

Part IV. Delivery**Chapter 13:
Administration****Federal Oversight**

While states are responsible for the hands-on operation of Medicaid, the federal government plays a very active oversight role. The Centers for Medicare & Medicaid Services (CMS), an agency within the U.S. Department of Health and Human Services (HHS), oversees the Medicaid program. CMS approves the Medicaid state plan that each state creates. The Medicaid state plan is a dynamic document that functions as a state's contract with CMS. The state plan documents the specific services, eligible populations, and payment methodologies that comprise the Texas Medicaid program. Significant changes to a state's Medicaid program require the state to submit a state plan amendment for CMS approval. CMS also approves any waivers for which states can apply. Medicaid waivers allow states the flexibility to test new ways to deliver and pay for health care services.

Single State Agency

Federal Medicaid regulations require that each state designate a single state agency responsible

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for the state's Medicaid program. The Health and Human Services Commission (HHSC) has been the single state agency for the Texas Medicaid program since January 1993. S.B. 200, 84th Legislature, Regular Session, 2015, required the transformation of the HHS system in Texas based on recommendations made by the Sunset Commission's review of the five HHS agencies. As a result, the majority of Medicaid functions are now consolidated within HHSC's newly created Medical and Social Services (MSS) Division. The Associate Commissioner of the Medicaid & CHIP Services (MCS) Department, who also serves as the State Medicaid Director, now reports to the Deputy Executive Commissioner of MSS.

As the single state agency, HHSC's Medicaid responsibilities include:

- Serving as the primary point of contact with the federal government;
- Establishing policy direction for the Medicaid program;
- Administering the Medicaid state plan and waivers;
- Overseeing managed care organization (MCO) contract compliance;
- Coordinating with other HHS departments and state agencies to carry out Medicaid operations;
- Operating the state's fee-for-service (FFS), pharmacy, 1115 Transformation Waiver, and managed care programs;
- Determining Medicaid eligibility;
- Establishing Medicaid policies, rules, reimbursement rates, and oversight of Medicaid program operations;
- Organizing and coordinating initiatives to maximize federal funding; and
- Administering the Medical Care Advisory Committee, a committee mandated by federal Medicaid law that reviews and makes recommendations on proposed Medicaid rules.

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Transformation

Prior to S.B. 200, H.B. 2292, 78th Legislature, Regular Session, 2003, directed the consolidation of 12 HHS agencies into five. In the ensuing

10 years, the HHS agencies worked to provide services under this streamlined model. When the Sunset Commission began its almost two-year analysis in 2013, that review was the first formal measure of the previous consolidation. The findings and recommendations of the Sunset review formed the basis for the 84th Legislature's directive to transform today's HHS system. With the passage of S.B. 200, the HHS system was directed to develop a more streamlined, efficient organization that provides services and benefits more effectively.

The goals of HHS transformation are to produce an accountable, organized system that is easier to navigate for Texans seeking information, benefits or services; promote a culture of shared responsibility for success through teamwork, effective communication and support of HHS staff; create clear lines of accountability for decision making; and use data to measure outcomes more clearly.

The creation of the MSS Division was a key transformation initiative. This new division brings all client services together, including Medicaid eligibility determination and service delivery, rather than being spread among the five HHS agencies. On September 1, 2016, client services programs and staff from the Department of Aging and Disability Services (DADS), Department of Assistive and

Rehabilitative Services (DARS), and Department of State Health Services (DSHS) transferred to HHSC's MSS Division. The division has four departments: Access & Eligibility Services; Health, Developmental & Independence Services; Intellectual and Developmental Disabilities & Behavioral Health Services; and MCS.

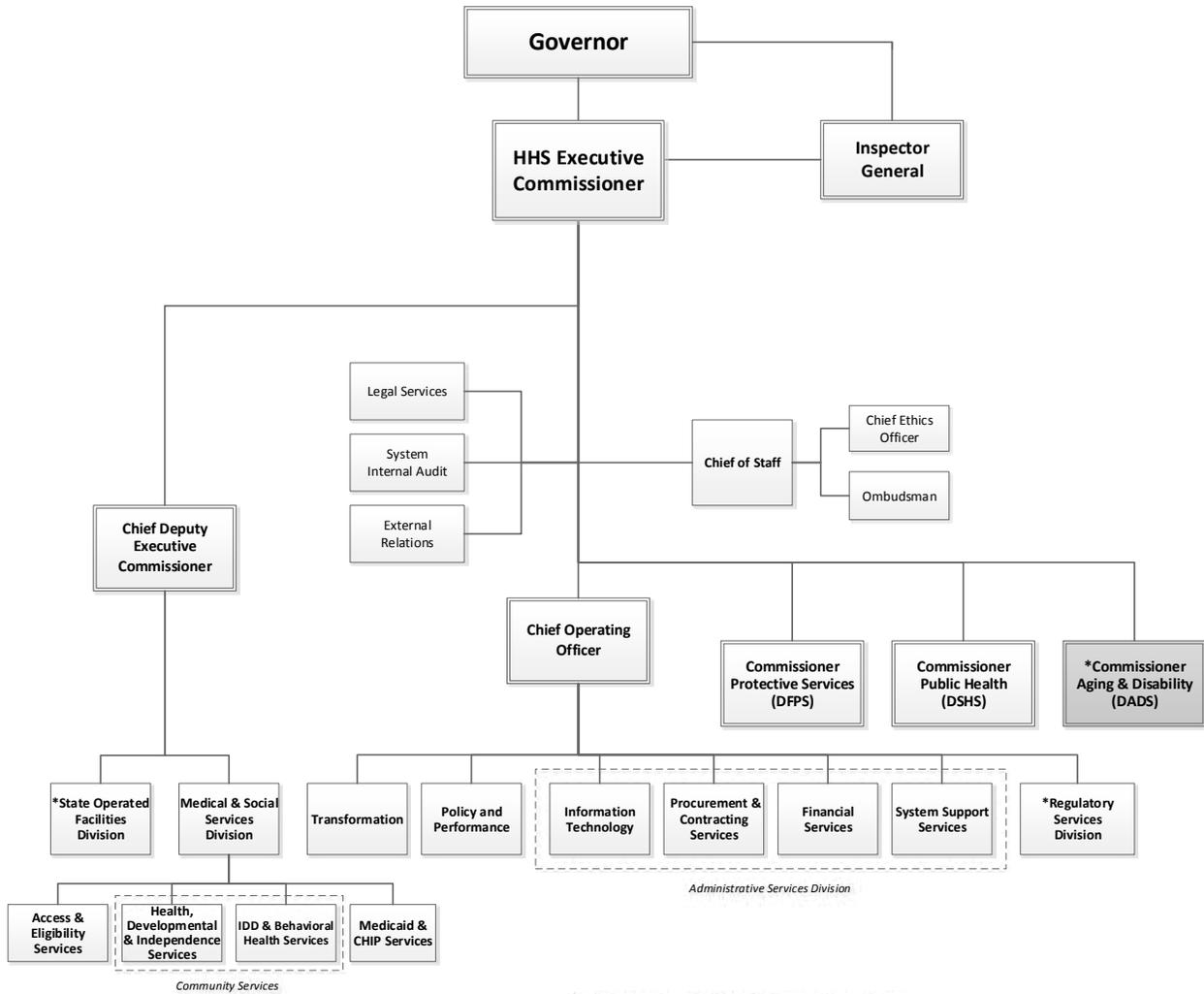
While the initial step in transformation is structural change, actual transformation will come from the improvement of processes and increased coordination across the system. The centralized structure of the MSS Division lays the foundation for better collaboration

and coordination between programs and will make it easier for individuals to locate and access a full array of services.

Figure 13.1 shows the post-transformation structure of HHSC. Within HHSC, **Figure 13.2** shows MSS' organizational structure, including the MCS Department.

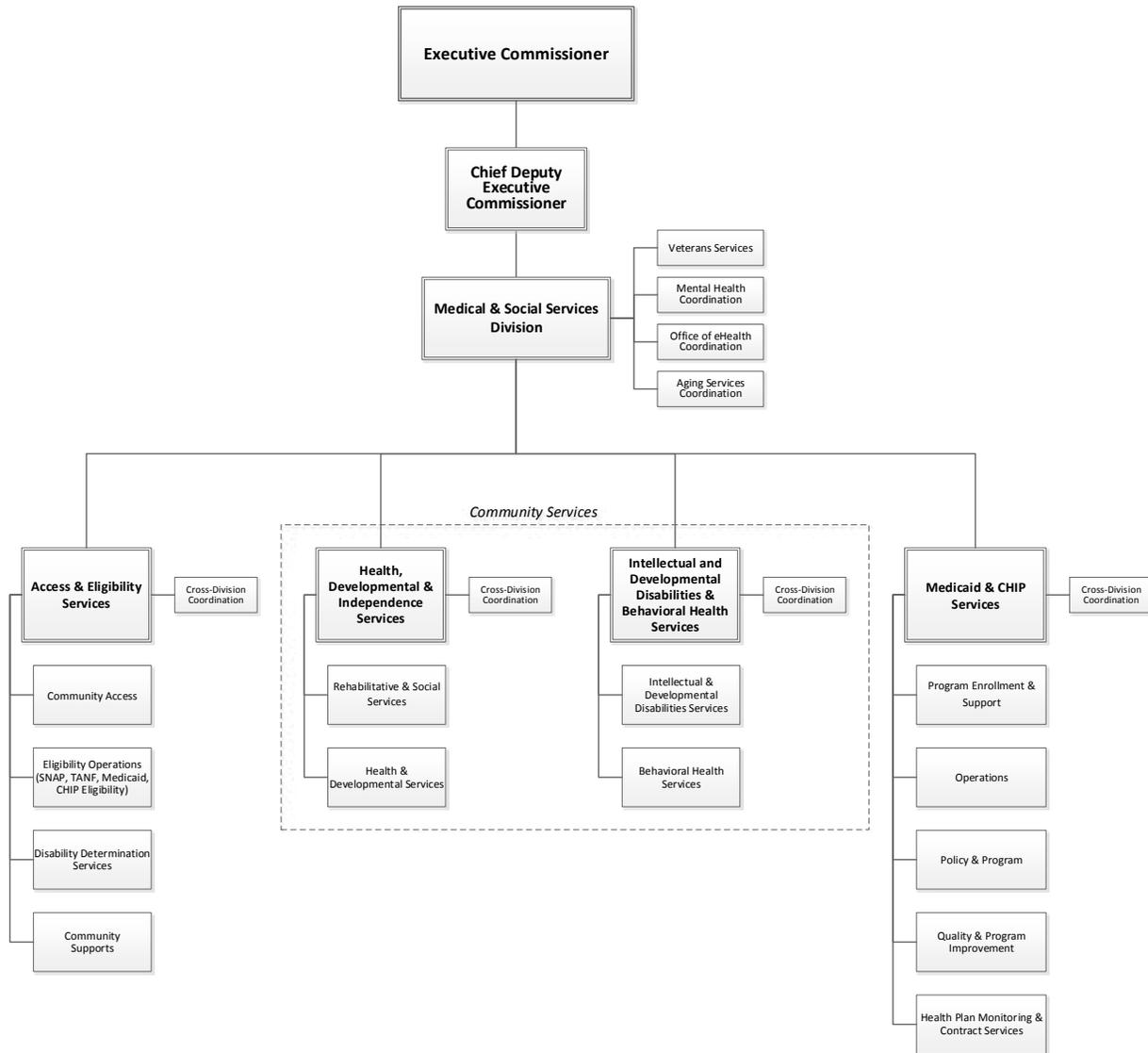
On September 1, 2017, remaining DADS programs (including operation of the state supported living centers (SSLCs)) and all regulatory functions from DADS, DSHS, and the Department of Family and Protective Services will transition to HHSC as part of the second phase of HHS transformation.

Figure 13.1: Health and Human Services Commission Organizational Structure



* On September 1, 2017, DADS ceases to exist and its remaining functions transfer to the Regulatory and State Operated Facilities Divisions.

Figure 13.2: Medical and Social Services Division Organizational Structure



Detecting Fraud and Abuse

In 2003, the 78th Legislature created the HHSC Inspector General (IG) to strengthen HHSC’s authority and ability to combat fraud, waste, and abuse in HHS system programs. The IG’s mission is to prevent, detect, audit, inspect, review, and investigate fraud,

waste, and abuse in the provision and delivery of services through the HHS system and programs in Texas. To fulfill its mandate, the IG establishes performance standards and implements best practices, emphasizes communication, collaboration and coordination with internal and external stakeholders, and adheres to its core values of professionalism, productivity, and

perseverance. The IG's guiding vision is to be the leading state-level IG organization in the country.

The IG is divided into seven divisions: Investigations, Audits, Inspections, Medical Services, Data and Technology, Operations, and Chief Counsel. These units help the IG fulfill its responsibilities by:

- Conducting investigations and making referrals to the appropriate outside agencies for further action;
- Performing risk-based performance and compliance audits involving the use of state and federal funds;
- Carrying out inspections and reviews of HHS programs and systems that provide practical recommendations for improving program efficiency and effectiveness;
- Identifying inappropriate Medicaid billings and recovering overpayments by analyzing Medicaid claims and encounter data, conducting medical policy research and performing utilization review activities;
- Supporting and leveraging cutting edge technological solutions to analyze trends and patterns of behavior and billing to detect fraud, waste, and abuse in HHS programs;
- Providing education, technical assistance, and training to the provider community and fostering

strong relationships with internal and external stakeholders;

- Issuing administrative enforcement measures and sanctions, and instituting and monitoring corrective actions against providers, contractors, and clients; and
- Recommending new policies and changes to existing policies to strengthen systems and processes that will enhance the prevention and detection of fraud, waste, and abuse.

The IG conducts criminal history background checks for existing providers and all new providers seeking to enroll in the Medicaid and Children with Special Health Care Needs programs through Texas' claims administrator, Texas Medicaid & Healthcare Partnership.

The IG continues to identify new and innovative ways to fulfill and further its mission accomplishment. To do so, the IG:

- Implemented new provider integrity initiatives required under the Affordable Care Act (ACA), including enhanced provider screening requirements;
- Adopted new rules implementing S.B. 200 and S.B. 207, 84th Legislature, Regular Session, 2015, that strengthen provider due process procedures, establish investigations timelines, and refine the extrapolation process;

- Created the IG Integrity Initiative, a voluntary collaboration between the IG, MCOs, and Medicaid providers, to strengthen collective efforts to improve the integrity of the Texas Medicaid program;
- Created the Medical Services Division to consolidate and focus clinical resources within the IG, including the Medical and Dental directors, nurses, and all clinical staff, in supporting investigations, audits, inspections, and reviews, and the rapid response to mission-critical needs;
- Expanded state hospital and SSLC criminal abuse, neglect, and exploitation investigations;
- Established an Inspections Division to conduct inspections and reviews of HHS programs, providers, and contractors, as required by the IG's enabling legislation; and
- Created a Data and Technology Division to centralize data analysis and intelligence activities to efficiently and effectively identify fraud, waste, and abuse trends in the delivery of health and human services. The new division leverages data from many sources to develop potential areas for investigation, audit, or inspection.

The IG continues to assess and enhance policies and procedures, and streamline its integrated fraud and abuse prevention and detection functions.

Affordable Care Act Program Integrity Initiatives

The ACA established new provider screening and enrollment requirements for providers and suppliers enrolling in Medicare, Medicaid, and CHIP effective March 2011. Newly enrolling providers are subject to the new provider screening requirements. Texas Medicaid began re-screening existing providers in January 2013.

Pursuant to federal law, states must implement the following changes to provider screening and enrollment requirements. The federal regulations allow states to rely on Medicare screening or screening in another state to ensure a provider has met the federal requirements.

Screening Categories

Providers enrolling in Medicaid or CHIP are subject to federal- and state-defined screening requirements. All applications, including applications for new practice locations, re-enrollment, or revalidation, are subject to the highest level of screening by federal- and state-defined risk categories: limited, moderate, or high. HHSC established risk categories for provider types that are not federally-defined and adjusted federal risk categories for provider(s) who pose increased risk of fraud in Medicaid

based on history of waste, fraud, or abuse.

Database Checks

Providers and any persons with five percent or greater direct or indirect ownership or controlling interest or who are agents or managing employees of the provider, shall be subject to routine federal and state database checks at a described frequency on an on-going basis. Database checks shall be used to confirm, identify and determine exclusion status through routine checks of federal databases.

Licensure Verification

Verification of provider licensure in accordance with any state laws and confirmation of licensure status (e.g., active or expired) and current licensure limitation is required. Verification must occur at federal- and state-defined intervals.

Site Visits

Moderate and high-risk providers must submit to an on-site pre- and post-enrollment visit conducted by federal agencies or a state Medicaid agency or its designee. A site visit consists of announced or unannounced on-site inspections of any and all provider locations to verify the accuracy of the information submitted on an enrollment application and determine

compliance with federal and state laws.

Criminal Background Checks

Providers must consent to criminal background checks, including fingerprinting, when required to do so under state law or if they are designated as high-risk providers under the new enrollment provisions. For providers designated as high-risk, each provider or persons with five percent or greater direct or indirect ownership interest in the provider will be subject to the federally-required criminal background check and subject to submitting to fingerprinting within 30 days of a request by federal agencies or HHSC in addition to complying with existing state laws.

Application Fee

Providers enrolling in Medicaid or CHIP, with the exception of physicians and non-physician practitioners (including physician and non-physician practitioner groups), must submit an application fee for enrollment prior to the state executing a provider agreement.

An application fee is required for:

- Newly enrolling providers;
- A new practice location;
- Re-enrollment; and
- Revalidation.

An application fee may be waived if the fee has been collected by Medicare, Medicaid (in the case of CHIP providers), or another state's Medicaid or CHIP program. In cases in which Medicare has granted a provider an exception to the application fee, an application fee will not subsequently be required in Medicaid or CHIP as the state may rely on Medicare for Medicaid or CHIP enrollment.

The application fee is non-refundable with the exception of applications denied prior to initiation of the screening process or if an application is subsequently denied as a result of an imposed temporary moratorium on enrollment.

Enrollment Revalidation

Revalidation and screening of all providers must occur at least every five years. Revalidations will consist of a full enrollment screening, including site visits and criminal background checks as required by designated risk categories.

National Provider Identifier (NPI)

All providers must submit their National Provider Identifier (NPI) for Medicaid enrollment and claims payment.

Enrollment Denial or Termination

Provider enrollment will be denied or terminated when any person with five percent or greater direct or indirect ownership or controlling interest in the provider has:

- Been convicted of a criminal offense related to Medicare, Medicaid, or CHIP in the past 10 years;
- Been terminated from any Medicare, Medicaid, or CHIP program on or after January 1, 2011;
- Failed to submit fingerprints in a manner designated by the Medicaid agency within 30 days of a federal or state Medicaid agency's request;
- Failed to permit access to provider locations for any site visits;
- Failed to cooperate with any of the required screening methods under law; or
- Failed to submit accurate or timely information as a provider, a person with five percent or greater direct or indirect ownership or controlling interest, an agent, or a managing employee of the provider.

Providers may appeal a termination or enrollment denial adhering to procedures established under state law and regulations.

Ordering, Referring or Prescribing Providers

All providers ordering, referring, or prescribing Medicaid services under the state plan or a waiver must be enrolled as a participating provider. Verification of ordering, referring, and prescribing provider status is required.

Additionally, the NPI of the provider who ordered, referred, or prescribed an item or service is required for claims payment.

An abbreviated enrollment process is used for providers who enroll for the sole purpose of ordering, referring, or prescribing services.

a determination by HHSC that the moratoria would not adversely affect beneficiaries' access to medical assistance and notification to the Secretary of HHS in writing. Moratoria are limited to six months and may be extended in six-month increments with Secretary of HHS approval.

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Temporary Moratoria

Pursuant to federal law, with concurrence from the U.S. Secretary of HHS, HHSC may impose:

- Temporary moratoria on enrollment of new providers;
- Numerical caps on enrollment; and
- Other enrollment limitations identified by the state and the Secretary of HHS for providers identified as being at high risk for fraud, waste, and abuse, if the limitations do not adversely affect beneficiaries' access to care.

Moratoria may be imposed for providers determined by the Secretary of HHS as posing an increased risk to Medicaid following