

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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

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December 2017
A-06-12-00043

Office of Inspector General

<https://oig.hhs.gov>

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EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Texas, the Health and Human Services Commission (State agency) administers the program.

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

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

The Texas Tech University (TTU) academic health system, one of the three State academic health systems covered by the SPA, provides health care services in Texas through its four health institutions: TTU Health Science Center at Amarillo, TTU Health Science Center at El Paso, TTU Health Science Center at Lubbock, and TTU Health Science Center at the Permian Basin (Odessa). The State agency made \$59,568,220 (\$36,160,575 Federal share) in supplemental payments to the TTU health institutions for Medicaid services provided between May 1, 2004, and September 30, 2007.

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

OBJECTIVE

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

SUMMARY OF FINDINGS

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

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

As a result, the TTU health institutions received \$16,319,625 (\$9,911,321 Federal share) in unallowable supplemental payments.

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

RECOMMENDATION

We recommend that the State agency refund to the Federal Government the \$9,911,321 Federal share of improper supplemental payments made to the TTU health institutions.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency neither agreed nor disagreed with our recommendation, but instead described actions that it planned to complete. For our recommendation to refund the Federal share of improper supplemental payments made to the TTU health institutions, the State agency said that it would:

- review the physician supplemental payment calculation and refund the Federal share of any improper payments related to overstated Medicare equivalent fees for claims that included modifiers,

- coordinate with the TTU health institutions to determine whether ineligible providers were included in the physician supplemental payment calculation and refund the Federal share of any payments that did not meet applicable requirements, and
- offset the understated Medicare services that did not have equivalent fees against any improper payments determined above.

Additionally, the State agency commented that it calculated supplemental payments with the methodology approved with CMS.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our findings and recommendation are valid. We maintain that the methodology the State agency used to calculate supplemental payments was not consistent with the terms of the SPA and compliant with Federal and State requirements in effect during our audit period.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Texas, the Health and Human Services Commission (State agency) administers the program.

Supplemental Payments

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

Public Consulting Group

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

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

² *Review of Physician Supplemental Payments Made to the University of North Texas* (A-06-10-00082), issued September 9, 2014, and *Texas Did Not Always Calculate Physician Supplemental Payments Made to the University of Texas Health Institutions in Accordance With Federal and State Requirements* (A-06-11-00004), issued August 8, 2016.

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

Texas Tech University Health Institutions

The Texas Tech University (TTU) academic health system, one of the three State academic health systems covered by the SPA, provides health care services in Texas through its four health institutions: TTU Health Science Center at Amarillo, TTU Health Science Center at El Paso, TTU Health Science Center at Lubbock, and TTU Health Science Center at the Permian Basin (Odessa). The State agency made \$59,568,220 (\$36,160,575 Federal share) in supplemental payments to the TTU health institutions for Medicaid services provided between May 1, 2004, and September 30, 2007.

Calculating Supplemental Payments

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

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

Current Procedural Terminology Codes

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

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

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

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

Current Procedural Terminology Code Modifiers

A CPT code modifier (modifier) is a two-character (alpha and/or numeric) code that gives Medicare, Medicaid, and commercial payers additional information needed to process a claim. Physicians use modifiers, such as payment and diagnostic test modifiers, to indicate that a special circumstance has altered a service or procedure without changing the code for that service or procedure. Some modifiers are informational only and do not affect reimbursement. Other modifiers affect reimbursement.

Payment Modifiers

The TTU health institutions used the following payment modifiers:

- 22 (increased procedural services);
- 50 (bilateral surgery);
- 51 (multiple procedures);⁷
- 52 (reduced services);⁸
- 54, 55, and 56 (split global care);⁹
- 62 (cosurgeons);
- 80 and 82 (assistant at surgery services);
- QK (medical direction of concurrent anesthesia procedures);¹⁰ and

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

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

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

¹⁰ Modifier QK identifies that a physician is not personally providing an anesthesia service but is providing medical direction of two, three, or four concurrent anesthesia services involving qualified individuals. Providers receive a 50-percent fee reduction for services amended with this modifier.

- QY (medical direction of one certified registered nurse anesthetist).¹¹

Diagnostic Test Modifiers

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

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed \$59,568,220 (\$36,160,575 Federal share) in supplemental payments made to the TTU health institutions for Medicaid CPT codes, or claim lines (services), provided from May 1, 2004, through September 30, 2007. We did not review the overall internal control structure of the State agency. We limited our review to internal controls directly related to our objective.

We performed our fieldwork at the State agency and the Texas Medicaid and Healthcare Partnership (TMHP)¹² in Austin, Texas.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- reviewed the Medicaid and Medicare fee schedules for our audit period;
- reviewed the *Texas Medicaid Provider Procedures Manuals* in effect during our audit period to understand claim processing requirements for Medicaid providers;

¹¹ Modifier QY identifies that an anesthesiologist is not personally providing an anesthesia service but is providing medical direction of one certified registered nurse anesthetist. Providers receive a 50-percent fee reduction for services amended with this modifier.

¹² TMHP is a contractor that has processed Texas Medicaid claims since January 1, 2004.

- reviewed the State agency’s responses to our questions;
- reviewed written and electronic documents the State agency provided;
- interviewed personnel from CMS, the State agency, and PCG about procedures for calculating supplemental payments;
- obtained a list from the TTU health institutions of all performing providers¹³ whose services were included in the supplemental payment calculations;
- reviewed the list of providers to determine whether the services submitted for supplemental payments were performed by eligible physicians;
- recalculated the ratio by:
 - obtaining the Medicaid Management Information System (MMIS) data that the State agency used to calculate the ratio,
 - identifying eligible Medicaid physician services,
 - matching commercial fees to eligible Medicaid services, and
 - matching Medicare fees to eligible Medicaid services;¹⁴
- recalculated the quarterly supplemental payments by:
 - obtaining the MMIS data that the State agency used to calculate quarterly supplemental payments,
 - identifying eligible Medicaid physician services, and
 - matching Medicare fees to eligible Medicaid services;¹⁵ and
- discussed our preliminary findings with the State agency, the TTU health institutions, and PCG.

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

¹³ Performing providers included physicians, nonphysicians, and facilities.

¹⁴ See Appendix A for more information on our ratio recalculations.

¹⁵ This step required us to correct Medicare equivalent fees for 3,283 Medicaid services for which the State agency had used incorrect Medicare equivalent fees. See Appendix B for more information on our supplemental payment recalculations.

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

FINDINGS AND RECOMMENDATION

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

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

As a result, the TTU health institutions received \$16,319,625 (\$9,911,321 Federal share) in unallowable supplemental payments.

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

OVERSTATED MEDICARE EQUIVALENT FEES FOR PAYMENT MODIFIERS AND DIAGNOSTIC TEST MODIFIERS

The State agency's supplemental payment calculations included overstated Medicare equivalent fees for claims that included payment modifiers and diagnostic test modifiers. Details about these overstatements are included below. The overstatements occurred because the State agency did not have any formal written policies and procedures to ensure that the supplemental payments were calculated in accordance with the terms of the SPA. As a result, the State agency overstated supplemental payments by \$16,669,236 (\$10,123,935 Federal share). See Appendix B for more information on the effect of these overstatements on the supplemental payment calculations.

Overstated Medicare Equivalent Fees for Claims That Included Payment Modifiers

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

The State agency calculated Medicare equivalent fees for Medicaid physician services at 100 percent of the Medicare fee schedule even when the CPT codes were appended with payment modifiers.¹⁶ For example:

- The State agency used 100 percent of the Medicare fee of \$2,578 for CPT code 61518, which had been appended with modifier 82. The State agency should have multiplied the Medicare fee by 16 percent, which would have yielded a \$412 Medicare equivalent payment. This error resulted in a Medicare equivalent overstatement of \$2,166.
- The State agency used 100 percent of the Medicare fee of \$665 for CPT code 49491, which had been appended with modifier 50. The State agency should have multiplied the Medicare fee by 150 percent, which would have yielded a \$998 Medicare equivalent payment. This error resulted in a Medicare equivalent understatement of \$333.

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

Overstated Medicare Equivalent Fees for Claims That Included Diagnostic Test Modifiers

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

The State agency used global service fees to calculate the Medicare equivalent fees for Medicaid physician services related to diagnostic tests even when Medicaid had paid for only the professional or the technical component of the services.¹⁷ In most cases, the global service fee is substantially higher than the professional component fee and moderately higher than the technical component fee.

¹⁶ The State agency used CPT code modifiers for 2008 reconciliation payments that it made to the TTU health institutions for services that TTU physicians performed in 2006. We factored the reconciliation payments into our supplemental payment recalculations.

¹⁷ The State agency used diagnostic test modifier 26 for 2008 reconciliation payments that it made to the TTU health institutions for services that TTU physicians performed in 2006. We factored the reconciliation payments into our supplemental payment recalculations.

In the following example, the State agency used the global service fee to calculate the Medicare equivalent fee, even though the Medicaid payment was for only the professional component fee.

Table: Incorrect Use of Global Service Fee

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

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

MEDICAID SERVICES PERFORMED BY INELIGIBLE PROVIDERS

Sections e(1) and e(2) of the SPA required that to be eligible for supplemental payments, services be rendered by physicians who were employed by group practices owned or operated by one of the three State academic health systems (eligible physicians).¹⁸ Those sections of the SPA also specifically excluded services that contractors performed.

The State agency included services performed by nonphysicians and contractors in calculating supplemental payments or did not provide documentation proving that the services were performed by eligible providers. The State agency made these errors because it did not have any formal written policies and procedures to ensure that it included in its supplemental payment calculations only services that eligible physicians provided. As a result, the State agency overstated supplemental payments by \$1,787,844 (\$1,085,286 Federal share). See Appendix A

¹⁸ Section e(1) of the SPA stated that "... supplemental payments are available ... to physicians who are recognized as essential to the Texas State Medicaid program. To be identified as an essential physician and qualify for a supplemental payment, the physician must be ... [a] Texas licensed physician ... and ... [e]mployed by an eligible physician group practice that is state-owned or operated."

for the errors' effect on the ratio and Appendix B¹⁹ for more information on the errors' effect on supplemental payment calculations.

MEDICAID SERVICES THAT DID NOT HAVE MEDICARE EQUIVALENT FEES

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

The State agency included Medicaid physician services that did not have Medicare equivalent fees listed in the Medicare fee schedule. The State agency included these services because it did not have any formal written policies and procedures to ensure that, in its supplemental payment calculations, it included only physician services that had Medicare equivalent fees. As a result, the State agency understated supplemental payments by \$2,137,455 (\$1,297,900 Federal share). The State agency's inclusion of these services accounted for most of the overstatements of the ratios it computed (Appendix A). See Appendix B for more information on the error's effect on supplemental payment calculations.

THE STATE AGENCY LACKED FORMAL WRITTEN POLICIES AND PROCEDURES

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

RECOMMENDATION

We recommend that the State agency refund to the Federal Government the \$9,911,321 Federal share of improper supplemental payments made to the TTU health institutions.

¹⁹ Tables 3 and 5 in Appendix B represent separate steps we took to identify Medicaid services performed by ineligible providers and are combined in the report under the heading "Medicaid Services Performed by Ineligible Providers."

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency neither agreed nor disagreed with our recommendation, but instead described actions that it planned to complete. For our recommendation to refund the Federal share of improper supplemental payments made to the TTU health institutions, the State agency said that it would:

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

Additionally, the State agency commented that it calculated supplemental payments with the methodology approved with CMS.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our findings and recommendation are valid. We maintain that the methodology the State agency used to calculate supplemental payments was not consistent with the terms of the SPA and compliant with Federal and State requirements in effect during our audit period.

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

APPENDIXES

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

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

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

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

TTU Health Science Center at Amarillo's (TTU-Amarillo) original ratio:

$$\frac{\$8,888,532}{\$6,902,820} = 128.7667\%$$

To recalculate the ratio for TTU-Amarillo, we made the following adjustments:

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

$$\frac{\$8,814,313}{\$6,864,599} = 128.4024\%$$

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

$$\frac{\$8,784,873}{\$6,864,599} = 127.9736\%$$

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

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

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

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

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

$$\frac{\$8,784,785}{\$6,864,522} = 127.9737\%$$

We used 127.9737 percent as the ratio in our recalculation of the supplemental payments made to TTU-Amarillo.

TTU Health Science Center at El Paso's (TTU-El Paso) original ratio:

$$\frac{\$8,829,210}{\$8,038,142} = 109.8414\%$$

To recalculate the ratio for TTU-El Paso, we made the following adjustments:

1. We removed the Medicaid services performed by ineligible providers, whom we identified by reviewing TTU-El Paso's personnel listing.

$$\frac{\$7,769,980}{\$6,983,796} = 111.2573\%$$

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

$$\frac{\$7,647,951}{\$6,983,796} = 109.5099\%$$

We used 109.5099 percent as the ratio in our recalculation of the supplemental payments made to TTU-El Paso.

TTU Health Science Center at Lubbock's (TTU-Lubbock) original ratio:

$$\frac{\$10,456,949}{\$7,091,126} = 147.4653\%$$

To recalculate the ratio for TTU-Lubbock, we made the following adjustments:

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

$$\frac{\$10,397,080}{\$7,046,884} = 147.5415\%$$

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

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

$$\frac{\$9,748,929}{\$7,046,884} = 138.3438\%$$

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

$$\frac{\$9,747,823}{\$7,046,517} = 138.3353\%$$

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

$$\frac{\$9,746,068}{\$7,045,013} = 138.3400\%$$

We used 138.3400 percent as the ratio in our recalculation of the supplemental payments made to TTU-Lubbock.

TTU Health Science Center at the Permian Basin's (TTU-Odessa) original ratio:

$$\frac{\$3,721,114}{\$2,908,559} = 127.9367\%$$

To recalculate the ratio for TTU-Odessa, we made the following adjustments:

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

$$\frac{\$3,155,721}{\$2,443,367} = 129.1546\%$$

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

$$\frac{\$3,105,570}{\$2,443,367} = 127.1021\%$$

We used 127.1021 percent as the ratio in our recalculation of the supplemental payments made to TTU-Odessa.

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

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

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

Table 1: State-Agency-Calculated Supplemental Payment

TTU Health Institution	Medicare Equivalent Fees	Ratio	Medicare Equivalent Fees x Ratio	Less What Medicaid Already Paid	Equals Supplemental Payment
TTU-Amarillo	\$25,206,580	128.77% ²	\$32,457,675	\$15,194,863	\$17,262,812
TTU-El Paso	26,074,692	109.84% ³	28,640,811	15,156,676	13,484,136
TTU-Lubbock	23,149,538	147.47% ⁴	34,137,531	13,969,517	20,168,014
TTU-Odessa	12,067,675	127.94% ⁵	15,438,985	6,785,726	8,653,259

Total State-agency-calculated supplemental payment: \$59,568,220 (\$36,160,575 Federal share).

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

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

² The actual ratio the State agency used in the original payment calculations for TTU-Amarillo was 128.76668 percent.

³ The actual ratio the State agency used in the original payment calculations for TTU-El Paso was 109.84142 percent.

⁴ The actual ratio the State agency used in the original payment calculations for TTU-Lubbock was 147.46528 percent.

⁵ The actual ratio the State agency used in the original payment calculations for TTU-Odessa was 127.93670 percent.

Table 2: Overstated Medicare Equivalent Fees

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

TTU Health Institution	Medicare Equivalent Fees	OIG-Calculated Ratio	Medicare Equivalent Fees x Ratio	Less What Medicaid Already Paid	Equals Supplemental Payment	Supplemental Payment (Decrease or Increase)
TTU-Amarillo	\$22,359,179	127.97% ⁶	\$28,613,877	\$15,194,863	\$13,419,013	(\$3,843,798)
TTU-El Paso	21,634,419	109.51% ⁷	23,691,838	15,156,668	8,535,170	(4,948,965)
TTU-Lubbock	20,606,243	138.34% ⁸	28,506,669	13,928,679	14,577,990	(5,590,024)
TTU-Odessa	10,346,970	127.10% ⁹	13,151,212	6,784,402	6,366,810	(2,286,449)

Total overstated Medicare equivalent fees questioned: \$16,669,236 (\$10,123,935 Federal share).

⁶ The actual ratio used in the payment recalculations was 127.97374 percent.

⁷ The actual ratio used in the payment recalculations was 109.50994 percent.

⁸ The actual ratio used in the payment recalculations was 138.33996 percent.

⁹ The actual ratio used in the payment recalculations was 127.10206 percent.

Table 3: Medicaid Services Performed by Ineligible Providers

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

TTU Health Institution	Medicare Equivalent Fees	OIG-Calculated Ratio	Medicare Equivalent Fees x Ratio	Less What Medicaid Already Paid	Equals Supplemental Payment	Supplemental Payment (Decrease or Increase)
TTU-Amarillo	\$22,112,941	127.97%	\$28,298,757	\$15,026,078	\$13,272,679	(\$146,334)
TTU-El Paso	19,723,064	109.51%	21,598,714	13,765,900	7,832,815	(702,356)
TTU-Lubbock	20,355,754	138.34%	28,160,143	13,735,707	14,424,437	(153,554)
TTU-Odessa	9,021,442	127.10%	11,466,439	5,879,410	5,587,028	(779,782)

Total Medicaid services provided by ineligible providers: \$1,782,025 (\$1,081,754 Federal share).

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

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

TTU Health Institution	Medicare Equivalent Fees	OIG-Calculated Ratio	Medicare Equivalent Fees x Ratio	Less What Medicaid Already Paid	Equals Supplemental Payment	Supplemental Payment (Decrease or Increase)
TTU-Amarillo ¹⁰	\$22,112,941	127.97%	\$28,298,757	\$14,343,160	\$13,955,598	\$682,918
TTU-El Paso ¹¹	19,723,064	109.51%	21,598,714	13,361,943	8,236,772	403,957
TTU-Lubbock ¹²	20,355,754	138.34%	28,160,143	12,939,938	15,220,206	795,769
TTU-Odessa ¹³	9,021,442	127.10%	11,466,439	5,624,600	5,841,838	254,810

Total Medicaid services that did not have Medicare equivalent fees questioned costs: \$2,137,455 (\$1,297,900 Federal share).

¹⁰ The underpayment was offset by the error's effect on the ratio. Removing these services accounted for 0.4289 percent of the 0.7929-percent ratio reduction.

¹¹ The underpayment was offset by the error's effect on the ratio. Removing these services accounted for 1.7473 percent of the 0.3315-percent ratio reduction.

¹² The underpayment was offset by the error's effect on the ratio. Removing these services accounted for 9.1977 percent of the 9.1253-percent ratio reduction.

¹³ The underpayment was offset by the error's effect on the ratio. Removing these services accounted for 2.0525 percent of the net 0.8346-percent ratio reduction.

Table 5: Medicaid Services Performed by Ineligible Providers

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

TTU Health Institution	Medicare Equivalent Fees	OIG-Calculated Ratio	Medicare Equivalent Fees x Ratio	Less What Medicaid Already Paid	Equals Supplemental Payment	Supplemental Payment (Decrease or Increase)
TTU-Amarillo	\$22,112,864	127.97%	\$28,298,659	\$14,343,121	\$13,955,537	(\$61)
TTU-El Paso	19,713,470	109.51%	21,588,208	13,355,365	8,232,843	(3,929)
TTU-Lubbock	20,353,557	138.34%	28,157,104	12,938,532	15,218,572	(1,633)
TTU-Odessa	9,021,020	127.10%	11,465,902	5,624,259	5,841,643	(196)

Total Medicaid services performed by ineligible providers questioned costs: \$5,819 (\$3,533 Federal share).

Aggregate Questioned Costs

TTU-Amarillo:	\$3,307,274	(\$2,010,244 Federal share)
TTU-El Paso:	5,251,293	(3,187,844 Federal share)
TTU-Lubbock:	4,949,442	(3,005,044 Federal share)
TTU-Odessa:	2,811,616	(1,708,189 Federal share)
Total Questioned Costs:	\$16,319,625	(\$9,911,321 Federal share)

APPENDIX C: STATE AGENCY COMMENTS



TEXAS
Health and Human
Services

Texas Health and Human Services Commission

Charles Smith
Executive Commissioner

November 30, 2017

Ms. Patricia Wheeler
Regional Inspector General for Audit Services
Office of Inspector General, Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

Reference Report Number A-06-12-00043

Dear Ms. Wheeler:

The Texas Health and Human Services Commission (HHSC) received a draft audit report entitled "*Texas Did Not Always Calculate Physician Supplemental Payments Made to the Texas Tech University Health Institutions in Accordance With Federal and State Requirements*" from the U.S. Department of Health and Human Services Office of Inspector General. The cover letter, dated August 22, 2017, requested that HHSC provide written comments, including the status of actions taken or planned in response to report recommendations.

I appreciate the opportunity to respond. Please find the attached HHSC management response which (a) includes comments related to the content of the findings and recommendations and (b) details actions HHSC has completed or planned.

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

Sincerely,

A handwritten signature in blue ink, appearing to read "Charles Smith".

Charles Smith

Attachment

Texas Health and Human Services Commission
Management Response to the
U.S. Department of Health and Human Services Office of Inspector General Report:
**Texas Did Not Always Calculate Physician Supplemental Payments
Made to the Texas Tech University Health Institutions in Accordance
With Federal and State Requirements**

Summary of Management Responses

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

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

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

DHHS - OIG Recommendation: *We recommend that the State agency refund to the Federal Government the \$9,911,321 Federal share of improper supplemental payments made to the Texas Tech University Health Institutions.*

HHSC Management Response:

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

(Audit reported that the federal share of overstated payments was \$10,123,935)

Actions Planned:

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

**HHSC Management Response – Physician Supplemental Payments – Texas Tech
November 30, 2017
Page 2**

Estimated Completion Date:

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

Title of Responsible Person:

Deputy Executive Commissioner for Financial Services

Medicaid Services Performed by Ineligible Providers

(Audit reported that the federal share of overstated payments was \$1,085,286)

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

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

Actions Planned:

HHSC will refund the federal share of any physician supplemental payments that did not meet applicable requirements.

Estimated Completion Date:

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

Title of Responsible Person:

Deputy Executive Commissioner for Financial Services

Medicaid Services that Did Not Have Medicare Equivalent Fees

(Audit stated that the federal share of understated payments was \$1,297,900)

Actions Planned:

None. This payment is understated. It will be offset against the overstatements listed above.