment program.

The State agency contracted with Public Consulting Group (PCG) to develop the supplemental payment program. PCG drafted the SPA; determined which physician group practices qualified for supplemental payments; and calculated the supplemental payments for the State agency until 2007, when the State agency began performing the calculations with assistance from PCG.

The University of Texas (UT) academic health system, one of the three State academic health systems covered by the SPA, provides health care services in Texas through its six health institutions: UT MD Anderson Cancer Center, UT Medical Branch at Galveston, UT Southwestern Medical Center, UT Health Science Center at Houston, UT Health Science Center at San Antonio, and UT Health Science Center at Tyler. The State agency made \$283,239,049 (\$171,929,299 Federal share) in supplemental payments to the UT health institutions for Medicaid services provided between May 1, 2004, and September 30, 2007.

The SPA required the State agency to calculate an average commercial ratio (ratio) based on fees that commercial carriers would have paid for Medicaid physician services (commercial fees) and fees that Medicare would have paid for the same services (Medicare equivalent fees). Commercial fees and Medicare equivalent fees are typically higher than Medicaid fees. To calculate each quarterly supplemental payment made during Federal fiscal years 2004 through 2007, the ratio was multiplied by the total of all Medicare equivalent fees for Medicaid services provided during the quarter. This amount, less Medicaid payments already made for those services, was the supplemental payment.

OBJECTIVE

Our objective was to determine whether the State agency calculated supplemental payments made to the UT health institutions in accordance with Federal and State requirements.

SUMMARY OF FINDINGS

The State agency did not always calculate supplemental payments made to the UT health institutions in accordance with Federal and State requirements. Specifically, the supplemental payment calculations included:

- overstated Medicare equivalent fees for claims that included payment modifiers and diagnostic test modifiers,
- Medicaid services that were performed by ineligible providers, and
- Medicaid services that did not have Medicare equivalent fees.

As a result, the UT health institutions received \$95,359,841 (\$57,884,268 Federal share) in unallowable supplemental payments.

The overpayments occurred because the State agency did not have any formal written policies and procedures to ensure that the methodology used to calculate supplemental payments was consistent with the terms of the SPA and complied with Federal and State requirements. According to a State agency official, PCG provided 6 months of hands-on training to a State agency rate analyst before the State agency assumed responsibility for calculating the supplemental payments. The official said that the rate analyst, who calculated the 2007 third- and fourth-quarter supplemental payments for the State agency, created a one-page document based on the training that PCG provided. That document did not contain any procedures for calculating the ratio or identifying eligible physicians and did not adjust supplemental payments for payment modifiers or diagnostic test modifiers.

RECOMMENDATIONS

We recommend that the State agency refund to the Federal Government the \$57,884,268 Federal share of improper supplemental payments made to the UT health institutions.

STATE AGENCY COMMENTS AND OUR RESPONSE

In its comments on our recommendation to refund the Federal share of improper supplemental payments made to the University of Texas health institutions, the State agency said that it would:

- review the physician supplemental payment calculation and refund the Federal share of any improper payments related to overstated equivalent fees for claims that included modifiers and Medicare services that did not have Medicare equivalent fees and
- work with the UT health institutions to determine whether ineligible providers were included in the calculation and refund the Federal share of any physician supplemental payments that did not meet applicable requirements.

In our draft report, we recommended that the State agency develop formal written policies and procedures to improve the supplemental payment calculations. The State agency noted in its

comments that the physician supplemental payment program has ended and that additional policies and procedures are unnecessary. We agree and have removed the recommendation.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security 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. In Texas, the Health and Human Services Commission (State agency) administers the program.

Supplemental Payments

CMS approved Texas State plan amendment 04-010 (SPA) on October 19, 2006, with an effective retroactive date of May 1, 2004. The SPA provided for quarterly physician supplemental payments (supplemental payments) for services provided by physicians who were employed by group practices owned or operated by one of three State academic health systems.¹ The State agency provides supplemental payments to encourage physicians to provide health care to more Medicaid patients. This is the second in a series of reports on the Texas physician supplemental payment program.²

Public Consulting Group

The State agency contracted with Public Consulting Group (PCG) to develop the supplemental payment program. PCG drafted the SPA; determined which physician group practices qualified for supplemental payments; and calculated the supplemental payments for the State agency until 2007, when the State agency began performing the calculations with assistance from PCG.³

University of Texas Health Institutions

The University of Texas (UT) academic health system, one of the three State academic health systems covered by the SPA, provides health care services in Texas through its six health institutions: UT MD Anderson Cancer Center, UT Medical Branch at Galveston, UT

¹ The State agency selected these three State academic health systems for supplemental payments because the doctors they employ serve a disproportionate share of Medicaid patients.

² *Review of Physician Supplemental Payments Made to the University of North Texas (A-06-10-00082)*, issued September 9, 2014.

³ Although PCG performed most of the supplemental payment calculations during our audit period, we use the term “State agency” when discussing supplemental payment calculations. The State agency is ultimately responsible for ensuring that supplemental payments are calculated correctly.

Southwestern Medical Center, UT Health Science Center at Houston, UT Health Science Center at San Antonio, and UT Health Science Center at Tyler. The State agency made \$283,239,049 (\$171,929,299 Federal share) in supplemental payments to the UT health institutions for Medicaid services provided between May 1, 2004, and September 30, 2007.

Calculating Supplemental Payments

To calculate quarterly supplemental payments made for services provided by physicians performed from May 1, 2004, through September 30, 2007, the State agency was to:

- calculate an average commercial ratio (ratio) based on fees that commercial carriers would have paid for Medicaid physician services (commercial fees) and fees that Medicare would have paid for the same services (Medicare equivalent fees)⁴ for Medicaid services provided during the base period (2005),
- calculate the aggregate of all of the Medicare equivalent payments for the Medicaid physician services performed during the quarterly payment period by multiplying Medicare fees by the number of times the services were performed,
- multiply the ratio by the aggregate of all of the Medicare equivalent payments, and
- subtract from that amount what Medicaid already had paid for the Medicaid physician services during the quarterly payment period to eligible physician group practices.⁵

Current Procedural Terminology Codes

The SPA required the State agency to use the American Medical Association's Current Procedural Terminology (CPT) codes when determining fees for physician services across commercial, Medicare, and Medicaid fee schedules. CPT is a uniform coding system that identifies medical services performed by physicians and other health care professionals.⁶

Current Procedural Terminology Code Modifiers

A CPT code modifier (modifier) is a two-character (alpha and/or numeric) code that gives Medicare, Medicaid, and commercial payers additional information needed to process a claim. Physicians use modifiers, such as payment and diagnostic test modifiers, to indicate that a special circumstance has altered a service or procedure without changing the code for that

⁴ See Appendix A for a detailed description of how the State agency calculated the ratio.

⁵ See Appendix B for a detailed description of how the State agency calculated supplemental payments.

⁶ The five-character codes and descriptions included in this report are obtained from Current Procedural Terminology (CPT®), copyright 2004–2007 by the American Medical Association (AMA). CPT is developed by AMA as a listing of descriptive terms and five-character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this report should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.

service or procedure. Some modifiers are informational only and do not affect reimbursement. Other modifiers affect reimbursement.

Payment Modifiers

The UT health institutions used the following payment modifiers:

- 22 (increased procedural services);
- 50 (bilateral surgery);
- 51 (multiple procedures);⁷
- 52 (reduced services);⁸
- 54, 55, and 56 (split global care);⁹
- 62 (cosurgeons);
- 66 (surgical team);¹⁰
- 80, 82, and AS (assistant at surgery services);
- AQ (physician service provided in an unlisted health professional shortage area);
- QK (medical direction of concurrent anesthesia procedures);¹¹

⁷ Modifier 51 signals that the highest valued procedure is paid at 100 percent of the fee schedule and the second through fifth highest valued procedures are paid at 50 percent of the fee schedule. Because we could not determine the order of procedures, we recalculated payments with modifier 51 at 100 percent of the fee schedule.

⁸ Claims with modifier 22 or 52 signal that providers must submit additional documentation to receive a payment adjustment. Because we had no way to determine whether any incentive payment would have been made for these services, we recalculated payments with modifiers 22 or 52 at 100 percent of the fee schedule.

⁹ Claims with modifier 54, 55, or 56 signal that providers performed less than all of the parts of a surgical procedure. Modifier 54 denotes the intraoperative part of the service, modifier 55 denotes the postoperative part of the service, and modifier 56 denotes the preoperative part of the service. We recalculated payments with these modifiers according to adjustments listed in the Medicare fee schedule.

¹⁰ When providers use modifier 66, they must submit additional documentation to receive payment. In determining the Medicare equivalent, we had no way to determine whether a payment would have been allowed for a team surgery. We used 100 percent of the Medicare fee schedule for claims with these modifiers.

¹¹ Modifier QK identifies that a physician is not personally providing an anesthesia service but is providing medical direction of two, three, or four concurrent anesthesia services involving qualified individuals. Providers receive a 50-percent fee reduction for services amended with this modifier.

- QU (physician service provided in an urban health professional shortage area);¹² and
- QY (medical direction of one certified registered nurse anesthetist).¹³

Diagnostic Test Modifiers

A diagnostic CPT code without any diagnostic test modifier indicates that the fee is for the “global” service, which includes both the professional and technical components of a diagnostic test. Providers add the modifier 26 or the modifier TC to diagnostic CPT codes on Medicare and Medicaid claims when only one component is claimed. Modifier 26 indicates that the fee is for the professional component of a diagnostic test, i.e., the physician’s interpretation of a test. Modifier TC indicates that the fee is for the technical component of a diagnostic test, i.e., the cost of the physician’s equipment, supplies, and personnel.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency calculated supplemental payments made to the UT health institutions in accordance with Federal and State requirements.

Scope

We reviewed \$283,239,049 (\$171,929,299 Federal share) in supplemental payments made to the UT health institutions for Medicaid CPT codes, or claim lines (services), provided from May 1, 2004, through September 30, 2007. We did not review the overall internal control structure of the State agency. We limited our review to internal controls directly related to our objective.

We performed our fieldwork at the State agency and the Texas Medicaid and Healthcare Partnership (TMHP)¹⁴ in Austin, Texas.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;

¹² Claims with modifiers AQ or QU signal that providers must submit additional documentation to receive a 10-percent incentive payment. In determining the Medicare equivalent, we had no way to determine whether any incentive payment would have been made for these services. We recalculated payments with modifiers AQ or QU at 100 percent of the fee schedule.

¹³ Modifier QY identifies that an anesthesiologist is not personally providing an anesthesia service but is providing medical direction of one certified registered nurse anesthetist. Providers receive a 50-percent fee reduction for services amended with this modifier.

¹⁴ TMHP is a contractor that has processed Texas Medicaid claims since January 1, 2004.

- reviewed the Medicare fee schedules for our audit period;
- reviewed the *Texas Medicaid Provider Procedures Manuals* in effect during our audit period to understand claim processing requirements for Medicaid providers;
- reviewed the State agency’s responses to our questions;
- reviewed written and electronic documents the State agency provided;
- interviewed personnel from CMS, the State agency, and PCG about procedures for calculating supplemental payments;
- obtained a list from the UT health institutions of all performing providers¹⁵ whose services were included in the supplemental payment calculations;
- reviewed the list of providers to determine whether the services submitted for supplemental payments were performed by eligible physicians;
- recalculated the ratio by:
 - obtaining the Medicaid Management Information System (MMIS) data that the State agency used to calculate the ratio,
 - identifying eligible Medicaid physician services,
 - matching commercial fees to eligible Medicaid services, and
 - matching Medicare fees to eligible Medicaid services;¹⁶
- recalculated the quarterly supplemental payments by:
 - obtaining the MMIS data that the State agency used to calculate quarterly supplemental payments,
 - identifying eligible Medicaid physician services, and
 - matching Medicare fees to eligible Medicaid services;¹⁷ and

¹⁵ Performing providers included physicians, nonphysicians, and facilities.

¹⁶ See Appendix A for more information on our ratio recalculations.

¹⁷ This step required us to correct Medicare equivalent fees for 11,461 Medicaid services for which the State agency had used incorrect Medicare equivalent fees. See Appendix B for more information on our supplemental payment recalculations.

- discussed our preliminary findings with the State agency, the UT health institutions, and PCG.

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.

FINDINGS AND RECOMMENDATIONS

The State agency did not always calculate supplemental payments made to the UT health institutions in accordance with Federal and State requirements. Specifically, the supplemental payment calculations included:

- overstated Medicare equivalent fees for claims that included payment modifiers and diagnostic test modifiers,
- Medicaid services that were performed by ineligible providers, and
- Medicaid services that did not have Medicare equivalent fees.

As a result, the UT health institutions received \$95,359,841 (\$57,884,268 Federal share) in unallowable supplemental payments.

The overpayments occurred because the State agency did not have any formal written policies and procedures to ensure that the methodology used to calculate the supplemental payments was consistent with the terms of the SPA and complied with Federal and State requirements.

OVERSTATED MEDICARE EQUIVALENT FEES FOR PAYMENT MODIFIERS AND DIAGNOSTIC TEST MODIFIERS

The State agency's supplemental payment calculations included overstated Medicare equivalent fees for claims that included payment modifiers and diagnostic test modifiers. Details about these overstatements are included below. The overstatements occurred because the State agency did not have any formal written policies and procedures to ensure that the supplemental payments were calculated in accordance with the terms of the SPA. As a result, the State agency overstated supplemental payments by \$90,475,481 (\$54,919,000 Federal share).¹⁸ See Appendix B for more information on the effect of these overstatements on the supplemental payment calculations.

¹⁸ The \$54,919,000 in overstated supplemental payments accounted for approximately 95 percent of the total unallowable supplemental payments identified during our audit period.

Overstated Medicare Equivalent Fees for Claims That Included Payment Modifiers

Chapter 12, section 20.4, of the *Medicare Claims Processing Manual* states that adjustments should be made to fees for services when there are multiple surgeries, bilateral surgeries, assistants at surgeries, two surgeons or a surgical team, or when a provider provides less than the global fee package. Chapter 12, sections 50(C) and 140.4.2, state that adjustments should be made to fees for anesthesia services when a physician medically directs a certified registered nurse anesthetist or other qualified individual in a single procedure or medically directs qualified individuals in two, three, or four concurrent procedures. These situations require payment modifiers that adjust the fees for the services.

The State agency calculated Medicare equivalent fees for Medicaid physician services at 100 percent of the Medicare fee schedule even when the CPT codes were appended with payment modifiers.¹⁹ For example:

- The State agency used 100 percent of the Medicare fee of \$2,347 for CPT code 33406, which had been appended with modifier 82. The State agency should have multiplied the Medicare fee by 16 percent, which would have yielded a \$376 Medicare equivalent payment. This error resulted in a Medicare equivalent overstatement of \$1,971.
- The State agency used 100 percent of the Medicare fee of \$468 for CPT code 49505, which had been appended with modifier 50. The State agency should have multiplied the Medicare fee by 150 percent, which would have yielded a \$702 Medicare equivalent payment. This error resulted in a Medicare equivalent understatement of \$234.

Additionally, the State agency should have adjusted fees for CPT codes appended with payment modifiers AS, QK, QY, 54, 55, 56, 62, and 80. The State agency should have multiplied the Medicare fee for modifiers AS and 80 by 16 percent and the Medicare fee for modifier 62 by 62.5 percent. The State agency should have reduced allowed amounts by 50 percent for anesthesia services appended with modifiers QK and QY. The State agency should have reduced Medicare fees for services appended with modifiers 54, 55, and 56. These modifiers have various percentage adjustments that are determined within the Medicare physician fee schedule.

Overstated Medicare Equivalent Fees for Claims That Included Diagnostic Test Modifiers

Section 1902(a)(30)(A) of the Social Security Act requires that Medicaid payments be “consistent with efficiency, economy and quality of care” Also, Office of Management and Budget Circular No. A-87 states: “A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost.” Sections e(2) through e(4) of the SPA required the State agency to make supplemental payments that were equal to the difference

¹⁹ The State agency used CPT code modifiers for 2008 reconciliation payments that it made to the UT health institutions for services that UT physicians performed in 2006. We factored the reconciliation payments into our supplemental payment recalculations.

between the Medicare equivalent fees multiplied by the ratio and the Medicaid payments that already had been made.

The State agency used global service fees to calculate the Medicare equivalent fees for Medicaid physician services related to diagnostic tests even when Medicaid had paid for only the professional or the technical component of the services.²⁰ In most cases, the global service fee is substantially higher than the professional component fee and moderately higher than the technical component fee. In the following example, the State agency used the global service fee to calculate the Medicare equivalent fee, even though the Medicaid payment was only for the professional component fee.

Table: Incorrect Use of Global Service Fee

Atherectomy, X-Ray Exam	Modifier	Medicare Fee 2005	Medicaid Fee 2005
CPT code 75992	No modifier (global fee)	\$657	\$457
CPT code 75992	26 (Professional component)	\$29	\$23
CPT code 75992	TC (Technical component)	\$628	\$434

The State agency should have used the Medicare fee of \$29 for its supplemental payment calculations. Instead, it used the \$657 global service fee, which overstated the Medicare equivalent fee by \$628 (2,166 percent).

MEDICAID SERVICES PERFORMED BY INELIGIBLE PROVIDERS

Sections e(1) and e(2) of the SPA required that to be eligible for supplemental payments, services be rendered by physicians who were employed by group practices owned or operated by one of the three State academic health systems (eligible physicians).²¹ Those sections of the SPA also specifically excluded services that contractors performed.

²⁰ The State agency used diagnostic test modifier 26 for 2008 reconciliation payments that it made to the UT health institutions for services that UT physicians performed in 2006. We factored the reconciliation payments into our supplemental payment recalculations.

²¹ Section e(1) of the SPA stated that "... supplemental payments are available ... to physicians who are recognized as essential to the Texas State Medicaid program. To be identified as an essential physician and qualify for a supplemental payment, the physician must be ... [a] Texas licensed physician ... and ... [e]mployed by an eligible physician group practice that is state-owned or operated."

The State agency included services performed by nonphysicians and contractors in calculating supplemental payments or did not provide documentation proving that the services were performed by eligible providers. The State agency made these errors because it did not have any formal written policies and procedures to ensure that it included in its supplemental payment calculations only services that eligible physicians provided. As a result, the State agency overstated supplemental payments by \$5,901,977 (\$3,583,020 Federal share). See Appendix A for the error's effect on the ratio and Appendix B²² for more information on the error's effect on supplemental payment calculations.

MEDICAID SERVICES THAT DID NOT HAVE MEDICARE EQUIVALENT FEES

Section e(3)III of the SPA directed the State agency to calculate the ratio for each Medicaid physician service using a Medicare equivalent fee. Section e(4)(i) of the SPA directed the State agency to calculate supplemental payments for only those Medicaid physician services that had Medicare equivalent fees listed in the Medicare fee schedule.

The State agency included Medicaid physician services that did not have Medicare equivalent fees listed in the Medicare fee schedule. The State agency included these services because it did not have any formal written policies and procedures to ensure that, in its supplemental payment calculations, it included only physician services that had Medicare equivalent fees. As a result, the State agency understated supplemental payments by \$1,017,617 (\$617,752 Federal share). The State agency's inclusion of these services accounted for most of the overstatements of the ratios it computed (Appendix A).²³ See Appendix B for more information on the error's effect on supplemental payment calculations.

THE STATE AGENCY LACKED FORMAL WRITTEN POLICIES AND PROCEDURES

The overpayments occurred because the State agency did not have any formal written policies and procedures to ensure that the methodology used to calculate the supplemental payments was consistent with the terms of the SPA and complied with Federal and State requirements. According to a State agency official, PCG provided 6 months of hands-on training to a State agency rate analyst before the State agency assumed responsibility for calculating the supplemental payments. The official said that the rate analyst, who calculated the 2007 third- and fourth-quarter supplemental payments for the State agency, created a one-page document based on the training that PCG provided. That document did not contain any procedures for calculating the ratio or identifying eligible physicians and did not adjust supplemental payments for payment modifiers or diagnostic test modifiers. We are not making any recommendations to develop and implement policies and procedures because the physician supplemental payment program ended in September 2011.

²² Tables 3 and 5 in Appendix B represent separate steps we took to identify Medicaid services performed by ineligible providers and are combined in the report under the heading "Medicaid Services Performed by Ineligible Providers."

²³ This is true for five of the six UT health institutions.

RECOMMENDATIONS

We recommend that the State agency refund to the Federal Government the \$57,884,268 Federal share of improper supplemental payments made to the UT health institutions.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our recommendation to refund the Federal share of improper supplemental payments made to the University of Texas health institutions, the State agency said that it would:

- review the physician supplemental payment calculation and refund the Federal share of any improper payments related to overstated equivalent fees for claims that included modifiers and Medicare services that did not have Medicare equivalent fees and
- work with the UT health institutions to determine whether ineligible providers were included in the calculation and refund the Federal share of any physician supplemental payments that did not meet applicable requirements.

In our draft report, we recommended that the State agency develop formal written policies and procedures to improve the supplemental payment calculations. The State agency noted in its comments that the physician supplemental payment program has ended and that additional policies and procedures are unnecessary. We agree and have removed the recommendation.

The State agency's comments are included in their entirety as Appendix C.

APPENDIXES

**APPENDIX A: UNIVERSITY OF TEXAS HEALTH INSTITUTIONS' ORIGINAL
AND RECALCULATED RATIOS¹**

The State agency calculated an average commercial ratio (ratio) for each of the University of Texas (UT) health institutions using fiscal year 2005 data from the Medicaid Management Information System using the following methodology. For each Current Procedural Terminology (CPT) code:

- Number of times the Medicaid service was provided × average commercial fee² (these amounts were aggregated to determine the numerator in the formula below).
- Number of times the Medicaid service was provided × Medicare equivalent fee³ (these amounts were aggregated to determine the denominator in the formula below).

$$\frac{\text{Aggregate average commercial payments}}{\text{Aggregate Medicare equivalent payments}} = \text{ratio}$$

UT MD Anderson Cancer Center's (MD Anderson) original ratio:

$$\frac{\$10,454,408}{\$6,419,171} = 162.8623\%$$

To recalculate the ratio for MD Anderson, we made the following adjustments:

1. We removed the Medicaid services performed by ineligible providers, whom we identified by reviewing MD Anderson's personnel listing.

$$\frac{\$9,749,968}{\$6,169,153} = 158.0439\%$$

2. We removed Medicaid services that did not have Medicare equivalent fees.⁴

$$\frac{\$9,730,499}{\$6,169,153} = 157.7283\%$$

We used 157.7283 percent as the ratio in our recalculation of the supplemental payments made to MD Anderson.

¹ For presentation purposes, we rounded dollar amounts to the nearest dollar and ratios to four decimal places.

² According to a State agency official, the average commercial fees are proprietary. Therefore, we could not independently verify their accuracy.

³ We verified the Medicare equivalent fees that the State agency provided us. We did not consider any modifiers for these fees because the State agency did not provide us with the effect of the modifiers on the commercial fees.

⁴ Removing services that had no Medicare equivalent fees left the denominator unchanged.

UT Health Science Center at Houston's (UT Houston) original ratio:

$$\frac{\$26,733,988}{\$23,065,399} = 115.9052\%$$

To recalculate the ratio for UT Houston, we made the following adjustments:

1. We removed the Medicaid services performed by ineligible providers, whom we identified by reviewing UT Houston's personnel listing.

$$\frac{\$26,593,917}{\$22,960,628} = 115.8240\%$$

2. We removed Medicaid services that did not have Medicare equivalent fees.⁵

$$\frac{\$26,513,268}{\$22,960,628} = 115.4727\%$$

3. We removed Medicaid services that had CPT code modifiers SA or U7, which indicate that ineligible providers (nonphysicians) performed the services.

$$\frac{\$26,450,689}{\$22,913,252} = 115.4384\%$$

We used 115.4384 percent as the ratio in our recalculation of the supplemental payments made to UT Houston.

UT Medical Branch at Galveston's (UTMB) original ratio:

$$\frac{\$30,487,859}{\$23,992,651} = 127.0717\%$$

To recalculate the ratio for UTMB, we made the following adjustments:

1. We removed Medicaid services performed by ineligible providers, whom we identified by reviewing UTMB's personnel listing.

$$\frac{\$30,218,806}{\$23,803,368} = 126.9518\%$$

⁵ Removing services that had no Medicare equivalent fees left the denominator unchanged.

2. We removed Medicaid services that did not have Medicare equivalent fees.⁶

$$\frac{\$30,158,112}{\$23,803,368} = 126.6968\%$$

3. We removed Medicaid services that had CPT code modifiers SA or U7, which indicate that ineligible providers (nonphysicians) performed the services.

$$\frac{\$28,569,390}{\$22,548,424} = 126.7024\%$$

We used 126.7024 percent as the ratio in our recalculation of the supplemental payments made to UTMB.

UT Health Science Center at San Antonio's (UTSA) original ratio:

$$\frac{\$14,298,406}{\$13,311,050} = 107.4176\%$$

To recalculate the ratio for UTSA, we made the following adjustments:

1. We removed Medicaid services performed by ineligible providers, whom we identified by reviewing UTSA's personnel listing.

$$\frac{\$14,294,213}{\$13,307,025} = 107.4185\%$$

2. We removed Medicaid services that did not have Medicare equivalent fees.⁷

$$\frac{\$14,264,262}{\$13,307,025} = 107.1935\%$$

3. We removed Medicaid services that had CPT code modifiers AH, SA, U7, or QZ, which indicate that ineligible providers (nonphysicians) performed the services.

$$\frac{\$14,128,485}{\$13,175,714} = 107.2313\%$$

We used 107.2313 percent as the ratio in our recalculation of the supplemental payments made to UTSA.

⁶ Removing services that had no Medicare equivalent fees left the denominator unchanged.

⁷ Removing services that had no Medicare equivalent fees left the denominator unchanged.

UT Southwestern's Medical Center (UTSW) original ratio:

$$\frac{\$67,928,229}{\$47,074,006} = 144.3009\%$$

To recalculate the ratio for UTSW, we made the following adjustments:

1. We removed Medicaid services performed by ineligible providers, whom we identified by reviewing UTSW's personnel listing.

$$\frac{\$67,781,011}{\$46,964,648} = 144.3235\%$$

2. We removed Medicaid services that did not have Medicare equivalent fees.⁸

$$\frac{\$67,732,785}{\$46,964,648} = 144.2208\%$$

We used 144.2208 percent as the ratio in our recalculation of the supplemental payments made to UTSW.

UT Health Science Center at Tyler's (UT Tyler) original ratio:

$$\frac{\$3,627,855}{\$2,493,285} = 145.5050\%$$

To recalculate the ratio for UT Tyler, we made the following adjustments:

1. We removed Medicaid services performed by ineligible providers, whom we identified by reviewing UT Tyler's personnel listing.

$$\frac{\$3,626,408}{\$2,492,773} = 145.4769\%$$

2. We removed Medicaid services that did not have Medicare equivalent fees.⁹

$$\frac{\$3,479,574}{\$2,492,773} = 139.5865\%$$

⁸ Removing services that had no Medicare equivalent fees left the denominator unchanged.

⁹ Removing services that had no Medicare equivalent fees left the denominator unchanged.

3. We removed Medicaid services that had CPT code modifier SA, which indicates that ineligible providers (nonphysicians) performed the services.

$$\frac{\$3,477,625}{\$2,491,164} = 139.5984\%$$

We used 139.5984 percent as the ratio in our recalculation of the supplemental payments made to UT Tyler.

APPENDIX B: UNIVERSITY OF TEXAS HEALTH INSTITUTIONS' ORIGINAL AND RECALCULATED SUPPLEMENTAL PAYMENTS¹

Table 1: State-Agency-Calculated Supplemental Payment

UT Health Institution	Medicare Equivalent Fees	Ratio	Medicare Equivalent Fees x Ratio	Less What Medicaid Already Paid	Equals Supplemental Payment
MD Anderson	\$18,758,347	162.86% ²	\$30,550,270	\$6,706,820	\$23,843,450
UT Houston	\$69,462,373	115.91% ³	\$80,510,475	\$39,100,380	\$41,410,095
UTMB	\$84,966,379	127.07% ⁴	\$107,968,180	\$48,911,080	\$59,057,100
UTSA	\$44,615,866	107.42% ⁵	\$47,925,275	\$23,106,961	\$24,818,314
UTSW	\$145,976,050	144.30% ⁶	\$210,644,798	\$84,854,546	\$125,790,252
UT Tyler	\$7,876,166	145.50% ⁷	\$11,460,215	\$3,140,377	\$8,319,838

Total State-agency-calculated supplemental payment: \$283,239,049 (\$171,929,299 Federal share).

To recalculate the supplemental payment for each of the UT health institutions, as shown below, we corrected the errors. In addition, we used the corrected ratios shown in Appendix A.

¹ For presentation purposes, we rounded dollar amounts to the nearest dollar and ratios to two decimal places.

² The actual ratio the State agency used in the original payment calculations for MD Anderson was 162.86227 percent.

³ The actual ratio the State agency used in the original payment calculations for UT Houston was 115.90516 percent.

⁴ The actual ratio the State agency used in the original payment calculations for UTMB was 127.07165 percent.

⁵ The actual ratio the State agency used in the original payment calculations for UTSA was 107.41756 percent.

⁶ The actual ratio the State agency used in the original payment calculations for UTSW was 144.30093 percent.

⁷ The actual ratio the State agency used in the original payment calculations for UT Tyler was 145.50499 percent.

Table 2: Overstated Medicare Equivalent Fees

We used the Medicare equivalent fees that corresponded with the modifiers used for diagnostic services rather than the global fees that the State agency had incorrectly used, and we used the payment modifiers that the State agency had incorrectly omitted.

UT Health Institution	Medicare Equivalent Fees	OIG-Calculated Ratio	Medicare Equivalent Fees x Ratio	Less What Medicaid Already Paid	Equals Supplemental Payment	Supplemental Payment (Decrease or Increase)
MD Anderson	\$11,086,530	157.73% ⁸	\$17,486,594	\$6,706,820	\$10,779,774	(\$13,063,676)
UT Houston	\$57,944,520	115.44% ⁹	\$66,890,221	\$39,100,380	\$27,789,841	(\$13,620,254)
UTMB	\$73,162,636	126.70% ¹⁰	\$92,698,801	\$48,911,080	\$43,787,721	(\$15,269,379)
UTSA	\$35,210,465	107.23% ¹¹	\$37,756,629	\$23,106,961	\$14,649,668	(\$10,168,646)
UTSW	\$122,228,118	144.22% ¹²	\$176,278,357	\$84,854,546	\$91,423,811	(\$34,366,441)
UT Tyler	\$5,353,306	139.60% ¹³	\$7,473,130	\$3,140,377	\$4,332,753	(\$3,987,085)

Total overstated Medicare equivalent fees questioned: \$90,475,481 (\$54,919,000 Federal share).

⁸ The actual ratio used in the payment recalculations was 157.72829 percent.

⁹ The actual ratio used in the payment recalculations was 115.43839 percent.

¹⁰ The actual ratio used in the payment recalculations was 126.70238 percent.

¹¹ The actual ratio used in the payment recalculations was 107.23127 percent.

¹² The actual ratio used in the payment recalculations was 144.22079 percent.

¹³ The actual ratio used in the payment recalculations was 139.59840 percent.

Table 3: Medicaid Services Performed by Ineligible Providers

We identified ineligible providers by reviewing the UT health institutions' personnel directories. We determined whether the providers were physicians or nonphysicians and whether they were employees or contractors. We removed ineligible providers.

UT Health Institution	Medicare Equivalent Fees	OIG-Calculated Ratio	Medicare Equivalent Fees x Ratio	Less What Medicaid Already Paid	Equals Supplemental Payment	Supplemental Payment (Decrease or Increase)
MD Anderson	\$10,626,173	157.73%	\$16,760,481	\$6,483,140	\$10,277,341	(\$502,433)
UT Houston	\$57,365,994	115.44%	\$66,222,380	\$38,746,210	\$27,476,170	(\$313,671)
UTMB	\$72,213,616	126.70%	\$91,496,370	\$48,390,047	\$43,106,323	(\$681,398)
UTSA	\$34,735,720	107.23%	\$37,247,554	\$22,868,437	\$14,379,117	(\$270,551)
UTSW	\$121,520,057	144.22%	\$175,257,186	\$84,450,137	\$90,807,049	(\$616,762)
UT Tyler	\$5,318,967	139.60%	\$7,425,193	\$3,111,555	\$4,313,638	(\$19,115)

Total Medicaid services provided by ineligible providers: \$2,403,930 (\$1,459,265 Federal share).

Table 4: Medicaid Services That Did Not Have Medicare Equivalent Fees

When we removed Medicaid physician services that did not have Medicare equivalent fees, supplemental payments increased because what Medicaid already had paid was reduced.

UT Health Institution	Medicare Equivalent Fees	OIG-Calculated Ratio	Medicare Equivalent Fees x Ratio	Less What Medicaid Already Paid	Equals Supplemental Payment	Supplemental Payment (Decrease or Increase)
MD Anderson ¹⁴	\$10,626,173	157.73%	\$16,760,481	\$6,454,037	\$10,306,444	\$29,103
UT Houston ¹⁵	\$57,365,994	115.44%	\$66,222,380	\$38,574,123	\$27,648,257	\$172,087
UTMB ¹⁶	\$72,213,616	126.70%	\$91,496,370	\$48,164,268	\$43,332,102	\$225,779
UTSA ¹⁷	\$34,735,720	107.23%	\$37,247,554	\$22,644,084	\$14,603,470	\$224,353
UTSW ¹⁸	\$121,520,057	144.22%	\$175,257,186	\$84,191,763	\$91,065,423	\$258,374
UT Tyler ¹⁹	\$5,318,967	139.60%	\$7,425,193	\$3,003,634	\$4,421,559	\$107,921

Total Medicaid services that did not have Medicare equivalent fees questioned costs: \$1,017,617 (\$617,752 Federal share).

¹⁴ The underpayment was offset by the error's effect on the ratio. Removing these services accounted for 0.3156% of the 5.1340-percent ratio reduction.

¹⁵ The underpayment was offset by the error's effect on the ratio. Removing these services accounted for most of the 0.4668-percent ratio reduction.

¹⁶ The underpayment was offset by the error's effect on the ratio. Removing these services accounted for most of the 0.3693-percent ratio reduction.

¹⁷ The underpayment was offset by the error's effect on the ratio. Removing these services accounted for most of the 0.1863-percent ratio reduction.

¹⁸ The underpayment was offset by the error's effect on the ratio. Removing these services accounted for most of the 0.0801-percent ratio reduction.

¹⁹ The underpayment was offset by the error's effect on the ratio. Removing these services accounted for most of the 5.9066-percent ratio reduction.

Table 5: Medicaid Services Performed by Ineligible Providers

After reviewing each UT health institution's personnel directory to identify services performed by nonphysicians and contractors, we identified and removed additional services performed by nonphysicians by reviewing data from the Medicaid Management Information System and identifying services that had modifiers AH, QX, QZ, SA, or U7. These modifiers indicate that nonphysicians had provided the services. On the basis of the UT health institutions' directories alone, we could not determine whether these providers were nonphysicians because nonphysicians in Texas are sometimes allowed to use physician provider numbers for billing purposes.

UT Health Institution	Medicare Equivalent Fees	OIG-Calculated Ratio	Medicare Equivalent Fees x Ratio	Less What Medicaid Already Paid	Equals Supplemental Payment	Supplemental Payment (Decrease or Increase)
MD Anderson	\$10,625,631	157.73%	\$16,759,626	\$6,453,946	\$10,305,680	(\$764)
UT Houston	\$57,117,458	115.44%	\$65,935,474	\$38,428,336	\$27,507,138	(\$141,119)
UTMB	\$67,091,572	126.70%	\$85,006,619	\$44,313,239	\$40,693,380	(\$2,638,722)
UTSA	\$34,544,422	107.23%	\$37,042,422	\$22,538,186	\$14,504,236	(\$99,234)
UTSW	\$120,531,263	144.22%	\$173,831,140	\$83,380,257	\$90,450,883	(\$614,540)
UT Tyler	\$5,315,260	139.60%	\$7,420,018	\$3,002,127	\$4,417,891	(\$3,668)

Total Medicaid services performed by ineligible providers questioned costs: \$3,498,047 (\$2,123,755 Federal share).

Aggregate Questioned Costs

MD Anderson:	\$13,537,770	(\$8,213,718 Federal share)
UT Houston:	\$13,902,957	(\$8,443,013 Federal share)
UTMB:	\$18,363,720	(\$11,147,028 Federal share)
UTSA:	\$10,314,078	(\$6,261,920 Federal share)
UTSW:	\$35,339,369	(\$21,449,611 Federal share)
UT Tyler:	\$3,901,947	(\$2,368,978 Federal share)
Total Questioned Costs:	\$95,359,841	(\$57,884,268 Federal share)

APPENDIX C: STATE AGENCY COMMENTS



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHRIS TRAYLOR
EXECUTIVE COMMISSIONER

April 29, 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-06-11-00004

Dear Ms. Wheeler:

The Texas Health and Human Services Commission (HHSC) received a draft audit report entitled "Texas Did Not Always Calculate Physician Supplemental Payments Made to the University of Texas Health Institutions in Accordance With Federal and State Requirements" from the Department of Health and Human Services Office of Inspector General. The cover letter, dated February 16, 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 actions HHSC has completed or planned.

If you have any questions or require additional information, please contact David Griffith, Deputy Inspector General for Audit. Mr. Griffith may be reached by telephone at (512) 491-2806 or by email at David.Griffith@hhsc.state.tx.us.

Sincerely,

A handwritten signature in cursive script, appearing to read "Chris Traylor".

Chris Traylor

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

**Texas Did Not Always Calculate Physician Supplemental Payments
Made to the University of Texas Health Institutions in Accordance
With Federal and State Requirements**

Summary of Management Response

The Texas Health and Human Services Commission (HHSC) calculated supplemental payments to physician groups affiliated with the University of Texas System institutions in accordance with the methodology approved by the Centers for Medicare and Medicaid Services (CMS) after an extensive, thorough, and transparent review process extending for a period of over two years. During this review process, CMS reviewed each component of the proposed supplemental payment methodology, developed by HHSC's contractor the Public Consulting Group (PCG), including methodologies for (a) supplemental payments related to Medicare equivalent fees, (b) global service fees, and (c) provider eligibility, and approved the resulting state plan amendment.

HHSC will coordinate with the University of Texas health institutions to make a final determination of whether ineligible providers were included in the physician supplemental payment calculation, and refund the federal share of any physician supplemental payments that did not meet applicable requirements. HHSC will work with CMS to resolve the remaining payment issues, with the goal of reaching a resolution within one year of the final audit report issue date.

Detailed responses to each of the recommendations included in the report follow.

DHHS - OIG Recommendation: *We recommend that the State agency refund to the Federal Government the \$57,884,268 Federal share of improper supplemental payments made to the UT health institutions.*

HHSC Management Response:

Overstated Medicare Equivalent Fees for Claims That Included Payment Modifiers and Diagnostic Test Modifiers

(Audit reported that the federal share of overstated payments was \$54,919,000)

Actions Planned:

HHSC will request and review the improper physician supplemental payment calculation documentation and refund the federal share of any improper supplemental payments.

Estimated Completion Date:

Within one year from the date of the final audit report.

HHSC Management Response – Review of Physician Supplemental Payments - UT System
April 29, 2016
Page 2

Title of Responsible Person:

Deputy Executive Commissioner for Financial Services

Medicaid Services Performed by Ineligible Providers

(Audit reported that the federal share of overstated payments was \$3,583,020)

HHSC relies upon the University of Texas health institutions and other physician groups to identify providers eligible for physician supplemental payments. If any ineligible providers were included, HHSC agrees these providers should not be considered in the supplemental payment calculation.

Subsequent to the audit period, HHSC implemented additional safeguards to identify and prevent prospective errors, including requiring hospitals to certify the list of eligible providers for inclusion in the supplemental payment calculation each quarter. The physician supplemental payment program ended in September 2011.

Actions Planned

HHSC will work with the University of Texas health institutions to determine whether any ineligible providers were included in the physician supplemental payment calculations. Once a determination is reached, HHSC will refund the federal share of any physician supplemental payments that did not meet applicable requirements.

Title of Responsible Person

Deputy Executive Commissioner for Financial Services

Medicaid Services that Did Not Have Medicare Equivalent Fees

(Audit stated that the federal share of understated payments was \$617,752)

Actions Planned:

HHSC will request and review the improper physician supplemental payment calculation documentation and refund the federal share of any improper supplemental payments.

Estimated Completion Date:

Within one year from the date of the final audit report.

HHSC Management Response – Review of Physician Supplemental Payments - UT System
April 29, 2016
Page 3

Title of Responsible Person:

Deputy Executive Commissioner for Financial Services

DHHS - OIG Recommendation: *We recommend that the State agency develop formal written policies and procedures to ensure that the supplemental payment calculations include only eligible services performed by eligible physicians and are performed in a manner that reduces the potential for errors.*

HHSC Management Response:

The physician supplemental payment program ended in September 2011, so additional policies and procedures are not needed.

bcc: Cecile Young
Charles Smith
Greta Rymal
Pam McDonald
Lisa Carruth
Karen Ray
Gary Jessee
Stuart Bowen
Sylvia Kauffman
David Griffith
Robert Anderson