TEXAS HEALTH AND HUMAN SERVICES COMMISSION

OFFICE OF INSPECTOR GENERAL

MULTIPLE MEDICAID IDENTIFICATION NUMBERS

*Inspection of Multiple Medicaid IDs
and the Texas Medicaid System*

June 8, 2018
OIG Report No. INS-17-011

HHSC OIG
TEXAS HEALTH AND HUMAN SERVICES COMMISSION

OFFICE OF INSPECTOR GENERAL

MULTIPLE MEDICAID IDENTIFICATION NUMBERS:
Inspection of Multiple Medicaid IDs and the Texas Medicaid System

WHY THE OIG CONDUCTED THIS INSPECTION

An inspection was conducted to determine if Texas Medicaid made multiple capitation payments for clients with multiple Medicaid ID numbers. The inspection objectives were to:

- Determine if the Texas Medicaid system identifies and prevents the creation of multiple Medicaid ID numbers for clients.
- Determine if the Texas Medicaid system recovers unallowable capitation payments associated with multiple Medicaid ID numbers.

A federal audit report identified concerns related to more than one Medicaid ID number assigned to a client and improperly paid capitation payments. The audit included data for the period of January 2013 through December 2014, and identified 3,045 clients assigned more than one Medicaid ID, resulting in $6.5 million in improperly paid capitation payments. HHSC requested a follow-up inspection to the federal audit to determine potential causes of multiple Medicaid IDs and whether improperly paid managed care payments are recovered.

WHAT THE OIG RECOMMENDS

The OIG recommends:

1. AES develop a policy and train TWAs on standardized naming conventions in the application process.
2. AES work with HHSC Information Technology Social Services Applications Business Automation (BA) to develop a TIERS program edit to prevent an SSN from being used more than once.
3. AES revise policy to require TWAs to query using the SSN on all initial applicants prior to any other inquiries.
4. MCS provide direction to BA to merge existing Medicaid IDs with CHIP, as appropriate, and develop policy for future merges to be completed within the 24-month period.

View the report online
For more information, contact:
IG_Inspections_Division@hhsc.state.tx.us

WHAT THE OIG FOUND

The OIG Inspections Division found that overall HHSC eligibility offices that handle the steps in the eligibility process have an effective process to generate alerts notifying Access and Eligibility (AES) Data Integrity (DI) staff of multiple Medicaid identification (ID) numbers when identified. However, the inspection revealed issues in the eligibility determination process performed by Texas Works Advisors (TWAs) in the Texas Integrated Eligibility Redesign System (TIERS), causing multiple IDs to be created.

During the inspection, conducted for the period of June 2015 through May 2017, the Inspections Division identified capitation payments totaling $4.4 million made for 2,965 multiple Medicaid ID numbers for 1,483 clients. While efforts have been made in recent years to improve the process and prevent the issuance of an additional Medicaid ID, the creation of multiple identifications is still occurring. The Inspections Division supplied AES with a list of multiple Medicaid IDs, which resulted in recovery of $1,119,617.

The OIG Inspections Division made the following observations:
- Multiple IDs are being created due to a lack of naming convention policy.
- The TIERS system allows multiple Medicaid IDs to be created using the same Social Security number (SSN).
- Multiple Medicaid IDs are not being merged in a timely manner, preventing PPS from adjusting erroneous capitation payments.

A review of client last names in the inspection data indicated that out of 1,483 individual SSNs in the data set, there were 157 naming convention issues, with associated capitation payments totaling $473,553. Clear policies and procedures that establish naming conventions for dual surnames and proper suffix placement will help reduce TWAs from creating multiple IDs.

Additionally, TIERS allows Medicaid IDs to be created using the same SSN and invalid number sequences. In reviewing the 2,965 multiple IDs, clients were found in TIERS with previously merged IDs and with two to four Medicaid IDs associated with a single SSN. A TIERS internal report indicated there were 200 clients with invalid SSNs in FY 2017. Inspectors found an additional 39 Medicaid IDs with invalid SSNs, created as recently as November 2017. An edit in TIERS to prevent an SSN from being used more than once, and a revised policy for TWAs to require using the SSN first, when possible, on all initial applicant inquiries prior to any other inquiries, will help identify and reduce the creation of multiple Medicaid IDs.

Of the 2,965 Medicaid IDs with CHIP eligibility or history, there were 1,377 IDs that remained unmerged, as of February 2018, with associated capitated payments of approximately $3,341,571. More research is needed to determine the appropriate way to take action on multiple Medicaid IDs that are not being merged in a timely manner to prospectively prevent erroneous capitation payments and recoup as appropriate.

These concerns led to four OIG recommendations listed to the left. AES and Medicaid and CHIP Services (MCS) agreed with the recommendations.

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I.   PURPOSE AND OBJECTIVES

The Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) Inspections Division conducted an inspection to determine if Texas Medicaid made multiple capitation payments for clients with multiple Medicaid identification numbers. The inspection focused on the following objectives:

- Determine if the Texas Medicaid system identifies and prevents the creation of multiple Medicaid identification numbers for clients.
- Determine if the Texas Medicaid system recovers unallowable capitation payments associated with multiple Medicaid identification numbers.

II.   BACKGROUND

The U.S. Department of Health and Human Services (HHS) Office of Inspector General issued an audit report, *Texas Made Unallowable Medicaid Managed Care Payments for Beneficiaries Assigned More Than One Medicaid Identification Number,*[1] which identified concerns related to more than one Medicaid identification (ID) number assigned to a client and improperly paid capitation payments. In the required corrective action for the federal audit finding, the HHS Office of Inspector General recommended that "[The State agency] strengthen its procedures to determine whether applicants are enrolled in any medical or public assistance benefits throughout the state and ensure that no beneficiary is issued more than one Medicaid identification number." The federal audit included data for the period of January 2013 through December 2014, and identified 3,045 clients assigned more than one Medicaid ID number. According to the federal audit, this resulted in $6.5 million in improperly paid capitation payments.

At the request of the HHSC Chief Deputy Executive Commissioner, the OIG Inspections Division performed a follow-up inspection to the federal audit to determine potential causes of multiple Medicaid IDs and whether improperly paid managed care payments are recovered. The data set

> Texas Medicaid paid $4.4 million in capitated payments for 2,965 multiple Medicaid ID numbers for 1,483 clients from June 2015 - May 2017.[2]

for the inspection included the period of June 2015 through May 2017.

According to the *Texas Health Care Spending Report: Fiscal 2015,*[3] Medicaid is

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[1] March 2017, Report A-06-15-00024: https://www.oig.hhs.gov/oas/reports/region6/61500024.pdf
[2] Per OIG Data and Technology (DAT)
[3] Texas Comptroller of Public Accounts: https://comptroller.texas.gov/economy/in-depth/special-reports/health-care/96-1796.pdf

"the single most expensive health care program administered by the state." The federal government shares responsibility of Medicaid costs with every state that administers the program. In fiscal year 2015, Texas spent more than $30.3 billion in state and federal funds for Medicaid and the Children's Health Insurance Program (CHIP). Medicaid represents 97 percent of that total amount.

Capitation Payments

Managed care organizations (MCOs) contract with the state to provide Medicaid healthcare services to clients who have applied for and have been approved to receive benefits. These MCOs are paid a capitation payment per member per month, which assumes an average annual amount needed to provide health services to a client. Capitation payments may be paid in error to an MCO for clients assigned more than one Medicaid ID by HHSC during the application process. If those IDs are active in the Texas Integrated Eligibility Redesign System (TIERS), and the client is eligible to receive benefits, this will trigger TIERS to send eligibility and enrollment information on multiple Medicaid IDs to the Premiums Payable System (PPS), which results in additional payments and adjustments to MCO capitation payments.

Application Options

Individuals applying for benefits in Texas have several options available to them. The self-service portal, commonly known as "Your Texas Benefits," is an online application that is also accessible by a smart phone application. Applicants may also apply for benefits in person at eligibility offices located across the state. Applicants can dial 2-1-1, which is an assistance hotline committed to helping Texas residents find out more about social service and health benefits available to them.

Eligibility Determination Process

The HHSC Access and Eligibility Services (AES) division is responsible for providing direction, training, policy and procedure updates, and oversight to staff in the eligibility offices. Eligibility for Medicaid and CHIP, Supplemental Nutrition Assistance Program, and Temporary Assistance for Needy Families benefits is determined by Texas Works Advisors (TWAs) located in offices across the state. The TWAs use several programs and links to websites to process applications and determine eligibility. The primary program used by TWAs for processing applications is TIERS. The HHSC Information Technology Social Services Applications Business Automation (BA) division provides technical assistance with TIERS, such as editing and reporting data. Applicants provide biographical and financial information when applying for benefits. TWAs review the information for completeness and accuracy for applications received in-person or by mail, fax, or the self-service portal and then enter the information into TIERS to determine eligibility. TIERS is considered the system of record for all Medicaid and CHIP clients and contains all records of applications processed, whether approved or denied.

Application Process

When processing the application, TIERS generates a nine-digit client ID number for the applicant, which becomes the Medicaid ID when eligibility is determined. Training manuals instruct TWAs to perform inquiries in TIERS and the HHSC Portal to determine benefit case history using a combination of at least two of the following: name, date of birth (DOB), gender, Medicaid ID number, or Social Security number (SSN). If there is a pre-existing case in TIERS associated with the applicant, TWAs are required to use the existing case to avoid the creation of multiple Medicaid IDs.

TWAs use additional links to websites through TIERS to verify applicant biographical and work information. For example, Data Broker[4] provides links to websites that assist the TWA in verifying information provided by the client such as work history, driver's license, child support, and criminal background checks. Also included in the TIERS application is the State Online Query (SOLQ) link, which allows for real-time online Social Security verification.

SSNs and SOLQ

SSNs are required when applying for Medicaid benefits. SSN verification is required by federal law as part of the application process.[5] An SSN is not required for emergency Medicaid or initially for newborn children.[6] Parents have six months to provide the SSN to an eligibility office for newborn children who qualify for Medicaid coverage.

TWAs perform the SSN verification using the SOLQ link in TIERS. SSN verification is not given unless the name and SSN match the Social Security Administration information exactly.

Multiple Medicaid IDs can be created under several circumstances, some include: when client names are misspelled, when client names are not entered into the correct spaces in the application form, and when clients are unsure of the SSN or use an incorrect SSN.

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[4] HHSC contracts with a Data Broker vendor to provide financial and other background information about applicants and clients. The vendor collects and combines information from several sources into one report. The report includes information such as clients' address, individuals living at that address, vehicle and real property ownership, credit, employment, income verification, Texas Workforce Commission wages and benefits, and other information reported to other sources.

[5] The agency must require, as a condition of eligibility, that each individual (including children) seeking Medicaid furnish his or her Social Security number. 42 Code of Federal Regulations (C.F.R.) § 435.910(a).

[6] Per AES Policy A-410 General Policy

Process for Correcting Eligibility Errors Due to Multiple Identifications

Two divisions within AES handle customer concerns, edits, and merges of erroneously assigned Medicaid IDs:

1.) The Customer Care Center (CCC) assists clients with concerns, such as needed corrections on the name field and name changes due to marriage or divorce. For example, a client contacts CCC staff for assistance with a name change if the client applied for benefits under one name and then had a marital status change. Clients are required to report any changes within 10 days of the change.

2.) The Data Integrity (DI) division handles issues identified by TWAs, which may include merging or performing a corrective action on Medicaid IDs. Merging multiple identifications causes one ID to become inactive and then connects the inactive ID with the client's true ID. Performing a corrective action on an ID may include correcting biographical data such as an erroneous gender assignment, correcting an SSN, or revising content pertaining to eligibility and enrollment history. When TWAs determine that a client may have multiple Medicaid IDs, a task is assigned to DI for further research or possible merging of the IDs. DI staff also generate TIERS internal reports monthly to identify possible occurrences of multiple Medicaid IDs. If the Medicaid IDs to be merged do not involve CHIP, they can be merged by AES DI staff. If the IDs to be merged involve CHIP, those merges can be conducted by staff in the BA division. The Medicaid and CHIP Services (MCS) division assists with the identification of multiple Medicaid IDs and provides a quarterly report to AES for research and potential merging.

Capitation payments are triggered when TIERS data on eligible clients, and their respective IDs, are sent to PPS. Once PPS processes the data, the adjustments take effect the following month.[7] When merges are performed on multiple Medicaid IDs, any capitation payments made in error are adjusted back to the state up to 24 months back from the date the merge is performed. Adjustments cannot be made on capitation payments that fall outside the 24-month rolling period.[8] Funds must be recovered another way if the payments fall outside the 24-month period.

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[7] The data is sent on the Medicaid cut-off date each month, which is typically the middle of the month.
[8] Due to system design and server data capacity, automated recoupment of capitation payments using PPS is limited to a rolling 24-month period.

III. INSPECTION RESULTS

Overall, the OIG Inspections Division found that the HHSC eligibility offices that handle the steps in the eligibility process have an effective process to generate alerts notifying DI staff of multiple Medicaid IDs when identified. Monthly, eligibility offices process more than four million cases. For the period of June 2015 through May 2017, the inspection team noted 2,965 multiple Medicaid IDs.

AES has implemented numerous process improvements to reduce the number of additional Medicaid IDs. In September 2016, AES implemented the use of the SOLQ link to validate SSNs provided by the applicant. After the federal audit and prior to this inspection, AES-DI staff began identifying and merging multiple Medicaid IDs. As of February 2018, AES-DI staff updated 1,220 IDs identified prior to and during the inspection.

Table 1 shows the recovered managed care payment amounts resulting from these merges.

Table 1. Adjustments to Capitation Payments Before and After OIG Inspections Division Initiated Inspection

Amounts adjusted due to AES efforts prior to inspection	Amounts adjusted due to OIG efforts after inspection initiation	Total
$434,680	$1,119,617	$1,554,297

Source: OIG Inspections Division from data provided by AES and DAT PPS capitation file as of 2/1/18

Despite AES efforts to improve the process to reduce issuing multiple Medicaid identification numbers, the inspection revealed issues in the eligibility application process, which results in the continued creation of multiple IDs.

<u>Observation 1</u>: Multiple IDs are being created due to a lack of naming convention policy.

The review of TWA policies and procedures revealed there is no established naming convention standard in the application process. Interviews with, and observations of, TWA staff during the eligibility determination process indicated TWAs had varying methodologies for entering dual surnames and surnames with suffixes. Variations included blending the names together without a space, hyphenating the dual surnames, and adding suffixes such as "Jr." at the end of the last name without a space. Data showed multiple instances where TWAs misplaced a client's second surname and placed it in the middle name field.

Handbooks and training manuals used by TWAs state that TWAs should perform inquiries in the HHSC Portal or TIERS prior to initiating the application process. Options for performing inquiries include name, DOB, gender, Medicaid ID, and SSN. Inquiries based on biographical data can also be performed before the application is registered in TIERS. This prevents TIERS from assigning an additional Medicaid ID to a client's application while the TWA is researching applicant history. Interviews and observations revealed that TWAs predominately perform inquiries using name and DOB. TWAs will then review match results provided by the HHSC Portal or TIERS and determine if there is a pre-existing Medicaid ID already assigned to the client. If the TWA does not find a match based on name and DOB, the TWA will create a new Medicaid ID.

When clients initiate the eligibility application process in person or online, clients may not know, remember, or have their Medicaid ID or SSN. Inaccurate information is sometimes provided to the TWA when different individuals from the same family apply for benefits for the same dependent. Family members who live separately may also apply for benefits at different times and at different eligibility office locations. If the family member does not provide historical applicant information to the TWA, or if the dependent's information is misspelled, the TWA will create a new Medicaid ID.

A review of client last names in the data indicated that out of 1,483 individual SSNs in the data set, there were 157 naming convention issues. Table 2 details the type of issue, instances, IDs associated, how many months were included in those issues, and the total number of capitation payments made.

Table 2. Instances and Types of Naming Convention Issues Leading to Multiple IDs Issued by HHSC

Issue	Instances	IDs Associated	Capitated Months	Associated Dollars
Suffix Run into Surname	83	164	1,075	$283,168
Hyphenated	33	63	359	$78,759
Surname Run Together	21	39	268	$64,201
Misspelled Names	20	40	268	$47,425
Total	**157**	**306**	**1,970**	**$473,553**

Source: OIG Inspections Division from data provided by DAT PPS capitation file as of 05/24/17

Clear policies and procedures that establish naming conventions for dual surnames and proper suffix placement will help reduce TWAs from creating multiple IDs. These policies and procedures should also address corrective actions to take when identifying cases with missing, misspelled, or misplaced names.

Recommendation 1: AES should develop a policy and train TWAs on standardized naming conventions in the application process.

Management Response:
AES accepts the recommendation.

AES has determined automation improvements would be more effective than a standardized naming convention relying on staff data entry. Accordingly, AES has made system and process improvements to address multiple Medicaid identification numbers.

In September 2016, AES implemented modifications to TIERS that AES believes mitigate the chance that multiple Medicaid identification numbers will be created for an individual. These changes include the real-time, pre-certification validation of Social Security Numbers (SSN) with the Social Security Administration (SSA) to quickly identify instances of multiple client identification numbers and the lock-down of biographical information after AES validates the SSN with SSA. Additionally, AES modified the criteria for system interfaces that create client identification numbers to reduce the number of instances when a new client identification number is created. A review of individuals identified in this inspection who potentially have multiple numbers indicated the majority of multiple client identification numbers were created before AES implemented these system changes.

In October 2017, AES implemented policy to allow staff to clear SSN discrepancies before approving benefits.

These modifications in TIERS and policy are proving effective. AES receives a file of individuals potentially assigned multiple Medicaid identification numbers to resolve on a monthly basis. Since December 2017, the number of records indicated on the file has declined by 54 percent.

AES plans additional system changes to enable the SSN validation process, which considers accuracy of the individual's name, before the client identification number is created to prevent the creation of the multiple client numbers. Implementing these system changes will further mitigate the naming convention issue because eligibility staff have to resolve the name before the SSN validates.

Responsible Party:
Todd Byrnes, Deputy Associate Commissioner for Eligibility Operations

Implementation Plan and Dates:
SSN Validation Prior to Case Certification project - Completed September 2016
SSN Validation Prior to ID creation - October 31, 2018

Observation 2: The TIERS system allows multiple Medicaid IDs to be created using the same SSN.

TIERS provides no restriction on how many Medicaid IDs can be created based on a single valid SSN already in use. In reviewing the 2,965 multiple IDs during the inspection, clients were found in TIERS with previously merged IDs and with two to four Medicaid IDs associated with a single SSN. Interviews with TWAs and BA indicated this should not be allowed.

TIERS also allows Medicaid IDs to be created using invalid number sequences such as "123456789" and "012345678." A TIERS internal report, retrieved for state fiscal year 2017, indicated there were 200 clients with these invalid SSNs. Inspectors found an additional 39 Medicaid IDs, created as recently as November 2017, with these invalid SSNs. Staff interviews indicated that the use of "123456789" for the SSN is due to the applicant not being able to provide an SSN. AES policies and procedures do not restrict this practice.

Training manuals instruct TWAs to perform inquiries and searches using the SSN first, however, AES policy does not have this requirement. During the inspection, interviews with TWA staff revealed that for initial inquiries and searches they predominantly use the client's name and DOB. Staff are trained to perform this type of inquiry to prevent the creation of additional IDs for the same client. Searches using name and DOB will result in TIERS supplying potential matches, but not all potential matches will be identified. Issues with misspelled, misplaced, or incomplete names results in an incomplete potential match listing.

Inspectors performed two types of inquiries in the HHSC Portal and TIERS: name and DOB only, and SSN only. The name and DOB search generated a list of potential matches, but not all potential matches were identified. Searches performed by inspectors using only the SSN retrieved all active and inactive cases of clients associated with that SSN, including those with name variations and misspelled names. Therefore, the SSN search identified all potential matches associated with the SSN.

Inquiries performed using the SSN will provide the TWA with all cases associated with that SSN and prevent the creation of multiple Medicaid IDs. This will also prevent potential fraudulent use of an SSN when the TWA verifies the name and DOB associated with that SSN. Not performing an initial inquiry using the SSN increases creation of multiple Medicaid IDs, which results in additional capitation payments being made to MCOs in error.

Interviews with BA and DI staff indicated an edit was previously in place that would alert the TWA that an SSN entered was already in use in TIERS. The intent of the edit was to prevent TWAs from creating a new ID for the same SSN or an SSN already in use. However, the edit did not prevent the creation of new IDs due to

work-arounds within the system. Interviews with BA and DI staff indicated it was unknown why or when the edit was altered in TIERS.

AES should program an edit in TIERS to prevent an SSN from being used more than once and revise policies and procedures for TWAs to require using the SSN first, when possible, on all initial applicant inquiries prior to any other inquiries. If implemented, these recommendations will identify and reduce the creation of multiple Medicaid IDs.

Recommendation 2.1: AES should work with BA to develop a TIERS program edit to prevent an SSN from being used more than once.

Management Response:
AES agrees with this recommendation.

In October 2017, AES worked with HHSC IT to obtain a list of SSNs associated with more than one client identification number. AES researched each instance and performed merges where appropriate.

AES plans additional system changes to enable the SSN validation process before a client identification number is created to prevent creating multiple Medicaid identification numbers. This project adds an edit within TIERS to alert staff when a SSN entered in the system already exists for another individual. Staff then have the opportunity to determine if the individual in the system is the same as the applicant. If the SSN is associated with a different individual in the system, TIERS will generate a task for staff to address the SSN validation for the existing individual.

Responsible Party:
Todd Byrnes, Deputy Associate Commissioner for Eligibility Operations

Implementation Plan and Date:
SSN Validation Prior to ID creation - October 31, 2018

Recommendation 2.2: AES should revise policy to require TWAs to query using the SSN on all initial applicants prior to any other inquiries.

Management Response:
AES agrees with the recommendation.

Training materials provide existing operational processes to staff and instruct staff to perform inquiries using the SSN and other biographical data.

AES will release a broadcast reminding staff of existing processes for inquiries and use of the SSN along with other biographical data.

Responsible Party:
Todd Byrnes, Deputy Associate Commissioner for Eligibility Operations

Implementation Plan and Date:
AES Eligibility Operations broadcast regarding inquiry processes will be released by
August 31, 2018.

**Observation 3: Multiple Medicaid IDs are not being merged in a timely manner,
preventing PPS from adjusting erroneous capitation payments.**

Capitation payments are triggered when TIERS data on eligible clients, and their
respective IDs, are sent to PPS. Once PPS processes the data, the adjustments take
effect the following month. Capitation payments made to MCOs in error can be
adjusted back to the state up to 24 months back from the date the merge is
performed. During the course of the inspection, some erroneous capitation payments
fell outside the 24-month adjustment period for merged and unmerged IDs and
cannot be adjusted through PPS. Adjustments cannot be made on capitation
payments that fall outside the 24-month period. Funds must be recovered another
way if payments fall outside the 24-month period.

Discussion with AES staff revealed IDs with CHIP eligibility or history are not being
merged. Of the 2,965 IDs, there are 1,377 IDs with CHIP and Medicaid components
that remain unmerged, as of February 2018, with payments that have fallen outside the
24-month period that continue to have payments made. Non-merged IDs will continue
to have increasing amounts of capitation payments fall outside of the 24-month rolling
period. Table 3 details the amount in capitation payments that fell outside the rolling
24 months for non-merged CHIP/Medicaid IDs and merged Medicaid IDs.

Table 3. Amounts Falling Outside 24-Month Rolling Period

Amounts Associated with Non-merged CHIP/Medicaid IDs	Amounts Associated with Merged Medicaid IDs	Total Amounts Associated
$1,724,847	$186,862	$1,911,709

Source: OIG Inspections Division from data provided by DAT, as of February 2018[9]

BA staff reported they have the ability to manually process merges of IDs with
CHIP eligibility without loss of coverage for the client. The IDs not merged by AES
staff have been provided to BA to determine if they are potential multiple IDs
requiring merges. There are 1,377 multiple Medicaid IDs with CHIP and Medicaid
components within the data set that can potentially be merged. As of February 2018,
the capitated payments associated with the 1,377 IDs is approximately $3,341,571.

[9] Per OIG DAT

Currently, the manual process to prevent the continued capitation payments on IDs with CHIP is not being implemented by BA. In some instances, the multiple Medicaid IDs for an individual may have claims paid against each of them. Merging those IDs would cause automatic recoupment of capitation payments covering those claims. Therefore, more research is needed to determine the appropriate way to take action on these multiple Medicaid IDs to prospectively prevent erroneous capitation payments and recoup as appropriate.

As part of this inspection, the OIG Inspections Division also reviewed the IDs noted in the federal audit to determine if the 3,045 IDs identified continued to have capitation payments made. Of those, 25 multiple Medicaid IDs continued to have capitation payments made during the inspection period.

Recommendation 3: MCS should provide direction to BA to merge existing Medicaid IDs with CHIP, as appropriate, and develop policy for future merges to be completed within the 24-month period.

Management Response:
MCS agrees with this recommendation.

In 2006 and 2013 agency leadership directed staff not to recoup capitation payments for instances of concurrent enrollment. At the time, actuarial analysis indicated that as capitation payments for Medicaid and CHIP managed care organizations (MCOs) are based on actual experience, it would not be actuarially appropriate to recoup premiums. Existing HHSC processes do not allow for merging IDs with concurrent eligibility without triggering a recoupment by the MCO; therefore, staff did not merge IDs to avoid recoupments in accordance with previous executive commissioner direction.

HHSC will amend processes or establish a manual process to allow staff to merge IDs for concurrent enrollment while recouping when appropriate. HHSC MCS will coordinate a cross-divisional initiative to evaluate options to ensure funds allocated to the State are spent appropriately while minimizing provider abrasion.

Responsible Party:
Ivan Libson, Deputy Associate Commissioner, Program Enrollment & Support, Medicaid and CHIP Services

Implementation Plan and Date:
August 2019

IV. CONCLUSION

The OIG Inspections Division completed an inspection, as a follow-up to the March 2017 federal audit, to determine if the Texas Medicaid system identifies and prevents the creation of multiple Medicaid IDs and recovers unallowable capitation payments associated with those IDs. During the course of the inspection, conducted for the period of June 2015 through May 2017, capitation payments totaling $4.4 million were made for 2,965 multiple Medicaid ID numbers for 1,483 clients.[10]

The inspection revealed issues in the eligibility determination process performed by TWAs in TIERS, causing multiple IDs to be created. While efforts have been made in recent years to improve the process and prevent the issuance of an additional Medicaid ID, the creation of multiple identifications is still occurring.

The OIG Inspections Division made the following observations:
- Multiple IDs are being created due to a lack of naming convention policy.
- The TIERS system allows multiple Medicaid IDs to be created using the same SSN.
- Multiple Medicaid IDs are not being merged in a timely manner, preventing PPS from adjusting erroneous capitation payments.

The OIG Inspections Division makes the following recommendations:
- AES should develop a policy and train TWAs on standardized naming conventions in the application process.
- AES should work with BA to develop a TIERS program edit to prevent an SSN from being used more than once.
- AES should revise policy to require TWAs to query using the SSN on all initial applicants prior to any other inquiries.
- MCS should provide direction to BA to merge existing Medicaid IDs with CHIP, as appropriate, and develop policy for future merges to be completed within the 24-month period.

Implementation of the OIG Inspections Division recommendations will result in reducing the number of multiple Medicaid IDs and payments made in error to MCOs. The OIG Inspections Division supplied AES with a list of multiple Medicaid IDs, which resulted in recovery of $1,119,617.

The OIG Inspections Division thanks HHSC Access and Eligibility Services, HHSC Social Services Applications Business Automation, Customer Care Center, Data Integrity, and Premiums Payable System management and staff at the inspected entities for their cooperation and assistance during this inspection.

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[10] Based on analysis conducted by OIG DAT

V.   APPENDICES

Appendix A: Detailed Methodology

This inspection focused on determining if multiple Medicaid ID numbers were assigned to clients during the eligibility determination process.

Data Sources

The inspection team reviewed records based on PPS production data provided by OIG Data and Technology (DAT), which included a 24-month period of eligibility data from June 2015 through May 2017. The data pulled included clients previously identified in the federal audit to determine if those clients were still assigned multiple Medicaid IDs, and if monthly capitation payments continued for those additional IDs. In addition, the data set identified multiple Medicaid IDs created within the inspection's identified time period of June 2015 through May 2017.

The inspection team observed the application process by shadowing and interviewing 21 TWAs and their supervisors at several offices. The team also conducted interviews with key personnel from:
- AES, including eligibility staff located at various offices
  - CCC division
  - DI division
- MCS, which provides direction and oversight to PPS (responsible for payments directed to MCOs)
- BA division, which provides assistance with the TIERS program

The inspection team reviewed the Texas Works Handbook, which contains policies and procedures for TWAs to determine eligibility. The team also reviewed federal and state regulations and rules related to this topic, including:

- 42 C.F.R. § 431
- 42 C.F.R. § 435
- Texas Government Code § 531
- 1 Texas Administrative Code § 351
- 1 Texas Administrative Code § 356

State of Texas Access Reform Medicaid Programs

There are several Medicaid programs available to clients. For the purpose of this inspection, and to mirror the federal audit, the data used by the inspection team encompassed clients enrolled in the State of Texas Access Reform (STAR) Medicaid programs (STAR, STAR Health, STAR +Plus, and STAR Kids). STAR is a

Medicaid program that provides coverage for pregnant women, newborns, and needy families. STAR Health is a Medicaid program for children in foster care. STAR +Plus is for individuals with disabilities or who are age 65 and older. STAR Kids is a program for children age 20 or younger with disabilities.

Data Collection and Analysis

The OIG Inspections Division requested a data set from OIG DAT that would encompass previously identified clients in the federal audit scope (January 2013 through December 2014) and any multiple Medicaid ID numbers created after the federal audit. OIG DAT pulled records based on PPS production, which contained managed care capitation payments, eligible benefit months, program codes, MCOs, and multiple Medicaid IDs based on the same SSN.

OIG DAT provided data identifying any multiple Medicaid IDs within an identified 24-month rolling period. The data was based on IDs found with the client having the same SSN. In the case where there was no SSN, a combination of DOB, gender, and name was applied.

Data was reviewed to determine:
- How many multiple Medicaid IDs were identified
- How many IDs were associated with the federal audit
- How much capitation payment amount was involved with the IDs
- How many capitation payments were paid per Medicaid ID
- How many were a result of inaccurate applicant information
- How many were created due to eligibility staff error
- Issues identified with surnames and naming conventions

Standards

The OIG Inspections Division conducts inspections of the Texas Health and Human Services programs, systems, and functions. Inspections are designed to be expeditious, targeted examinations into specific programmatic areas to identify systemic trends of fraud, waste, or abuse. Inspections typically result in recommendations to strengthen program effectiveness and efficiency. The OIG Inspections Division conducted the inspection in accordance with Quality Standards for Inspection and Evaluation issued by the Council of the Inspectors General on Integrity and Efficiency.

Appendix B: Report Team and Report Distribution

Report Team

The OIG staff members who contributed to this OIG Inspections Division report include:

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Appendix C: OIG Mission and Contact Information

Inspector General Mission

The mission of the OIG is to prevent, detect, and deter fraud, waste, and abuse through the audit, review, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of OIG's mission and statutory responsibility includes:

- Sylvia Hernandez Kauffman, Inspector General
- Anita D'Souza, OIG Chief Counsel and Chief of Staff
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Olga Rodriguez, Chief Strategy Officer
- Lizet Hinojosa, Deputy IG for General Investigations
- Brian Klozik, Deputy IG for Medicaid Program Integrity
- David Griffith, Deputy IG for Audit
- Quinton Arnold, Deputy IG for Inspections and Investigations
- Alan Scantlen, Deputy IG for Data and Technology
- Judy Knobloch, Assistant Deputy IG for Division of Medical Services

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- OIG website: https://oig.hhsc.texas.gov/

To Report Fraud, Waste, and Abuse in Texas HHS Programs

- Online: https://oig.hhsc.texas.gov/report-fraud
- Phone: 1-800-436-6184

To Contact the Inspector General

- Email: OIGCommunications@hhsc.state.tx.us
- Mail: Texas Health and Human Services Commission
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                  P.O. Box 85200
                  Austin, Texas 78708-5200
- Phone: (512) 491-2000