Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Texas Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Texas Medicaid Program. The MIG review team conducted the onsite portion of the review at the Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) offices. The Medicaid Fraud Control Unit (MFCU) met with the MIG review team at the HHSC OIG office.

This review focused on the activities of HHSC, the Single State agency. The HHSC has direct oversight for four Texas Health and Human Services departments: the Department of Aging and Disability Services (DADS), the Department of State Health Services, the Department of Assistive and Rehabilitative Services and the Department of Family and Protective Service. All departments have responsibility for some program integrity activities within their individual program areas. The HHSC OIG is directly accountable to HHSC with no line authority for the four departments. The HHSC OIG is responsible for providing any appropriate policy and/or operational recommendations to executive program management in the arena of preventing, detecting and successfully pursuing waste, fraud and abuse. This report describes nine effective practices, five regulatory compliance issues, and six vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Texas improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Texas' Medicaid Program

The HHSC administers the Texas Medicaid program. As of January 2009, the program served 2,955,749 beneficiaries. At the time of the review, HHSC had 113,411 participating Medicaid providers. Medicaid expenditures in Texas for the State fiscal year (SFY) ending August 31, 2009 totaled $407,167,698. The State utilizes managed care through four different programs with a variable number of vendors in each program. The largest has 16 vendors with the smallest having 1 vendor. The total number of managed care enrollees is 2,014,305. The Federal medical assistance percentage (FMAP) for Texas for Federal fiscal year (FFY) 2009 was 66.76 percent. However, with adjustments attributable to the American Recovery and Reinvestment Act of 2009, the State's effective FMAP was 68.76 percent for the first three quarters of FFY 2009 and 69.85 percent in the fourth quarter.

The HHSC contracts with two fiscal agents. One fiscal agent, hereafter referred to as the primary fiscal agent, processes the Medicaid claims payments for fee-for-service (FFS), except for non-emergency medical transportation (NEMT) claims, primary care case management, and long term care. The primary fiscal agent also processes provider enrollment for all providers in the Medicaid

program with the exception of NEMT, long term care and pharmacy providers. A separate fiscal agent processes the Medicaid prescription drug claims.

As was noted in MIG's 2008 program integrity review, all providers must be enrolled by the primary fiscal agent and then be placed on the provider master database. After successfully completing that enrollment process, managed care organizations (MCOs) select providers and credential and enroll them for provider networks. The DADS contracts with providers of waiver services and institutional services in the Texas Medicaid program, including nursing facilities and intermediate care facilities for persons with mental retardation. The HHSC/Medical Transportation Program (MTP) does not utilize the primary fiscal agent for enrollment of transportation service area providers (TSAPs) and their contracted drivers; MTP contracts directly with the TSAPs.

Program Integrity Division

The HHSC OIG is the organizational component dedicated to fraud and abuse activities. At the time of the review, the HHSC OIG had approximately 655 full-time equivalent employees focusing on program integrity for Texas health and human services programs, which include not only Texas Medicaid but other public assistance programs (e.g., Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families). During SFY 2007 through SFY 2009, HHSC OIG's Medicaid Provider Integrity section staff conducted an annual average of 400 preliminary investigations and 69 full investigations. The table below presents the total number of investigations for the last four SFYs as a result of program integrity activities. The amount of overpayments collected includes global settlements, outside litigation judgments, and program integrity activities.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified***	Amount of Overpayments Collected
2006	304	not tracked	not tracked	$56,199,067
2007	365	47	not tracked	$49,243,910
2008	456	105	not tracked	$98,639,172
2009	474	54	not tracked	$100,914,400

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition.
*** Texas does not track identified overpayments specific to Medicaid.

Methodology of the Review

In advance of the onsite visit, the review team requested that HHSC complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosures, managed care, and the MFCU.
A four-person team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of February 8, 2010, the MIG review team visited the HHSC. The team conducted interviews with numerous HHSC officials, as well as with staff from the State's provider enrollment contractor and the MFCU. The team reviewed the managed care contract provisions and gathered information through interviews with representatives of four MCOs. The team also conducted sampling of provider enrollment applications, case files, and other primary data from DADS, the primary fiscal agent, the prescription drugs contractor, MCOs and the HHSC OIG to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the HHSC. Texas' Children's Health Insurance Program operates under Title XXI of the Social Security Act and was, therefore, not included in this review.

Unless otherwise noted, Texas provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that HHSC provided.

RESULTS OF THE REVIEW

Effective Practices

The State of Texas has highlighted several practices that demonstrate its commitment to program integrity. These practices include participation in the Quad State Meeting, the HHSC OIG online reporting system, a provider reinstatement policy, the relationship with the MFCU, a provider enrollment software program, a dedicated team conducting criminal background checks, unannounced onsite durable medical equipment (DME) provider visits, and the annual review of managed care compliance plans.

Participation in Quad State Meeting

The Quad State Meeting is a new initiative whose primary function is to provide line level program integrity staff the opportunity to share and learn from their peers in other states. The meetings, which began in June 2009, were initiated by Florida's Data Detection Unit and include Florida, New York, California and Texas. Discussion issues to date have focused on best fraud detection tools, MFCU referrals, surveillance and utilization review subsystem, Medi-Medi, case studies, and suggestions for next steps in detection.

HHSC OIG website

The HHSC OIG maintains a website that allows users to report fraud. The website also provides information about the types of waste, abuse, and fraud HHSC OIG investigates, which includes third party resources, providers and contractors, beneficiaries, and internal affairs. The site contains links to HHSC OIG contact information, structure, reports, a searchable link to the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG), information on the exclusions program (including the ability to search for state-level exclusions), and provider self-audit guidance.

Provider reinstatement policy
It is HHSC OIG policy not to reinstate any provider who the State has excluded for fraud. Providers that are reinstated, such as providers that were previously excluded due to health care licensure issues, must still complete the provider enrollment process after reinstatement before the provider is permitted to actively participate in Medicaid. Once a provider is reinstated her/his name remains on the State exclusion list with a notation that she/he has been reinstated. This practice creates a history of actions taken over the course of the provider's enrollment in Texas Medicaid.

A high level of cooperation between the State agency and the MFCU
The HHSC OIG and MFCU relationship is one of mutual cooperation that works well for both parties. A MFCU referral must contain the minimum criteria set forth in the Acceptable Referrals from States to MFCUs Performance Standard released by CMS in October, 2008 in conjunction with the Best Practices For Medicaid Program Units Interactions With Medicaid Fraud Control Units document. The HHSC OIG referrals meet this standard. Further, in SFY 2009, HHSC OIG referred 291 cases and only 10 were declined for a variety of reasons. The agencies meet regularly, have developed and consistently apply one standard for deciding when to refer a case, regularly update each other on cases and provide education and consultation to one another.

Matching technology used in provider enrollment
As identified during MIG's 2008 program integrity review, the State's primary fiscal agent employs an innovative software package which automates the verification of licenses of potential Medicaid providers and ensures that Medicaid does not allow payments to non-qualified health care providers. The software allows the primary fiscal agent to match a provider's information against its Master File, the Federal Provider Exclusion List, the Texas State Provider exclusion list, the Texas Medicaid Do Not Enroll List, and the Open Investigations list, so the user can easily determine if the provider is eligible to be enrolled.

Prior to the software package, the primary fiscal agent's process was to manually validate providers listed on the HHSC OIG open case list prior to enrollment. In an internal October 2006 audit, it was discovered in a random sample of enrolled providers that validation through this manual process was inconsistent and resulted in the enrollment of providers who were on the HHSC OIG open case list. Since the implementation of the software package, the primary fiscal agent has increased the overall quality related to this validation process to 99 percent. An August 2009 HHSC OIG audit report identified a significant improvement in this area of performance related to the contractor.

Dedicated team that conducts criminal background history checks
The HHSC OIG Program Integrity Research (PIR) team is responsible for conducting criminal history background checks on all provider enrollment applicants processed by the primary fiscal agent. Provider applications cannot be approved until the team conducts the background check. The PIR team consists of a team leader, an administrative assistant, four research specialists and a senior policy advisor who is an attorney. Approximately 265 new provider applicants are processed per day. In the first quarter of 2010, the team completed 9,442 applications, of which approximately 10 percent of applicants have been denied for

various reasons.

Unannounced onsite visits to DME providers prior to enrollment
Once PIR receives a DME provider enrollment applicant file, it notifies the Medicaid Program Integrity (MPI) area, within the HHSC OIG. An enforcement division investigator makes an unannounced visit to the DME provider to question the applicant about certain information that is not necessarily disclosed during the application process but is related to DME certification requirements. The investigator does a visual inspection and takes photographs of the location. The goals are to assess onsite inventory and to confirm that the provider correctly completed the enrollment application regarding the information about onsite management personnel and subcontractor information. The onsite visit findings are communicated back to the PIR team and are incorporated into HHSC OIG's decision to approve or disapprove the provider applicant.

Annual review of the Texas MCOs compliance plans
The MCOs are required to adopt a compliance plan to prevent and reduce fraud and abuse. This plan must be filed annually with the HHSC OIG for approval by the MPI. Based on certain risk factors, the Outpatient Hospital/Managed Care Organization Unit of HHSC OIG reviews the MCOs to ensure that they are fulfilling the requirements of their approved plans. These reviews demonstrate effective oversight of the MCO investigative activity by ensuring that MCOs are aggressively conducting integrity work with emphasis on preventing and detecting fraud, waste and abuse in the Medicaid program.

Additionally, the MIG review team identified one practice that is particularly noteworthy. The State requires managed care network providers to be enrolled in Medicaid.

Managed care network providers are required to be enrolled in Texas Medicaid
Managed care providers must be enrolled by the primary fiscal agent before they are eligible to become a member of a managed care provider network. This process ensures that Texas providers in an MCO network will have had a criminal background check conducted by the HHSC OIG. This practice was also noted in MIG's 2008 program integrity review.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations regarding payment withholding notices, disclosure of ownership, control, relationship, criminal conviction, and business transaction information and reporting requirements.

All of the regulatory compliance issues in this report, except for the 42 CFR § 455.23(b) finding, are repeat findings from the 2008 MIG program integrity review. In response to the 2008 findings, Texas submitted a corrective action plan (CAP) dated February 6, 2009 indicating that corrective actions would be taken by the respective departments, but not delineating clear responsibility for ensuring implementation. Texas has failed to implement the corrective actions. The repeat findings all relate to provider enrollment, which is a program integrity function under the Texas Medicaid State Plan. It is suggested that Texas assign clear responsibility for all program integrity functions

to one specific organizational area and grant necessary resources and authority to that area to ensure compliance with Federal requirements.

The HHSC OIG notice of payment withholding does not include all required information.
The regulation at 42 CFR § 455.23(b) stipulates that the Medicaid agency's notice of withholding state that the payments are being withheld in accordance with the Federal regulation.

The withholding letter that HHSC OIG utilizes to enforce payment withhold of providers in cases of fraud and willful misrepresentation does not meet the requirements of 42 CFR § 455.23. The letter references the Texas Administrative Code (TAC) and the TAC cited does not reference the Federal regulation.

NOTE: The program integrity regulation at 42 CFR § 455.23 has been substantially revised and the amendment was effective March 25, 2011. The regulation as amended requires payment suspension pending investigations of credible allegations of fraud and referral to the MFCU, or other law enforcement agency if there is no certified MFCU in the State.

***Recommendation*:** Modify the withholding letter to include language that references 42 CFR § 455.23 as required by the regulation. Texas modified its withholding letter to include language that references 42 CFR § 455.23 while the MIG review team was onsite.

The State does not capture all required ownership, control, and relationship information in its FFS operations and from the fiscal agent, MCOs and TSAPs. (Repeat Finding)
Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

With the exception of DADS, FFS enrollment applications for all disclosing entities do not request disclosure information regarding subcontractors.

The enrollment application for the primary fiscal agent, MCO contracts, and MTP contracts with TSAPs do not include the required information regarding the name and address of each person with ownership or control interest in any subcontractor in which the provider has an ownership.

Subsequently, no relationship information for subcontractors is obtained as required.

The State's February 2009 CAP is on target for the primary fiscal agent with an anticipated completion date of March 1, 2010. While the HHSC/MTP CAP originally anticipated a completion date of September 1, 2010, the MIG review team was informed that the CAP will not be implemented until January 2011.

NOTE: The CMS reviewed the FFS agreements, TSAP, managed care and fiscal agent contracts and other provider agreements for compliance with 42 CFR § 455.104 as it was effective at the time of this review. That section of the program integrity regulations has been substantially revised and the amendment was effective on March 25, 2011. The amendment adds requirements for provision of Social Security Numbers and dates of birth as well as more complete address information regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any actions the State takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

Recommendations: Modify all provider enrollment applications and contracts to capture the required ownership, control, and relationship information. Obtain necessary disclosures from all providers, fiscal agents and MCOs.

Transportation and Vendor Drug Program provider enrollment applications do not require disclosure of certain business transactions upon request. (Repeat Finding)
The regulation at 42 CFR §455.105(b) requires that, upon request, providers furnish to the State or the U.S. Department of Health & Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors. Providers must submit business information within 35 days of the date on a request by the Secretary or the Medicaid agency.

Despite the HHSC/MTP February 2009 CAP response with a due date of September 1, 2009, the MTP provider application still does not include a statement that the provider agrees to furnish business transaction disclosures within 35 days of a request by HHSC or HHS.

Furthermore, the State Vendor Drug Program's "Application for Participation" does not capture information about business transactions with wholly owned suppliers or any subcontractors.

Recommendation: Modify all provider applications to require disclosure upon request of the information identified in 42 CFR §455.105(b)(c).

Texas' MTP provider enrollment applications do not capture required criminal conviction information. (Repeat Finding)
The regulation at 42 CFR §455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made.

According to the HHSC/MTP February 2009 CAP, because the transportation contracts are subject to re-procurement only periodically, HHSC/MTP was to ensure that an amendment was added to the contract that would be in compliance with the regulation no later than September 2009. The MTP transportation provider contract still does not ask for disclosure of criminal conviction information. Because the State is not collecting the information, such disclosures cannot be reported to the HHS-OIG as required by the regulation.

Recommendation: Modify provider enrollment applications and contracts to meet the full criminal conviction disclosure requirements of the regulation.

The State does not report to HHS-OIG adverse actions taken on MTP provider applications. (Repeat Finding)

The regulation at 42 CFR §1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

Within MTP, neither driver terminations nor denials for participation are reported to HHSC and therefore, HHSC cannot report the actions to HHS-OIG.

Recommendation: Develop and implement procedures to collect and report to HHS-OIG all actions taken against and limits placed on providers applying to participate in the program.

Vulnerabilities

The review team identified six areas of vulnerability in Texas' practices regarding not capturing managing employee information, not collecting disclosure of ownership, control, and relationship information, not verifying with managed care beneficiaries whether billed services were received, not having adequate policies and procedures, not conducting complete exclusion searches, and not reporting to HHS-OIG adverse actions taken on managed care provider applications.

Not capturing managing employee information in the transportation program and for MCO network providers.

Under 42 CFR § 455.101, a managing employee is defined as "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency."

Texas MCOs do not solicit managing employee information in all provider enrollment and credentialing forms. Nor does MTP solicit such information from its contracted providers. In addition, MTP does not solicit managing employee information from TSAP entities and does not require TSAPs to solicit such information from their subcontractors. Thus, the State would have no way of knowing if excluded individuals are working for TSAPs or MCOs in such positions as billing managers, department heads, or drivers.

***Recommendations*:** Modify provider enrollment forms and contracts to require the disclosure of

managing employee information. Maintain such information in a database where it can be used to search for exclusions at the point of initial enrollment and periodically thereafter.

Not collecting disclosure of ownership, control, and relationship information from managed care providers.

The MIG team interviewed staff from four Texas MCOs and reviewed the MCOs' enrollment and credentialing forms. The team found that none of the MCOs' forms request information related to name and address of subcontractors, related persons for subcontractors, and names of any other disclosing entity with ownership and control interest as is required for FFS providers at 42 CFR § 455.104. The State contracts with the MCOs do not require that they request the information.

NOTE: The CMS reviewed the managed care enrollment forms and other provider agreements for compliance with 42 CFR § 455.104 as it was effective at the time of this review. That section of the program integrity regulations has been substantially revised and the amendment was effective on March 25, 2011. The amendment adds requirements for provision of Social Security Numbers and dates of birth as well as more complete address information regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any actions the State takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

Recommendation: Require all contracted MCOs to modify provider enrollment and credentialing applications to capture all the required ownership, control, and relationship information.

Not verifying with managed care beneficiaries whether services billed by providers were received. (Repeat Vulnerability)

While the State meets the requirements of 42 CFR § 455.20 by sending explanations of medical benefits to FFS beneficiaries, information obtained by the MIG review team during interviews with the four MCOs indicated that the MCOs are not performing any verification of beneficiary services. A review of the contract between the State agency and MCOs revealed that Texas does not require the direct verification of services with beneficiaries.

Recommendation: Develop and implement a procedure for verifying with MCO beneficiaries whether billed services were actually received.

Not having adequate written policies and procedures.

The State has inadequate written policies and procedures for oversight of managed care program integrity functions. For example, the State does not have a policy or procedure regarding verifying that MCOs do not have a relationship with an individual who has been debarred, suspended, or otherwise excluded from participating in a contract paid with Federal funds. If the State does request disclosure information from the MCOs, the State does not verify the submitted disclosure information, nor does it verify if an MCO takes any action on a provider's application for participation. The shortage of written policies and procedures and absence of specific requirements

in the contractual language leaves the State open to legal challenge of its processes and vulnerable to inconsistent operations and ineffective functioning.

Recommendation: Develop and implement written policies and procedures for the managed care program to ensure consistency and continuity of operations in the event of staff changes.

Not conducting complete exclusion searches.
On June 12, 2008, CMS issued State Medicaid Director Letter (SMDL) #08-003 providing guidance to States on checking providers and contractors for excluded individuals. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own staff and subcontractors for excluded parties, including owners, agents, and managing employees. A new regulation at 42 CFR § 455.436, effective March 25, 2011, now requires States to check enrolled providers, persons with ownership and control interests, and managing employees for exclusions in both the List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS) on a monthly basis.

The State does not verify ownership and disclosure information collected from the fiscal agents, the transportation providers, or the MCOs prior to contracting with the entities. The State does not check for exclusions on a monthly basis for entities doing business with HHSC.

In the FFS program, the primary fiscal agent only runs provider names against the HHS-OIG LEIE, State Exclusion List, and Licensing Board at enrollment. Currently, transportation providers are not enrolled by the fiscal agent and are not conducting any exclusion checks of drivers. As previously reported, transportation providers will need to collect information required at 42 CFR § 455.104 and § 455.106 in order to comply with this requirement.

The DADS, the HHSC component that administers programs for older Texans, persons with disabilities, and persons with mental retardation, does not conduct monthly checks of its providers. The DADs does conduct screening on enrollment and prior to monitoring.

The MCO programs are conducting monthly exclusion checks of their providers, but not for owners, managing employees, agents, and subcontractors. The MCOs must first collect such information in order to be in compliance with SMDL #09-001.

Recommendation: Develop and implement policies and procedures for appropriate collection and maintenance of disclosure information to ensure that the FFS program, contracted MCOs, the transportation broker, and network providers conduct exclusion searches using the LEIE (or the Medicare Exclusion Database) and the EPLS at the time of provider enrollments, re-enrollments, and at least monthly thereafter in accordance with SMDLs #08-003 and #09-001.

Not reporting to HHS-OIG adverse actions taken on managed care provider applications.
The State does not require its MCOs to inform them when the MCOs have denied enrollment or credentialing of a provider due to program integrity concerns. The State is therefore unable to make

the required report to the HHS-OIG, as the regulation at 42 CFR §1002.3(b) would require in the FFS program.

***Recommendation*:** Require MCOs to report all denials of enrollment or credentialing or terminations of providers based on program integrity concerns to HHS-OIG.

CONCLUSION

The State of Texas applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. These effective practices include:

- participation in the Quad State meeting,
- HHSC OIG online reporting system,
- provider reinstatement policy,
- a high level of cooperation between the State agency and MFCU,
- matching technology used in provider enrollment,
- dedicated team conducting criminal background checks on provider applications,
- unannounced onsite visits to DME providers prior to enrollment,
- annual review of managed care compliance plans, and
- provider enrollment in Texas Medicaid as a precondition to credentialing as an MCO network provider.

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of five areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, six areas of vulnerability were identified. The CMS encourages HHSC to closely examine the vulnerabilities that were identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require HHSC to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Texas will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If Texas has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Texas on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

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Texas Medicaid Corrective Action Plan Comprehensive PI Review Final Report – April 2011

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Introduction

The Medicaid Integrity Group (MIG) in the Centers for Medicare & Medicaid Services (CMS) recently completed a comprehensive program integrity review of the Texas Medicaid Program. The review began in October 2009 and concluded via issuance by CMS MIG of a final report dated April 27, 2011. The final report found nine effective practices, five regulatory compliance deficiencies, and six vulnerabilities in the State's Medicaid program integrity operations.

CMS MIG requested that Texas provide a corrective action plan to address each regulatory compliance and vulnerability finding, to include the timeframes for each correction as well as an explanation of how Texas will ensure that the identified deficiencies will not recur.

ACA Requirements

Applicable federal law changed between the completion of the on-site portion of the review and the issuance of the final report. Specifically, the Affordable Care Act (ACA) was signed into law in March 2010, and CMS on March 25, 2011 substantially revised existing federal regulations, and adopted new federal regulations, to implement provider enrollment related requirements found in section 6401 of the ACA. The changes in federal law took effect for newly enrolling providers on March 25, 2011, and will take effect for all providers on March 25, 2012. CMS MIG requested that this corrective action plan address the curing of the identified compliance issues and vulnerabilities in light of these federal law changes. CMS MIG also requested that an explanation be provided if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 days.

As next explained, complete correction in accordance with the ACA of all of the regulatory compliance issues and vulnerabilities discussed below will require more than 90 days to complete, due to the changes in law and related substantial changes to provider enrollment requirements that occurred between the completion of the on-site portion of the review and the issuance of the final report.

The HHSC Executive Commissioner recently approved agency staff recommendations to replace Texas Medicaid's current provider enrollment systems and processes with a single new enrollment system and process for all Texas Medicaid and CHIP providers. The new MITA compliant system will provide a single, centralized mechanism for enrollment of all Texas Medicaid & CHIP providers, and it will provide the necessary functionality for Texas Medicaid to meet all of the new ACA enrollment and screening requirements. Please find enclosed the current implementation timeline and major milestones for the building and rollout of the new system.

As is indicated by the enclosed timeline, this single long term enrollment solution for all Texas Medicaid and CHIP providers is contingent on federal approval and funding, with a slated implementation date of March 1, 2013. Complete correction in compliance with the new ACA requirements of all of the identified regulatory compliance issues and vulnerabilities will therefore require more than 90 days, and in fact will not be achieved until all providers are re-enrolled through the new system. However, as explained below in Texas' responses to the findings, interim solutions have been developed that will be implemented before rollout of the new system, in conformity with the changes in federal law that fully take effect in March 2012.

Program Integrity Responsibility

CMS MIG also noted in its final report that four of the five regulatory non-compliance findings each constitutes a repeat finding from the 2008 CMS MIG program integrity review. CMS MIG observed that although Texas submitted a corrective action plan in response to the 2008 review, that plan did not delineate clear responsibility for ensuring implementation, and all promised corrective actions were not implemented.

Given that provider enrollment is a program integrity function under the Texas Medicaid State Plan, CMS MIG suggested that "Texas assign clear responsibility for all program integrity functions to one specific organizational area and grant the necessary resources and authority to that area to ensure compliance with Federal requirements." Texas has studied the matter and concurs with this suggestion. Although the provider enrollment function is assigned to and performed under the auspices of the State Medicaid Director, the Office of Inspector General (OIG) for the Health and Human Services Commission (HHSC) is assigned primary responsibility for coordinating and facilitating efforts to ensure that the Texas Medicaid program complies with federal and state program integrity requirements relating to provider enrollment.

HHSC and its OIG are also working together towards the issuance of a revised Texas health and human services policy circular relating to program integrity. It is anticipated that the revised policy circular will require each Texas health and human services agency and division that administers any part of the Texas Medicaid program to designate one or more agency executives to serve as a dedicated liaison to the Inspector General on program integrity matters. This will establish formal lines of communication between OIG and each Texas Medicaid program area that is involved in the enrollment of providers. Establishment of these protocols will help ensure that both responsibility and authority for every provider enrollment-related program integrity requirement is clearly assigned, so that each such requirement will be met.

The HHSC Internal Audit Division will track the implementation of corrective actions by periodically requesting status updates from responsible management, and will provide quarterly reports on implementation status to the Inspector General and HHSC executive management.

The above assignments of roles, responsibilities, and monitoring/reporting will collectively help to ensure that the identified deficiencies will not recur.

Regulatory Compliance Findings and Responses

Each of the five regulatory compliance issues that CMS MIG found in the State's program integrity operations is next restated below, followed by Texas' response.

1. The HHSC OIG notice of payment withholding does not include all required information.

   CMS Recommendation:
   Modify the withholding letter to include language that references 42 CFR § 455.23 as required by the regulation.

OIG concurs with the above finding, and reports that it has been corrected. In February 2010, while the MIG review team was onsite, OIG modified its "template" for payment hold notices to include language that references 42 CFR § 455.23.

2. The state does not capture all required ownership, control, and relationship information in its [fee for service] operations and from the fiscal agent, [Medicaid Managed Care Organizations] and [Transportation Service Area Providers] (Repeat Finding)

   CMS Recommendation:
   Modify all provider enrollment applications and contracts to capture the required ownership, control, and relationship information. Obtain necessary disclosures from all providers, fiscal agents, and MCOs.

OIG concurs with the finding and recommendation. The Inspector General is the agency executive assigned primary responsibility for correcting the above finding. OIG has determined that completion of all necessary corrective action will require more than 90 days, as next explained.

As earlier stated, the ACA related federal requirements took effect for newly enrolling providers on March 25, 2011, and will take effect for all providers on March 25, 2012. However, these changes in federal law first required passage of state-level statutory authority for HHSC to implement the requirements. This has occurred, in that the Texas Legislature as part of its 82nd regular legislative session recently passed the necessary state-level statutory authority, which takes effect September 1, 2011. HHSC has also recently assigned to OIG the responsibility for ensuring implementation of the requirements of the legislation.

Consistent with the new state laws that take effect September 1, 2011, HHSC next is required to propose and then adopt new agency administrative rules in order for the provider enrollment related requirements to be enforceable. OIG is the agency division with lead responsibility for drafting the new administrative rules and this work is underway. The needed administrative rule authority is anticipated to be proposed and adopted according to the following schedule:

Table 1

Description of activity:	Completed by:
Rule Package Drafted	08/15/2011
Stakeholder input and changes incorporated	09/15/2011
Packet submission to HHSC	10/10/2011
Presentation to Medical Care Advisory Committee	11/10/2011
Presentation to HHSC Council	12/01/2011
Texas Register Publication of Proposed Rules	12/29/2011
30 day comment period	01/29/2012
Responses to comments completed/approved	02/24/2012

The necessary administrative rule authority is thus anticipated to be adopted in alignment with the date when the new provider enrollment related federal regulations fully take effect.

Texas Medicaid policy is also required to be updated to reflect the new disclosure and screening requirements. Accordingly, in parallel with the above rule promulgation activities, OIG will work with HHSC policymakers and with each affected program area to revise disclosure of ownership and control interest policy, and create forms by provider type. The disclosure form(s), instructions, and related policy are anticipated to be proposed and adopted according to the following schedule:

Table 2

Description of activity:	Completed by:
Standardized Form, Policy and Instructions Drafted	09/30/2011
Internal stakeholder input and changes incorporated	10/31/2011
External stakeholder input and changes incorporated	12/31/2011
Policy adoption by HHSC	02/28/2012

For each of the above specific findings under finding number 2, corrective action is next described:

Table 3

Specific Finding:	Completed by:
Transportation Service Area Providers (TSAPs) – Obtain Required Disclosures	10/31/2011
Corrective action has been completed with respect to the required disclosures, and verification is currently underway. OIG provided training to MTP Program Staff and to the TSAPs in September 2010 concerning the disclosure requirements. Each TSAP was subsequently required by the Medical Transportation Program to complete required disclosure forms in accordance with the training provided. All TSAP disclosures have been received, and the OIG Program Integrity Research Unit is currently in the process of conducting background/criminal history checks, with completion anticipated by no later than October 31, 2011.	

Table 4

Specific Finding:	Completed by:
Medicaid Managed Care Organizations – Obtain Required Disclosures	04/01/2012
OIG and HHSC Managed Care Operations are collaborating to complete this corrective action. Revision of disclosure forms is necessary to meet all disclosure requirements. Following is the agreed timeline for completion: Develop Revised Disclosure Form(s) – by 9/30/2011 HHSC Legal and MCO Management Approval – by 10/31/2011 Revised Disclosure Form(s) Proposed (30 day comment period) – until 12/1/2011 Comments Considered/Revised Disclosure Form(s) Adopted – by 1/1/2012 Requests sent for Disclosure by each Managed Care Organization – by 1/1/2012 Deadline for Receipt of Managed Care Organization Disclosures – by 3/1/2012 OIG Completes Verifications/Background Checks – by 4/1/2012	

Table 5

Specific Finding:	Completed by:
Primary Fiscal Agent – Obtain Required Disclosures	04/01/2012
OIG and HHSC Claims Administrator Operations (CAO) are collaborating to complete this corrective action. Revision of disclosure forms is necessary to meet all disclosure requirements. Following is the agreed timeline for completion: • Develop Revised Disclosure Form(s) – by 9/30/2011 • HHSC Legal and CAO Management Approval – by 10/31/2011 • Revised Disclosure Form(s) Proposed (30 day comment period) – until 12/1/2011 • Comments Considered/Revised Disclosure Form(s) Adopted – by 1/1/2012 • Requests sent for Disclosure by the Primary Fiscal Agent – by 1/1/2012 • Deadline for Receipt of Primary Fiscal Agent Disclosures – by 3/1/2012 OIG Completes Verifications/Background Checks – by 4/1/2012	

Table 6

Specific Finding:	Completed by:
Fee For Service Providers – Obtain Required Disclosures	After April 2013
As explained above under "ACA Requirements" above, complete correction of this finding in compliance with the new ACA requirements will not be achieved until all fee-for-service providers are re-enrolled through the new system. Interim solutions are therefore next explained.	

Regarding the above specific finding, OIG has determined that certain corrective actions can feasibly be completed in advance of the slated March 2013 rollout of the new enrollment system, as follows:

Table 7

Interim Solution 1:	Implemented by:
ACA Compliant Re-enrollment of all Texas Medicaid DMEs:	04/01/2012
OIG and CAO will collaborate to develop of a customized plain English fully compliant paper enrollment application specifically for DMEs. OIG will deploy its Provider Enrollment Tracking System (PETS), an interim automated solution to capture and maintain identifying information on each provider and its owners/controlling parties. OIG and CAO will collaborate to require reenrollment of all DME providers through the primary fiscal agent, in accordance with the ACA screening requirements. This will begin no later than April 2012 and continue each month until all DMEs have re-enrolled.	

Table 8

Interim Solution 2:	Implementation:
ACA Compliant Re-enrollment of all Texas Medicaid Medical Transportation Providers:	Upon completion of all DMEs
OIG, CAO, and the Medical Transportation Program (MTP) will collaborate to develop one or more customized plain English fully compliant paper enrollment application(s) specifically for medical transportation providers. OIG will utilize its Provider Enrollment Tracking System (PETS) to capture and maintain identifying information on each provider and its owners/controlling parties. OIG, CAO, and MTP will collaborate to require reenrollment of all medical transportation providers through the primary fiscal agent, in accordance with the ACA screening requirements. This will begin upon completion of the required re-enrollment of all DMEs.	

Table 9

Interim Solution 3 (contingency plan):	Implementation
ACA Compliant Re-enrollment of all Texas Medicaid Pharmacies:	Upon completion of all medical transportation providers
If rollout of the new enrollment system has not yet occurred upon completion of the above two interim solutions, OIG and the Texas Medicaid Vendor Drug Program (VDP) may trigger a contingency plan to require ACA compliant reenrollment of all pharmacies. If this contingency is triggered, OIG and VDP will collaborate to develop/revise a fully compliant paper enrollment application specifically for pharmacies, and OIG will utilize its Provider Enrollment Tracking System (PETS) to capture and maintain identifying information on each provider and its owners/controlling parties.	

3. Transportation and Vendor Drug Program provider enrollment applications do not require disclosure of certain business transactions upon request. (Repeat Finding).

CMS Recommendation:
Modify all provider applications to require disclosure upon request of the information identified in 42 CFR § 455.105(b)(c).

OIG concurs with the finding and recommendation, in part. All provider enrollment applications and related contracts indirectly already meet the above requirement because each already requires compliance with Texas Medicaid program administrative rules, and the administrative rule at Title 1, Texas Administrative Code, Section 371.1617(2)(B) specifically provides that failure to comply with the above referenced federal regulation is a program violation for which sanctions may be imposed. Nevertheless, corrective actions have been completed or will be completed as follows:

Table 10

Specific Finding:	Completed by:
Transportation Service Area Providers (TSAPs) – Modify contracts to require compliance with *42 CFR § 455.105(b)(c)*	Completed

Table 11

Specific Finding:	Completed by:
Vendor Drug Program – Modify contracts to require compliance with *42 CFR § 455.105(b)(c)*	12/01/2011
OIG and VDP will collaborate to accomplish amendment to the vendor drug program pharmacy contract by the above completion date.	

4. Texas' MTP provider enrollment applications do not capture required criminal conviction information (Repeat Finding).

   CMS Recommendation:
   Modify provider enrollment applications and contracts to meet the full criminal conviction disclosure requirements of the regulation.

OIG concurs with the finding and recommendation. Upon completed implementation of the above-described Interim Solution 2, this finding will be corrected.

5. The State does not report to HHS OIG adverse actions taken on MTP provider applications.

   CMS Recommendation:
   Develop and implement procedures to collect and report to HHS OIG all actions taken against and limits placed on providers applying to participate in the program.

OIG concurs with the finding and recommendation. Upon completed implementation of the above-described Interim Solution 2, this finding will be corrected.

Vulnerabilities Findings and Responses

Each of the six vulnerabilities that CMS MIG found in the State's program integrity operations is restated below, followed by CMS's recommendation and Texas' response.

1. Not capturing managing employee information in the transportation program and for MCO network providers.

   CMS Recommendation:
   Modify provider enrollment forms and contracts to require the disclosure of managing employee information. Maintain such information in a database where it can be used to search for exclusions at the point of initial enrollment and periodically thereafter.

OIG concurs with the finding and recommendation with respect to the Medical Transportation program, and corrective actions have been or will be completed as explained immediately below. OIG does not concur with the finding with respect to MCO network providers. The CMS MIG final report specifically acknowledges that Texas Medicaid requires all managed care network providers to first enroll through the primary fiscal agent, and managing employee information is obtained in connection with those enrollment. It is therefore unnecessary to again require disclosure of such information in connection with the provider then joining an MCO network.

Table 12

Specific Finding:	Completed by:
Transportation Service Area Providers (TSAPs) – The contracts have been amended to require the disclosure of managing employee information, and disclosures have been obtained. OIG will add the data to PETS and proceed to conduct monthly checks by no later than 12/01/2011.	12/01/2011

Table 13

Specific Finding:
All other medical transportation providers – Upon completed implementation of the above-described Interim Solution 2, this finding will be corrected.

2. Not collecting disclosure of ownership, control, and relationship information from managed care providers.

CMS Recommendation:
Require all contracted MCOs to modify provider enrollment and credentialing applications to capture all the required ownership, control, and relationship information.

OIG does not concur with the finding, in that the CMS MIG final report specifically acknowledges that Texas Medicaid requires all managed care network providers to first enroll through the primary fiscal agent, and collection of ownership, control, and relationship information occurs at that time. It is therefore unnecessary to again require disclosure of such information in connection with the provider then joining an MCO network. As explained under "ACA Requirements" above, in regard to enrollment of managed care providers through the primary fiscal agent, OIG concurs with the finding. As explained above, complete correction of the finding in this regard, in compliance with the new ACA requirements, will not be achieved until all managed care providers are re-enrolled through the new system. With respect to the above finding in regard to MCOs, it should be noted that upon rollout of the single new enrollment system for all Texas Medicaid and CHIP providers, MCOs will not separately perform provider enrollment activities.

3. Not verifying with managed care beneficiaries whether services billed by providers were received (Repeat Vulnerability).

   CMS Recommendation:
   Develop and implement a procedure for verifying with MCO beneficiaries whether billed services were actually received.

OIG concurs with the finding. Corrective action will be implemented by no later than 12/1/2011, in that OIG will request that each MCO include its solution for the above finding in the annual waste, fraud, and abuse plan that it must file with OIG and that OIG must approve. The MCOs will next be required to final annual waste, fraud, and abuse plans beginning October 2011.

4. Not having adequate written policies and procedures.

   CMS Recommendation:
   Develop and implement written policies and procedures for the managed care program to ensure consistency and continuity of operations in the event of staff changes.

OIG concurs with the finding and recommendation. Policies and procedures are being drafted at this time through collaboration between OIG, HHSC Managed Care Operations, and the Medicaid participating MCOs. OIG anticipates correction of this finding by no later than 1/1/2012.

5. Not conducting complete exclusion searches.

   CMS Recommendation:
   Develop and implement policies and procedures for appropriate maintenance of disclosure information to ensure that the FFS program, contracted MCOs, transportation broker, and network providers. Conduct exclusion searches using the LEIE (or the Medicare Exclusion Database) and the EPLS at the time of provider enrollments, re-enrollments, and at least monthly thereafter in accordance with SMDLs #08-003 and #09-001.

OIG concurs with the finding and recommendation. As part of the interim solutions that are explained in response to compliance issue number 2 above, PETS will be deployed by OIG to proceed to conduct monthly data matches against the federal and state exclusion lists, as required by the new ACA regulations, during the time that the permanent long term provider enrollment solution is still being built. Once the new system is built and ready to deploy, the implementation process for the new system will include migrating the data already captured in PETS (i.e., from all providers that have re-enrolled), from PETS to the new MITA compliant automated system that is maintained by the primary fiscal agent for conducting the required monthly data matches.

In addition, while the permanent long term provider enrollment solution is still being built, DADS will also proceed to require re-disclosure by all DADS providers in accordance with the ACA requirements, and DADS will capture the disclosed information electronically. This data will be leveraged by DADS to proceed to conduct monthly data matches according to the following implementation schedule:

Table 14

Action Step	Date of Completion	Responsible Area
At enrollment, require applicants to complete DADS Disclosure of Ownership and Control Interest Statement (Form 5871) to capture all required information, to include date of birth and driver's license number, for each individual and/or business entity with direct or indirect ownership interest of 5 percent or more and controlling interests of a legal entity.	August 2011	Lead: Regulatory Services (RS), Access & Intake (A&I) Contract Oversight & Support (COS) Participants: Center for Policy & Innovation (CPI), Legal Services (LS), COS
Communicate Action Plan to contractors.	September 2011	Lead: CPI Participants: COS, LS, RS, A&I
Require 25 percent of all DADS contractors to complete and return a new Form 5871. Begin with "oldest" contracts.	December 2011	Lead: RS, A&I Participants: CPI, COS, LS
DADS staff enter ownership/control interest information for each contract associated with each Texas Identification Number (TIN) into Health and Human Services Contract Administration and Tracking System (HCATS).	June 2012	Lead: COS Participants: RS, A&I, (Information Technology) IT
Extract data from HCATS in a searchable format.	July 2012	Lead: COS Participants: IT
Procure a data broker for conducting monthly LEIE searches.	September 2012	Lead: COS Participants: IT

Initiate monthly LEIE searches (25 percent compliance).	November 2012	Lead: COS Participants: IT
Require additional 25 percent of all DADS contractors to complete and return a new Form 5871.	December 2012	Lead: RS, A&I Participants: CPI, COS, LS
DADS staff enter ownership/control interest information for each contract associated with each TIN into HCATS (50 percent compliance).	June 2013	Lead: COS Participants: RS, A&I, IT
Require additional 25 percent of all DADS contractors to complete and return a new Form 5871.	July 2013	Lead: RS, A&I Participants: CPI, COS, LS
DADS staff enter ownership/control interest information for each contract associated with each TIN into HCATS (75 percent compliance).	January 2014	Lead: COS Participants: RS, A&I, IT
Require additional 25 percent of all DADS contractors to complete and return a new Form 5871.	May 2014	Lead: RS, A&I Participants: CPI, COS, LS
DADS staff enter ownership/control interest information for each contract associated with each TIN into HCATS (100 percent compliance).	December 2014	Lead: COS Participants: RS, A&I, IT

Complete resolution of this finding will not be achieved until all providers have been required to re-enroll under the new enrollment system.

6. Not reporting to HHS-OIG adverse actions taken on managed care provider applications.

   CMS Recommendation:
   Require MCOs to report all denials or enrollment or credentialing or terminations of providers based on program integrity concerns to HHS-OIG.

OIG concurs with the finding. Corrective action will be implemented by no later than 1/1/2012, in conjunction with the implementation of the corrective action for vulnerability number 4, explained above.