Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# TEXAS INAPPROPRIATELY CLAIMED MEDICAID BALANCING INCENTIVE PAYMENTS PROGRAM AND FAMILY PLANNING FUNDING

*Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.*

Patricia Wheeler
Regional Inspector General
for Audit Services

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A-06-14-00059

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## OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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## EXECUTIVE SUMMARY

***The Texas Health and Human Services Commission inappropriately claimed approximately $1.9 million in Balancing Incentive Payments Program and Family Planning funding.***

## WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act of 2010 (ACA) established the State Balancing Incentive Payments Program (BIPP), which authorized a $3 billion Federal appropriation over the program's 4-year period. The purpose of the BIPP was to move States' long-term-care programs away from institutional care and toward community-based care. As such, States were required to use the BIPP funding to provide new or expanded community-based long-term services and supports (LTSS). The Centers for Medicare & Medicaid Services (CMS) awarded funds to approved States through an increase in their Federal Medical Assistance Percentage (FMAP) for eligible Medicaid community-based LTSS. We reviewed Texas because it received one of the highest BIPP funding amounts of any participating State.

The initial objective of this review was to ensure that the Texas Health and Human Services Commission (State agency) claimed eligible BIPP expenditures at the increased FMAP. Because of an issue that came to our attention during testing, we expanded our objective to also ensure that the State agency refunded the Federal share of family planning experience rebates.

## BACKGROUND

In Texas, the State agency administers the Medicaid program. The Federal Government pays its share of a State's Medicaid expenditures based on the FMAP, which varies depending on the State's relative per capita income. Within 30 days after the end of each quarter, States report to CMS expenditures and the associated Federal share on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report). The amounts that States report must represent actual expenditures.

The State agency's regular FMAP was 59.3 percent for Federal fiscal year (FY) 2013 and 58.69 percent for FY 2014. Under BIPP, the State agency received a 2-percent increase to its FMAP for eligible LTSS expenditures. For family planning services, the State agency received a higher, fixed-reimbursement rate of 90 percent.

The State agency contracts with managed care organizations (MCOs) to provide medical services to beneficiaries enrolled in the Medicaid program for a fixed monthly capitation payment. In Texas, the State agency's contracts with MCOs include a settlement requirement in the form of a profit-sharing arrangement, known as an experience rebate. The MCOs refund to the State agency experience rebates owed to it, and the State agency calculates a Federal share of those rebates to return to the Federal Government.

Some providers (e.g., mental health case management and rehabilitative services providers) are paid an interim fee, which is later adjusted to actual cost. If payments made through the interim

fee were less than a provider's actual cost, the provider received an additional payment (i.e., a cost settlement payment) to compensate for the difference. Conversely, if the interim fee was greater than a provider's actual costs, the provider would owe the State money.

## WHAT WE FOUND

The State agency claimed $7,938,656,447 in eligible BIPP expenditures at the increased FMAP and appropriately received $158,773,129 in BIPP funding for them. The State agency claimed the remaining $72,186,182 in expenditures that were not related to eligible noninstitutional LTSS. The State agency inappropriately received $1,443,724 in BIPP funding for the ineligible expenditures:

- $1,091,237 in experience rebates that the State agency did not return at the BIPP-increased FMAP,
- $212,671 in capitated payments for ineligible nursing home beneficiaries,
- $101,326 for cost settlements of services provided before the BIPP, and
- $38,490 for additional expenditures the State agency incorrectly claimed under the BIPP.

Additionally, the State agency did not calculate or return the family planning Federal share of experience rebates, which totaled $502,062.

## WHAT WE RECOMMEND

We recommend that the State agency:

- refund $1,945,786 to the Federal Government, consisting of
    - $1,443,724 in BIPP funding that it received for ineligible expenditures and
    - $502,062 in family planning funding related to experience rebates and
- ensure the accuracy of the FMAPs applied to expenditures and recoveries by
    - using all appropriate FMAPs when calculating the Federal share of experience rebates,
    - ensuring that institutional LTSS expenditures are not claimed at the BIPP-increased FMAP, and
    - ensuring that public provider cost settlements are claimed as prior-period expenditures.

## STATE AGENCY COMMENTS

In written comments on our draft report, the State agency stated that, for the first recommendation, it had already refunded part of the inappropriately received Federal share and would calculate and return the remaining Federal share. For the second recommendation, the State agency stated that it had implemented or strengthened its processes and had fully implemented each of the three parts of the recommendation.

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# INTRODUCTION

## WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act of 2010 (ACA) established the State Balancing Incentive Payments Program (BIPP), which authorized a $3 billion Federal appropriation over the program's 4-year period. The purpose of the BIPP was to move States' long-term-care programs away from institutional care and toward community-based care. As such, States were required to use the BIPP funding to provide new or expanded community-based long-term services and supports (LTSS). The Centers for Medicare & Medicaid Services (CMS) awarded funds to approved States through an increase in their Federal Medical Assistance Percentage (FMAP) for eligible Medicaid community-based LTSS. We reviewed Texas because it received one of the highest BIPP funding amounts of any participating State.

## OBJECTIVES

Our initial objective was to ensure that the Texas Health and Human Services Commission (State agency) claimed eligible BIPP expenditures at the increased FMAP. Because of an issue that came to our attention during testing, we expanded our objective to also ensure that the State agency refunded the Federal share of family planning experience rebates.

## BACKGROUND

### Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. In Texas, the State agency administers the Medicaid program. Although the State agency has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. The Federal Government pays its share of a State's Medicaid expenditures based on the FMAP, which varies depending on the State's relative per capita income.

The State agency's regular FMAP was 59.3 percent for Federal fiscal year (FY) 2013 and 58.69 percent for FY 2014. For family planning services, the State agency receives a higher, fixed-reimbursement rate of 90 percent. Family planning services are those that prevent or delay pregnancy or otherwise control family size.

Within 30 days after the end of each quarter, States report to CMS expenditures and the associated Federal share on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report). The amounts that States report must represent actual expenditures. The State agency uses line items on the CMS-64 report to split expenditures based on the type of services provided. For example, State agencies use line 12 to report home health services expenditures and line 18A to report managed care organization (MCO) expenditures.

### State Balancing Incentive Payments Program

Section 10202 of the ACA established BIPP, which allowed eligible states to receive an increase in their FMAPs for eligible Medicaid noninstitutional LTSS expenditures. States that spent less than 50 percent of total Medicaid LTSS expenditures on noninstitutional LTSS were eligible for the BIPP. States that spent less than 25 percent were eligible for a 5-percent increase; States that spent between 25 percent and 50 percent were eligible for a 2-percent increase. The State agency received a 2-percent increase to its FMAP. CMS identified specific CMS-64 report line items eligible for the increased FMAP. See Appendix A for those eligible line items.

### Experience Rebates

The State agency contracts with MCOs to provide medical services to Medicaid beneficiaries for a fixed monthly capitation payment. In Texas, the State agency's contracts with MCOs include a settlement requirement in the form of a profit-sharing arrangement, known as an experience rebate. The MCOs refund to the State agency experience rebates owed to it, and the State agency calculates a Federal share of those rebates to return to the Federal Government.

### Cost Settlements

Some providers (e.g., mental health case management and rehabilitative services providers) are paid an interim fee, which is later adjusted to actual cost. If payments made through the interim fee were less than a provider's actual cost, the provider received an additional payment (i.e., a cost settlement payment) to compensate for the difference. Conversely, if the interim fee was greater than a provider's actual costs, the provider would owe the State money.

## HOW WE CONDUCTED THIS REVIEW

From October 1, 2012, through June 30, 2014, the State agency claimed $8,010,842,629 in expenditures at the increased FMAP and received $160,216,853 in BIPP funding. We assessed the overall accuracy of amounts claimed on the CMS-64 report by tracing them to supporting summary reports from the State agency's accounting system. We then selected six CMS-64 report line item amounts eligible for BIPP funding and obtained and analyzed supporting claim data.

In addition, the State agency recovered $1,608,920 in family planning experience rebates for FYs 2013 and 2014. We compared supporting schedules to the CMS-64 reports and identified the FMAP the State agency used to calculate the Federal share of those experience rebates.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix B contains the details of our audit scope and methodology.

## FINDINGS

The State agency claimed $7,938,656,447 in eligible BIPP expenditures at the increased FMAP and appropriately received $158,773,129 in BIPP funding for them. The State agency claimed the remaining $72,186,182 in expenditures that were not related to eligible noninstitutional LTSS. The State agency inappropriately received $1,443,724 in BIPP funding for the ineligible expenditures:

- $1,091,237 in experience rebates that the State agency did not return at the BIPP-increased FMAP,
- $212,671 in capitated payments for ineligible nursing home beneficiaries,
- $101,326 for cost settlements of services provided before the BIPP, and
- $38,490 for additional expenditures the State agency incorrectly claimed under the BIPP.

Additionally, the State agency did not calculate or return the family planning Federal share of experience rebates, which totaled $502,062.

## THE STATE AGENCY DID NOT RETURN STATE BALANCING INCENTIVE PAYMENTS PROGRAM FUNDING OR FAMILY PLANNING FUNDING FOR EXPERIENCE REBATES

The CMS *State Medicaid Manual* (the Manual), instructs States to refund the Federal share of a prior expenditure's recovery by reporting the recovery on the CMS-64 report at the FMAP used to calculate the amount it originally had received (§ 2500.6(B)).

Although the State agency recovered MCO payments through experience rebates that it claimed at either the BIPP-increased FMAP or the 90-percent family planning FMAP, the State agency did not return the appropriate Federal share for those rebates to the Federal Government. MCOs refunded more than $302 million in experience rebates related to FYs 2013 and 2014 capitated payments, $54,561,853 of which was associated with BIPP and $1,608,920 with family planning. The State agency used the lower regular FMAP percentages to calculate a Federal share for those rebates. As a result, the State agency retained $1,091,237 in BIPP-increased funds and $502,062 in family planning funds. The State agency did not have a procedure in place to return the BIPP or family planning Federal share for the experience rebates.

## THE STATE AGENCY INCORRECTLY CLAIMED CAPITATED PAYMENTS

According to the ACA, the BIPP-increased FMAP is not available for institutional LTSS, defined as services provided in institutions, including nursing facilities (§ 10202). The State agency claimed $10,633,560 in capitated payments for nursing home beneficiaries at the BIPP-increased FMAP and received $212,671 in additional BIPP funding. Although the State agency designed programing to exclude expenditures for ineligible beneficiaries from being claimed at the BIPP-increased FMAP, the programming did not work as intended.

## THE STATE AGENCY INCORRECTLY CLAIMED COST SETTLEMENTS

The Manual instructs States to claim cost settlements involving public providers as prior-period expenditures (§ 2500.1).[1] The State agency's practice was to claim all cost settlements as current expenditures, including public provider cost settlements. The State agency claimed $5,066,285 in cost settlements for public providers' services delivered before the BIPP as current expenditures rather than prior-period expenditures. As a result, the State agency inappropriately received $101,326 in BIPP funding.

## THE STATE AGENCY INCORRECTLY CLAIMED ADDITIONAL EXPENDITURES

The ACA states that the BIPP-increased FMAP is available only for noninstitutional LTSS expenditures (§ 10202). The State agency claimed $1,924,484 in expenditures at the BIPP-increased FMAP that were not eligible LTSS expenditures. The State agency incorrectly claimed this amount because BIPP and non-BIPP expenditures were transposed while manually completing a voucher. As a result, the State agency inappropriately received $38,490 in BIPP funding.

## RECOMMENDATIONS

We recommend that the State agency:

- refund $1,945,786 to the Federal Government, consisting of
    - $1,443,724 in BIPP funding that it received for ineligible expenditures and
    - $502,062 in family planning funding related to experience rebates and
- ensure the accuracy of the FMAPs applied to expenditures and recoveries by
    - using all appropriate FMAPs when calculating the Federal share of experience rebates,
    - ensuring that institutional LTSS expenditures are not claimed at the BIPP-increased FMAP, and
    - ensuring that public provider cost settlements are claimed as prior-period expenditures.

[1] Public providers are owned or operated by a State, county, city, or other local governmental agency or instrumentality.

## STATE AGENCY COMMENTS

In written comments on our draft report, the State agency stated that, for the first recommendation, it had already refunded part of the inappropriately received Federal share and would calculate and return the remaining Federal share. For the second recommendation, the State agency stated that it had implemented or strengthened its processes and had fully implemented each of the three parts of the recommendation. The State agency's comments are included in their entirety as Appendix C.

## APPENDIX A: CMS-64 REPORT LINE ITEMS ELIGIBLE FOR THE STATE BALANCING INCENTIVE PAYMENTS PROGRAM PERCENTAGE

| Line Item(s)[2] | Description |
|---|---|
| 12 | Home health services |
| 18A | MCO payments |
| 18B1 and 18B2 | Prepaid health plan payments |
| 19A, 19B, and 19C | Home and community-based services |
| 19D | Community First Choice services |
| 22 | Programs of All-Inclusive Care Elderly |
| 23A and 23B | Personal care services |
| 24A and 24B | Case management services |
| 40 | Rehabilitative services |
| 41 | Private duty nursing services |
| 43 | Health Homes for Enrollees with Chronic Conditions |

[2] For line items 18A, 18B1, and 18B2, only the portion of the expenditures that related to noninstitutional LTSS was eligible for the increased BIPP FMAP. Also, for line item 40, only expenditures for mental health and substance use were eligible.

## APPENDIX B: AUDIT SCOPE AND METHODOLOGY

### SCOPE

From October 1, 2012, through June 30, 2014, the State agency claimed $8,010,842,629 in expenditures at the increased FMAP and received $160,216,853 in BIPP funding.[3] In addition, the State agency recovered $1,608,920 in family planning experience rebates for FYs 2013 and 2014.

Our objectives did not require a review of the State agency's overall internal control structure. Therefore, we limited our internal control review to the State agency's procedures for claiming expenditures on the CMS-64 report.

We conducted fieldwork at the State agency's offices in Austin, Texas.

### METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal laws and regulations;
- held discussions with CMS officials to gain an understanding of CMS guidance furnished to the State agency concerning the claiming of BIPP funds;
- interviewed State agency officials to obtain an understanding of the State agency's policies and procedures for claiming BIPP funds;
- assessed the overall accuracy of the amounts claimed on the CMS-64 report by tracing them to supporting summary reports from the State agency's accounting system;
- selected six CMS-64 report BIPP line items that represented 98 percent of the State agency's claimed expenditures for the audit period;
- traced expenditures included in the selected line items to detailed records and analyzed them;
- identified the experience rebate amounts related to BIPP and family planning expenditures and calculated the additional Federal share that should have been returned; and
- discussed our results with the State agency.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain

[3] The State agency claimed expenditures totaling $2,312,871 on the CMS-64 reports for expenditures identified as administrative costs in the State's computer system and received $46,257 in BIPP funding for them. These expenditures will be addressed in a separate report (A-06-15-00054).

sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

# APPENDIX C: STATE AGENCY COMMENTS

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHRIS TRAYLOR
EXECUTIVE COMMISSIONER

January 15, 2016

Ms. Patricia Wheeler
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General,
Office of Audit Services Region VI
1100 Commerce, Room 632
Dallas, Texas 75242

Reference Report Number A-06-14-00059

Dear Ms. Wheeler:

The Texas Health and Human Services Commission (HHSC) received a draft audit report entitled "Texas Inappropriately Claimed Medicaid Balancing Incentive Payments Program and Family Planning Funding" from the Department of Health and Human Services Office of Inspector General. The cover letter, dated December 1, 2015, requested that HHSC provide written comments, including the status of actions taken or planned, in response to the 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 M. Griffith, Deputy Inspector General for Audit. Mr. Griffith may be reached by telephone at (512) 491-2806 or by e-mail at David.Griffith@hhsc.state.tx.us.

Sincerely,

Chris Traylor

P. O. Box 13247 • Austin, Texas 78711 • 4900 North Lamar, Austin, Texas 78751 • (512) 424-6500

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

**Texas Inappropriately Claimed Medicaid Balancing Incentive Payments Program and Family Planning Funding**

**Summary of Management Response**

The Texas Health and Human Services Commission (HHSC), in coordination with the Department of State Health Services (DSHS), has strengthened processes and improved allocation methodologies, reporting processes, and procedures, to ensure payments associated with Balancing Incentive Payments Program (BIPP) enhanced FMAP are accurately tracked and reported on the CMS-64 report.

**DHHS - OIG Recommendation 1:** *We recommend that the State agency refund $1,945,786 to the Federal Government, consisting of:*

- *$1,443,724 in BIPP funding that it received for ineligible expenditures, and*
- *$502,062 in family planning funding related to experience rebates to the Federal Government.*

**HHSC Management Response:**

Of the $1,443,742 in BIPP funding HHSC received for ineligible expenditures, $101,326 was returned on the fourth quarter 2014 CMS-64 report for expenditures related to cost settlements of services provided before BIPP was in effect, and therefore ineligible for BIPP enhanced FMAP.

**Actions Planned:**

BIPP Funding for Ineligible Expenditures

HHSC received the remaining $1,342,398 in BIPP funding for ineligible expenditures related to (a) capitated payments for ineligible nursing home beneficiaries, (b) additional expenditures incorrectly claimed under BIPP and (c) experience rebates not returned at the BIPP enhanced FMAP.

HHSC will confirm that it has already refunded BIPP overpayments to CMS for $212,671 in capitated payments for ineligible nursing home beneficiaries and $38,490 for additional expenditures incorrectly claimed under BIPP. If the refunds have not occurred, HHSC will return the overpayments to CMS.

HHSC will also calculate and refund to CMS the appropriate federal share of experience rebates using the same FMAP applied to the corresponding original payments HHSC made to the MCOs.

Family Planning Funding

HHSC will calculate and refund to CMS the appropriate federal share of experience rebates using the same FMAP applied to the corresponding original family planning payments HHSC made to the MCOs.

**Estimated Completion Date:** Within one year from the date of the final audit report

**Title of Responsible Person:** Director, Medicaid/CHIP Division Financial Reporting

**DHHS - OIG Recommendation 2:** *We recommend that the State agency ensure the accuracy of the FMAPs applied to expenditures and recoveries by using all appropriate FMAPs when calculating the Federal share of experience rebates.*

**HHSC Management Response:**

HHSC has strengthened its processes for identifying and allocating experience rebates across varying FMAP rates during a rebate year. This revised process compares the sum of capitation payments eligible for BIPP enhanced FMAP within a rebate year to total Medicaid capitation payments for that same rebate year, to calculate the percentage of total capitation payments eligible for BIPP enhanced FMAP. This recommendation is fully implemented.

**DHHS - OIG Recommendation 3:** *We recommend that the State agency ensure the accuracy of the FMAPs applied to expenditures and recoveries by ensuring that institutional LTSS expenditures are not claimed at the BIPP-increased FMAP.*

**HHSC Management Response:**

HHSC has strengthened its processes to ensure payments associated with client populations categorized in the Nursing Facility Risk Group or designated under the Money Follows the Person Program are not claimed at the BIPP enhanced FMAP, as these are institutional LTSS expenditures. This recommendation is fully implemented.

**DHHS - OIG Recommendation 4:** *We recommend that the State agency ensure the accuracy of the FMAPs applied to expenditures and recoveries by ensuring that public provider cost settlements are claimed as prior-period expenditures.*

**HHSC Management Response:**

HHSC, in coordination with DSHS, has implemented processes to ensure cost settlements involving mental health case management and rehabilitative services expenditures are appropriately considered and recorded as prior-period expenditures when calculating and

reporting expenditures eligible for BIPP enhanced FMAP. This recommendation is fully implemented.