TEXAS Health and Human Services

UNIFORM MANAGED CARE MANUAL
5.5.1 Deliverables to the Office of Inspector General

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	2.0	March 1, 2019	Initial version Uniform Managed Care Manual Chapter 5.5.2 Deliverables to the Office of the Inspector General Chapter 5.5.2 applies to contracts issued as a result of HHSC RFP -0293, 529-08-0001, 529-10-0020, 529-12- 0002, and 529-13-0042.numbers 529-06
Revision	2.1	April 26, 2019	Chapter 5.5.2 has changed to Chapter 5.5.1 to improve organization and ease of use for OIG chapters.
Revision	2.2	May 30, 2022	Section IV of Chapter 5.5.1 has changed to clarify the MCOs/DMOs referral process.
Revision	2.3	September 1, 2023	Section I of Chapter 5.5.1 has been changed to include MMP-Medicaid and Dental Maintenance Contractors. Section II (5) of Chapter 5.5.1 has been changed to replace “Annual Report on Certain Fraud and Abuse Recoveries” with “MCO Overpayment Recoveries Report.” Section IV (5) of Chapter 5.5.1 has been changed to provide the requirements for the MCO Overpayment Recoveries Report
Revision	2.4	September 5, 2023	Administrative Change – Updated page numbers to correct format.
Revision	2.5	June 1, 2024	Section IV (5) of Chapter 5.5.1 has been changed to delete “Annual Report on Certain Fraud and Abuse Recoveries.” Section IV (5) of Chapter 5.5.1 has been changed to revise the requirements for the MCO Overpayment Recoveries Report. Section IV (7) of Chapter 5.5.1 has been added to provide the requirements for the Annual Report on Certain Fraud and Abuse Recoveries.

[1] Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.

[2] Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.

[3] Brief description of the changes to the document made in the revision.

I. Applicability of Chapter 5.5.1

This chapter applies to Managed Care Organizations (MCOs) participating in STAR, STAR+PLUS, Medicare-Medicaid Demonstration (MMP), Children's Health Insurance Program (CHIP), the STAR Kids and STAR Health Programs, and Dental Contractors providing Texas Medicaid and CHIP Dental Services. In this chapter, references to "CHIP" or the "CHIP Managed Care Program(s)" apply to the CHIP MCOs and CHIP Dental Contractors. References to "Medicaid" or the "Medicaid Managed Care Program(s)" apply to the STAR, STAR+PLUS, STAR Kids, and STAR Health Programs, and the Medicaid Dental Contractors. For purposes of this Chapter, the term "MCO" includes health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers, Dental Contractors, MMPs, and any other entities licensed or approved by the Texas Department of Insurance. For purposes of this chapter, the term "MCO" also includes the MCO's Subcontractors. The requirements in this chapter apply to all Programs listed in this section, except where noted.

II. Purpose

This Chapter provides guidance for submitting select deliverables to the Office of Inspector General (OIG). The deliverables in this chapter relate to:

1. Fraudulent Practices Referrals
2. Fraud, Waste, and Abuse Compliance Plan
3. Open Case List Report
4. Annual Lock-In Actions Report
5. MCO Overpayment Recoveries Report
6. Pre-payment Review Monthly Report
7. Annual Report on Certain Fraud and Abuse Recoveries.

III. General Information

The HHSC OIG may amend guidance at any time and distribute changes to the MCO. The HHSC OIG will review any concerns or comments the MCO submits in writing to the HHSC OIG. Throughout this chapter, FWA refers to Fraud, Waste, and Abuse.

IV. Reports

1. **Fraudulent Practices Referrals (also known as the WAFERS report)**

The MCO's assigned officer or director must report and refer all possible acts of FWA to the HHSC OIG. All reports and referrals of possible acts of FWA, with the exception of

an expedited referral, must include all items related to the referral as listed in 1 Tex. Admin. Code § 353.502(c)(5)(D):

The report must be submitted through the HHSC OIG Waste, Abuse, Fraud Electronic Reporting System (WAFERS). A referral must include no more than one National Provider Identifier (NPI) per referral. Any NPI for which a list of claims and associated overpayments, or possible acts of FWA, that are identified by the MCO investigation must be contained in its own individual referral. Known affiliations, including affiliated NPIs, must also be documented in the referral.

Deliverable Timing

WAFERS referrals must be submitted within 30 working days of receiving the reports of possible acts of fraud, waste, or abuse from the Special Investigation Unit (SIU).

References

1. 1 Tex. Admin. Code § 353.502(c)(5)(D)
2. UMCC Section 8.1.20.2(c)

2. Fraud, Waste, and Abuse Compliance Plan

MCO must develop a plan to prevent and reduce FWA pursuant to title 42 of the Code of Federal Regulations (C.F.R.), 1 Tex. Admin. Code §§ 353.501 (Medicaid) and § 370.502 (CHIP) and other references as noted below. The plan must be submitted annually within 90 days prior to the start of the State Fiscal Year (SFY) to the HHSC OIG for approval each year the MCO is enrolled with the State of Texas.

The plan must address how the MCO will comply with state and federal program integrity requirements. If the initial plan to prevent and reduce FWA is not approved, the MCO must resubmit the plan to HHSC OIG within 15 working days of receiving the denial letter, which will explain the deficiencies.

MCO must submit the Annual Lock-In Actions with this plan demonstrating how the MCO complies with the "HHSC OIG Lock-In Program Policies and Procedure" requirement.

The plan must be submitted in the format specified by the HHSC OIG.

Deliverable Timing

Fraud, Waste, and Abuse Compliance Plans are due 90 days prior to the start

of the SFY. MCOs must submit one Compliance Plan per MCO. The HHSC OIG will send out an email prior to the due date with detailed instructions on where to submit.

References

1. 42 C.F.R. §§ 438.608(a), 455.20, and 455.23
2. Tex. Gov't Code § 531.113(b)
3. 1 Tex. Admin. Code § 353.502
4. 1 Tex. Admin. Code § 370.502
5. UMCC Section 8.1.19(2) – applies to all managed care contracts

3. Open Case List Report (further described in UMCM Chapter 5.5.2)

On a monthly basis, MCOs must submit to the HHSC OIG a report of all Medicaid FWA investigations opened by their MCO-SIU and the status of each investigation. The report must contain the elements required in 1 Tex. Admin Code § 353.502(d) and will be in the format specified by the HHSC OIG.

Deliverable Timing

Monthly reports are due on the first business day following the 14th day of the month and will include investigations opened in the previous month. For example, investigations opened in January will be reported on the first business day following the 14th of February.

References

1. 1 Tex. Admin Code § 353.502(d)
2. UMCM Chapter 5.5.2 includes information about the format for the MCO Open Case List Report which is an XML schema data file.

4. Annual Lock-In Actions Report

Medicaid MCOs must provide documentation demonstrating how it will comply with the "HHSC OIG Lock-in Program MCO Policies and Procedures."

Deliverable Timing

Lock-In Policies and Procedures are due 90 days prior to the start of the state fiscal year along with the Fraud, Waste, and Abuse Compliance Plan. MCOs must submit one report per MCO.

References

1. UMCC Section 8.1.19.7 Lock-In Actions - applies to all Medicaid managed

care contracts with the exception of the Dental Services for Texas Children's Medicaid and CHIP contracts.

2. 1 Tex. Admin. Code Chapter 354, Subchapter K 3. 42 C.F.R. §431.54(e)

5. MCO Overpayment Recoveries Report

The MCO Overpayment Recoveries Report adheres to Centers for Medicare and Medicaid Services (CMS) regulation 42 CFR § 438.608(d)(3). 42 CFR § 438.608(d)(3) requires MCOs to report their recoveries of overpayments to the state annually. "Overpayment" means any payment made to a Network Provider by a MCO, PIHP, or PAHP to which the Network Provider is not entitled to under Title XIX or Title XXI of the Social Security Act or any payment to a MCO, PIHP, or PAHP by HHSC to which the MCO, PIHP, or PAHP is not entitled to under Title XIX or Title XXI of the Social Security Act. For purposes of this Chapter, "Network Provider" means any provider, group of providers, or entity that has a network provider agreement with a MCO, PIHP, or PAHP, and receives Medicaid or CHIP funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO, PIHP, or PAHP; or a Subcontractor. For purposes of Section IV, 5. MCO Overpayment Recoveries Report, MCOs must also report overpayment amounts collected from non-participating providers. A Network Provider is not a Subcontractor by virtue of the Network Provider agreement.

General Information

The MCO Overpayment Recoveries Reports will be used to report MCO overpayment recoveries to CMS as part of the state's managed care program annual report (42 C.F.R. § 438.66(e)).

Overpayment recoveries are overpayment amounts collected as a result of MCO action or monitoring including, but not limited to: (1) SIU investigations; (2) HHSC OIG investigation referrals; (3) MCO audits; (4) MCO utilization reviews; (5) MCO post-payment review of claims; (6) MCO post-payment review of payments to Subcontractors; or (7) Network Provider, non-participating provider, or Subcontractor notification to MCO of an overpayment.

For each SFY, MCOs must report annually all overpayment recovery amounts collected by the MCO, unless the recovery is explicitly excluded from reporting requirements by this chapter. Recovery amounts collected, or any portion thereof, must be reported in the month and SFY in which they were collected.

MCOs must submit data in the format and with the information specified by the HHSC OIG.

Information must include:

- The amount of Overpayment recoveries collected from a Network Provider, non-participating provider or Subcontractor.
- Overpayment recoveries include those from all sources and fact patterns, such as:
  (1) Services that did not occur.
  (2) Services for which documentation was insufficient to support the services billed.
  (3) Duplicate services.
  (4) Services reimbursed at a rate higher than the agreed upon/contracted rate.
  (5) Claim processing errors.
  (6) Network Provider, non-participating provider or Subcontractor billing errors.
  (7) Services that were not medically necessary.
  (8) Coding errors.
  (9) Coding errors in accordance with CMS' National Correct Coding Initiative.
  (10) Improper or incorrect payment for items or services furnished, or administrative services rendered.
  (11) Recoveries made as a reduction of a payment to a Network Provider, non-participating provider or Subcontractor (e.g., claims adjustments or claim offsets, reduced payment to Subcontractor.)
  (12) Recoveries collected by the SIU or contractor under Tex. Gov't. Code § 531.113(a)(2), including those related to cases returned by the HHSC OIG that the OIG did not investigate.
  (13) The full amount of Overpayment recoveries collected by any contractor and vendor.
  (14) Recoveries from settlements that were not captured through claims adjustments in the claims processing system.
  (15) Recoveries of capitation and sub-capitation amounts from a Network Provider, non-participating provider or Subcontractor.
  (16) Amounts required to be recouped from a Network Provider by an MCO following removal of the Network Provider from a

Directed Payment Program for failure to meet any conditions of participation.

(17) The amount of Overpayment recoveries collected from Network Providers that were received under a Directed Payment Program and are not required to be excluded from reporting by this chapter.

The MCO must exclude the following type of information from this report:

- Recoveries from cases where the HHSC OIG investigated and recovered, in which no portion of the recovery was shared with the MCO.
- Recoveries from cases where the HHSC OIG investigated and recovered, in which a portion of the recovery was shared with the MCO.
- Third Party Liability recoveries.
- Reinsurance recoveries.
- Liquidated damages.
- Amounts attributed/categorized as cost savings or pre-payment review, as that is not recovered money but rather money saved (never paid out).
- Amounts required to be recouped from one or more Network Providers and redistributed to one or more other Network Providers by an MCO following a reconciliation of payments made under a Directed Payment Program, if the payments were based on an interim allocation of funds based on historical Medicaid clients served or historical Medicaid utilization.

Deliverable Timing

The MCO must submit the MCO Overpayment Recoveries Report annually for each SFY, in the format and timeframe specified by the HHSC OIG. MCO must submit the report electronically to the HHSC OIG via TexConnect no later than December 2, 2024 for SFY 2024 and no later than November 1st following the end of each SFY, beginning with SFY 2025 Should November 1st fall on a weekend, the report will be due on the Business Day prior to the 1st.

References

1. 42 C.F.R. § 438.608(d)(3)
2. 42 C.F.R. § 438.2
3. 42 C.F.R. § 438.66(e)

4. Medicaid and CHIP Managed Care Services RFP, Uniform Managed Care Contract Terms and Conditions, Attachment A, Article 2. Definitions.
5. Uniform Managed Care Contract Section 8.1.19.5 (6)
6. CHIP Rural Service Area Managed Care Services Contract Section 8.1.19.5 (6)
7. Dental Services for Texas Children's Medicaid and the Children's Health Insurance Program Contract Attachment B Section 2.3.31.6 (5)
8. STAR+PLUS Dallas and Tarrant Service Areas Managed Care Services Contract Section 8.1.19.5 (6)
9. STAR+PLUS Medicaid Rural Service Area Managed Care Services Contract Section 8.1.21.5 (6)
10. STAR Health Managed Care Services Contract Section Exhibit B Section 2.6.29.5
11. STAR Kids Managed Care Services Contract Section 8.1.21.5 (6)

6. Pre-payment Review Monthly Report

When notified by the HHSC OIG, the MCOs must place a provider on pre-payment review and cease payment of claims submissions that have not been reviewed. The HHSC OIG notification letter will include the following information:

a. A copy of the notification letter from HHSC OIG to the provider,
b. A memo with specific instructions for the pre-payment review, including the effective date, procedure codes to be reviewed, and instructions to forward all correspondence between the MCO and the provider regarding the pre-payment review to HHSC OIG, and
c. A template to use when preparing the Pre-payment Review Monthly Report for submission.

Within 10 business days of the implementation date identified by HHSC OIG, the MCOs must conduct pre-payment reviews of identified providers before payment of claims submissions. The MCOs will use their internal policies for pre-payment review.

MCOs with providers on pre-payment review as directed by HHSC OIG must submit the Pre-payment Review Monthly Report.

Deliverable Timing

MCOs must provide to the HHSC OIG the Pre-payment Review Monthly Report on a monthly basis for providers for whom HHSC OIG-directed pre-payment review has been implemented. Monthly reports are due on the first business day following the 6th day of the month. For example, MCOs will submit a report in February covering all providers placed on pre-payment review with claims subject to that review submitted in January.

Reference

1. 1 Tex. Admin. Code § 371.1701
2. UMCC Section 8.1.19(3)

7. Annual Report on Certain Fraud and Abuse Recoveries

MCOs are required to recover overpayments subject to 1 T.A.C. §353.505. Pursuant to Government Code §531.1132, the HHSC OIG is required to submit information on MCO fraud and abuse recoveries as a result of investigations and recovery efforts by the SIUs to the legislature on an annual basis.

General Information

MCOs must submit data in the format and with the information specified by the HHSC OIG.

Information must include:

- Recoveries by the SIU, including cases returned by the HHSC OIG that were not investigated.
- Money recouped from your SIU recovery efforts, not from cases where the HHSC OIG investigated and recovered overpayments.

The MCO must exclude the following type of information from this report:

- Any recoveries that take place due to normal routine utilization review activities conducted outside of the scope of SIU work. If, during the course of normal routine utilization review activities, an MCO identifies possible acts of FWA, the SIU is responsible for investigating and referring those acts to the HHSC OIG and the Texas Office of the Attorney General's Medicaid Fraud Control Unit as appropriate pursuant to 1 T.A.C. §353.502.
- Amounts attributed/categorized as cost savings or pre-payment review, as that is not recovered money but rather money saved (never paid out).

Deliverable Timing

MCOs must submit the data to the HHSC OIG no later than the second Friday in October of each year.

References

1. Tex. Government Code §531.1132
2. Uniform Managed Care Contract Section 8.1.19.5 (6)
3. CHIP Rural Service Area Managed Care Services Contract Section 8.1.19.5 (6)
4. Dental Services for Texas Children's Medicaid and the Children's Health Insurance Program Contract Attachment B Section 2.3.31.6 (5)
5. STAR+PLUS Dallas and Tarrant Service Areas Managed Care Services Contract Section 8.1.19.5 (6)
6. STAR+PLUS Medicaid Rural Service Area Managed Care Services Contract Section 8.1.21.5 (6)
7. STAR Health Managed Care Services Contract Section Exhibit B Section 2.6.29.5
8. STAR Kids Managed Care Services Contract Section 8.1.21.5 (6)