DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Office of Audit Services
1100 Commerce, Room 6B6
Dallas, TX 75242

September 27, 2001

Common Identification Number: A-06-00-00075

Mr. Don A. Gilbert
Commissioner
Texas Health and Human Services Commission
P.O. Box 13247
Austin, Texas 78711-3247

Dear Mr. Gilbert:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, "Review of Managed Care Payments Made Under the State of Texas Access Reform Managed Care Program." A copy of this report will be forwarded to the action official noted below for his/her review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-06-00-00075 in all correspondence relating to this report.

Sincerely,

Gordon L. Sato

Gordon L. Sato
Regional Inspector General
for Audit Services

Attachment

HHS Action Official:

Dr. James R. Farris, MD
Regional Administrator
Health Care Financing Administration
1301 Young Street, Room 714
Dallas, Texas 75202

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MANAGED CARE PAYMENTS MADE UNDER THE STATE OF TEXAS ACCESS REFORM MANAGED CARE PROGRAM

SEPTEMBER 2001
A-06-00-00075

Office of Inspector General

http://www.hhs.gov/oig/

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MANAGED CARE PAYMENTS MADE UNDER THE STATE OF TEXAS ACCESS REFORM MANAGED CARE PROGRAM

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Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in the report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS divisions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 6B6
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September 27, 2001

Common Identification Number: A-06-00-00075

Mr. Don A. Gilbert
Commissioner
Texas Health and Human Services Commission
P.O. Box 13247
Austin, Texas 78711-3247

Dear Mr. Gilbert:

This report provides you with the results of an audit of Medicaid payments made by the Texas Department of Health (TDH) under the State of Texas Access Reform (STAR) managed care program. The objectives of our review were to determine whether: (1) STAR members were eligible for managed care and assigned to the appropriate risk group and location for payment purposes, and (2) any unallowable Medicaid payments were made in the fee-for-service sector for STAR members for services provided under the managed care program.

The Texas Health and Human Services Commission (Commission) delegated the authority to operate the STAR program to TDH. Under the STAR program, TDH implements a managed health care delivery system in selected Texas counties targeting individuals receiving Temporary Assistance to Needy Families (TANF) and related programs. This delivery system includes contracting with:

- health maintenance organizations (HMOs) to provide comprehensive health care in return for a fixed monthly payment. The payment amount varies according to the type of Medicaid eligibility mix enrolled and the HMO's location; and

- primary care providers (PCPs) to provide primary care services in return for a fixed monthly case management fee and regular fee-for-service reimbursement for rendering health care services.

The TDH created a Medicare risk group that STAR enrollees were automatically placed into by the automated payment system when they reached age 65. This risk group was created because the payment system assumed that all STAR enrollees turning age 65 were Medicare eligible, and could not determine when Medicare eligibility ended. However, individuals with both Medicaid and Medicare coverage (dual eligible) were not eligible for STAR enrollment. Therefore, managed care payments should not have been made for this risk group if in fact all members of this risk group were Medicare eligible.

Our review disclosed that managed care payments were made for the 437 STAR members assigned to this Medicare risk group during the period September 1, 1998 through August 31, 2000 (197 members in fiscal year (FY) 1999 and 240 members in FY 2000). These members were either: (1) not eligible and the payment amount should have been zero; or (2) misclassified as dual eligible and the payment amount may need to be adjusted. The TDH officials could not determine the total amount paid for the 437 members without conducting some additional work.

Therefore, we are recommending that the Commission:

- Review and revise as necessary, the State's payment system for STAR enrollees in order to ensure that: (a) Medicare entitlement dates are identified in a timely manner, and (b) managed care payments are not made for ineligible STAR enrollees.

- Ensure that TDH: (a) reviews and makes the appropriate payment adjustments for the 437 members inappropriately enrolled in the STAR program under the Medicare risk group during FYs 1999 and 2000 and (b) report the results of the adjustments to the Office of Inspector General.

- Ensure that TDH identifies, reviews, and makes the appropriate payment adjustments for STAR members assigned to the Medicare risk group for prior years.

The Commission reviewed the draft report and commented that no major changes need to be made in the report. The Commission did have a few minor suggestions to the report. We incorporated these suggestions into the final report. The complete text of the Commission's response is presented as APPENDIX A to this report.

INTRODUCTION

BACKGROUND

The Texas State Legislature authorized the Commission to implement a managed care program for Texas Medicaid clients. As a result of House Bill 7 passed by the 72nd Texas Legislature, the TDH Bureau of Managed Care was created in 1991. House Bill 7 mandated the establishment of Medicaid managed care pilot projects for delivering comprehensive health care.

In a managed care program, each client may choose a PCP who is responsible for ensuring the continuity and quality of care. The PCP is also responsible for administering preventive and primary care, including medical screens and immunizations. When specialized or acute care is necessary, the PCP serves as the manager of care by referring the client to other health care providers for those services. Through coordination of medical services, the program was

designed to improve access to services, quality and continuity of care, client and provider satisfaction, cost effectiveness, and health status.

In 1993, Texas began a new Medicaid managed care program called "STAR". The first pilot program, referred to as LoneSTAR, was implemented in August 1993 in Travis County and included approximately 30,000 Medicaid clients. Under the original Travis County model, an HMO and a pre-paid health plan (PHP) received a fixed monthly fee for providing covered health care services. A second pilot program was implemented in December 1993 in the Jefferson, Chambers, and Galveston counties (Gulf Coast area).

In 1995, the Texas State Legislature authorized, through Senate Bill 10, implementation of additional managed care pilot programs in other areas of the State. This expansion was an effort to control the costs associated with medical services and to improve access to health care services for Medicaid clients. This legislation expanded the previous two pilot programs instituted in Travis County and the Gulf Coast area. Today, the STAR program has expanded to over 500,000 members in 51 counties in the Austin, Dallas, El Paso, Fort Worth, Houston, Lubbock, and San Antonio metropolitan areas, and Gulf Coast area. The STAR program operates under three managed care models:

- **HMO model**: The TDH enters into risk contracts with HMOs to provide comprehensive health care to eligible STAR members in return for a fixed monthly payment. The TDH makes the payment regardless of the amount of services used by HMO members. Monthly payments are based on the HMO's location and enrollment counts in each plan and in each of the eight Medicaid eligibility risk groups: (1) TANF Adults, (2) TANF Children, (3) Expansion Children, (4) Newborns, (5) Federal Mandate Children, (6) Children s Health Insurance Program Phase I, (7) Pregnant Women, and (8) Disabled or Blind. Capitation rates are established by the State for each risk group category.

- **PHP model**: The TDH contracts with entities either on a non-risk basis, or on a risk basis under a capitation arrangement for selected services.

- **PCCM model**: The TDH contracts with PCPs and establishes the physicians' referral network. Under this arrangement, the PCP receives a fixed monthly case management fee for each member and regular fee-for-service reimbursement for rendering health care services.

Enrollment in the STAR program is mandatory for TANF and TANF-related clients who reside in the service areas. Blind or disabled Medicaid clients who are not dual eligible and do not live in an institution are eligible to enroll on a voluntary basis. Individuals with both Medicare and Medicaid coverage are not eligible to enroll in the STAR program.

To determine who is eligible and to calculate the payment amounts under the STAR program, TDH uses the State's eligibility and payment systems. Medicaid eligibility information is maintained by the Texas Department of Human Services (TDHS) on its System of Application Verification Eligibility Referral and Reporting (SAVERR). The managed care Premium Payables System (PPS), also maintained by TDHS, interprets the information on the SAVERR to determine STAR eligibility and make risk group assignments for payment purposes. Members are assigned to a payment risk group based on their designated Medicaid eligibility category and type program.

OBJECTIVES and SCOPE

Objectives

The objectives of our review were to determine whether: (1) STAR members were eligible for managed care and assigned to the appropriate risk group and location for payment purposes, and (2) any unallowable Medicaid payments were made in the fee-for-service sector for STAR members for services provided under the managed care program.

Scope and Methodology

Our audit was performed in accordance with generally accepted government auditing standards. We limited consideration of the internal control structure to those controls concerning STAR capitation payments because the objectives of our review did not require an understanding or assessment of the complete internal control structure at TDH. Our site work was conducted at TDH in Austin, Texas during the period September 1999 through May 2001.

We obtained an understanding of the STAR program requirements and payment process. We reviewed the HMO contract for eligibility and payment rate information. To verify the accuracy of capitation payments made by TDH to managed care plans in the STAR program, we:

- judgmentally selected 10 STAR members enrolled in September 1998 and reviewed their managed care enrollment period, Medicaid eligibility status, risk group assignment, and payment history during FY 1999 (September 1, 1998 through August 31, 1999);

- identified the number of Medicaid clients enrolled in the STAR program under an ineligible risk group category (Medicare related) for FYs 1999 and 2000; and

- verified the September 1998 capitation payments for 12 of the 21 designated STAR plan payment codes. Each of the 11 health plans in the STAR program receives a different plan code (in each different service delivery area).

To assess the internal controls in place to preclude unallowable fee-for-service payments on behalf of Medicaid clients enrolled in the STAR program, we:

- interviewed an official with the National Heritage Insurance Company under contract with the State to process Medicaid fee-for-service claims; and

- reviewed paid claims made in the Medicaid fee-for-service sector for 10 STAR members.

FINDINGS AND RECOMMENDATIONS

Our review disclosed that managed care payments were made for the 437 STAR members (1,551 member months) assigned to an ineligible Medicare risk group during the period September 1, 1998 through August 31, 2000 (197 STAR members (802 member months) in FY 1999 and 240 members (749 member months) in FY 2000**)**. Payments for members assigned to the Medicare risk group were made at the TANF-Adult rate. However, these members were either: (1) not eligible and the payment amount should have been zero; or (2) misclassified as dual eligible and the payment amount may need to be adjusted.

The STAR enrollees were automatically assigned to the Medicare risk group by PPS when they reached age 65. This risk group was created because the payment system assumed that all STAR enrollees turning age 65 were Medicare eligible, and could not determine when Medicare eligibility ended. However, individuals with both Medicaid and Medicare coverage were not eligible for STAR enrollment. Therefore, managed care payments should not have been made for this risk group if in fact all members of this risk group were Medicare eligible.

The TDH officials could not determine the amount paid for the 437 members without conducting some additional work. Total payments for the Medicare risk group were not identified in the PPS for FYs 1999 and 2000. According to TDH officials, the payments were combined with another risk group making it difficult to provide the amounts for our audit. The TDH is responsible for evaluating the impact of members who should have been disenrolled or were misclassified for payment purposes, and for making the appropriate payment adjustments.

Our limited review of fee-for-service claims for STAR members did not identify any unallowable payments for services provided under the STAR program.

Ineligible/Misclassified Members Reaching Age 65

STAR members reaching age 65 were automatically assigned to the Medicare risk group for payment purposes. These members were either: (1) ineligible for STAR, or (2) eligible but misclassified for payment purposes. The Medicare risk group is an ineligible risk group. However, the PPS identified those reaching age 65 as Medicare in the birth month and assigned the Medicare risk group for payment purposes. No payment should be made for individuals assigned to an ineligible risk group. Members were ineligible for STAR if they turned age 65 and were already receiving Social Security benefits because Medicare eligibility is automatically effective in the birth month. On the other hand, Medicare entitlement could be delayed and become effective some time after the birth month if the member turned age 65 and needed to apply for Social Security and Medicare benefits. In these cases, the member was eligible for STAR but an inappropriate risk group assignment was made.

EXAMPLE 1

For example, member A was already receiving Social Security benefits and turned age 65 in August. The PPS considers the client age 65 in August and assigns the member to an ineligible Medicare risk group. Payment was incorrectly made at the TANF-Adult rate of $158 for August. No payment should have been made for member A for August.

EXAMPLE 2

Member B, who was blind and disabled, was not already receiving Social Security benefits and turned age 65 in August. Member B did not apply for Social Security and Medicare benefits timely. Therefore, the Medicare entitlement date is delayed, but PPS still places member B in the ineligible Medicare risk group in the birth month. Payment is made at the TANF-Adult rate of $158 for August. In this case, a misclassification into the Medicare risk group occurred. However, the payment is correct if member A is in fact a TANF adult. If not, then the monthly payment should be at the blind and disabled rate of $14.

Misclassified Members with Previously Terminated Medicare Entitlement

Managed care payments were made for STAR members misclassified as dual eligible because the SAVERR and PPS did not contain Medicare end dates. Until November 1999, the PPS considered a client "once Medicare, always Medicare." The SAVERR and PPS contained conflicting evaluations of STAR eligibility:

- The SAVERR used the Medicare Supplementary Medical Insurance Part B (SMIB) code to determine whether a client was eligible for the STAR program. The SMIB code has been maintained for years based on a combination of Medicaid Part B State buy-in and privately purchased Part B. There is no separate Medicare end date provided on SAVERR. Furthermore, the SMIB code does not work well for PPS; if a client's entitlement changes and places the client in a different risk group, PPS needs to know when the change was effective.

- The PPS used the Medicare from date as an indication of entitlement. The problem was that SAVERR did not contain a Medicare end date. Consequently, PPS incorrectly evaluated the SAVERR data as indicating the Medicare risk group for an individual qualified for the STAR program.

EXAMPLE 3

For example, the SAVERR sent member C data to the PPS as eligible for STAR for the period September 1998**,** and November 1998 through August 1999. The PPS assigned member C to an ineligible Medicare risk group and 11 monthly payments of $158 were made at the TANF-Adult rate. However, member C was not Medicare eligible for this 11-month period, but had been previously eligible for Medicare in 1994. The SAVERR showed that Medicare terminated but SAVERR did not contain an end date. The PPS contained the Medicare start date but not an end date. Member C was actually eligible for STAR under the blind and disabled risk group, and monthly payments should have been made at the rate of $14. As a result, an overpayment of $1,586 was made to member C's HMO. However, if member C had been eligible for STAR under the TANF-Adult risk group, then no adjustment would be required.

According to a TDHS official, a Medicare end date was added to the SAVERR and PPS in November 1999 improving the PPS's means of evaluating risk group prospectively. In July 2000, a further refinement was made for individuals whose Medicare end date could not be determined because Medicare termination occurred several years previously. Although these corrections were made, adjustments are needed to handle the problem retroactively.

Quantify Medicare Risk Group

We have requested numerous times between February and May 2001 that TDH quantify the amount paid for the Medicare risk group in FYs 1999 and 2000. In May, TDH officials stated that it would be difficult to determine the paid amount because the Medicare risk group was rolled into the TANF-Adult group for payment purposes. A TDHS official stated that it would be difficult to recreate the Medicare risk group data because the data bases are not saved and the system would apply new edits that were not in place for our audit period. The TDH officials recently found the hard copy back up to quantify the amount paid. We believe that the client and adjustment files also could be used to calculate the amount of payments made for Medicare risk group members.

Conclusion

Our review disclosed that managed care payments were made for the 437 STAR members assigned to an ineligible Medicare risk group during the period September 1, 1998 through August 31, 2000. These members were either: (1) not eligible and the payment amount should have been zero; or (2) misclassified as dual eligible and the payment amount may need to be adjusted. The TDH officials could not determine the amount paid for the 437 members without conducting some additional work.

Recommendations

We recommend that the Commission:

- Review and revise as necessary, the State's payment system for STAR enrollees in order to ensure that: (a) Medicare entitlement dates are identified in a timely manner, and (b) managed care payments are not made for ineligible STAR enrollees.

- Ensure that TDH: (a) reviews and makes the appropriate payment adjustments for the 437 members inappropriately enrolled in the STAR program under the Medicare risk group during FYs 1999 and 2000 and (b) report the results of the adjustments to the Office of Inspector General.

- Ensure that TDH identifies, reviews, and makes the appropriate payment adjustments for STAR members assigned to the Medicare risk group for prior years.

The Commission reviewed the draft report and commented that no major changes need to be made in the report. The Commission did have a few minor suggestions to the report. We incorporated these suggestions into the final report. The complete text of the Commission's response is presented as APPENDIX A to this report.

Sincerely,

Gordon L. Sato

GORDON L. SATO
Regional Inspector General
for Audit Services

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

Don A. Gilbert, M.B.A.
COMMISSIONER

September 14, 2001

Amy Voight
Department of Health and Human Services
Office of Inspector General
8000 Centre Park Dr., Suite 375
Austin, TX 78754

Dear Ms. Voight:

After carefully reviewing the Draft "Review of Managed Care Payments Made Under the State of Texas Access Reform Managed Care Program," we find no major changes need to be made to this report. A few minor recommended changes to the report follow:

- Page 1, paragraph 2 - "... individuals receiving Temporary Assistance to Needy Families (TANF) and related benefits." Change "related benefits" to "related programs."
- Page 2, last paragraph - Delete or modify last sentence "This pilot is based on a primary care case management (PCCM) model and currently serves approximately 40,000." The PCCM is no longer a pilot, but rather actually part of the STAR program.
- Page 4, under Scope and Methodology, third bullet - In 1998, there were only 11 health plans in the STAR program. Each health plan receives a different plan code in each different service delivery area. Each health plan also receives different rates based on Service Delivery area and risk groups.
- Page 6, last paragraph, second sentence – "The problem was that SAVERR does not contain..." The sentence should read, "The problem was that SAVERR did not contain..." As explained in paragraph 1 of the next page, this problem was corrected in November of 1999.

Finally, Cathy Rossberg is no longer with our agency. Please address your final report to me.

Thank you for the opportunity to review this draft of the review of the STAR Program.

Sincerely,

Linda K. Wertz
Deputy Commissioner
for Medicaid and CHIP

c: Maureen Milligan, Health & Human Services Commission
Martha Rodriguez, Health & Human Services Commission

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