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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.

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represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.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, STAR Kids, STAR Health, and CHIP. In this chapter, references to “CHIP” or the “CHIP Managed Care Program(s)” apply to the Children’s Health Insurance Program. References to “Medicaid” or the “Medicaid Managed Care Program(s)” apply to the STAR, STAR+PLUS, STAR Kids, and STAR Health, Programs. For purposes of this Chapter, the term “MCO” includes health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers, and any other entities licensed or approved by the Texas Department of Insurance. The requirements in this chapter apply to all Programs listed in this section, except where noted.

The term MCO in this chapter is used to refer to both managed care organizations and dental maintenance organizations.

II. Purpose

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



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

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. (T.A.C.) §353.502(5)(D):

The report must be submitted through the HHSC OIG Waste, Abuse, Fraud Electronic Reporting System (WAFERS).

Deliverable Timing

WAFER referrals must be submitted within 30 working days of receiving the reports of possible acts of waste, abuse, or fraud from the SIU.

References

1. 1 T.A.C. §353.502(5)(D)
2. UMCC section 8.1.20(c)



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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 T.A.C. §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 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 state fiscal year. 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. Government Code 531.113(b)
3. 1 T.A.C. §353.502
4. 1 T.A.C. §370.502
5. UMCC section 8.1.19(2) - applies to all Medicaid 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 T.A.C. §353.502(d) and will be in the format specified by the HHSC OIG.



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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 T.A.C. §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 8.1.19.6 Lock-In Actions - applies to all Medicaid managed care contracts
2. 1 T.A.C. Chapter 354, Subchapter K
3. 42 C.F.R. §431.54(e)

5. 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 recoveries as a result of investigations and recovery efforts by the SIUs to the legislature on an annual basis.

General Information



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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 MFCU 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

HHSC OIG will request data from the MCOs due on the second Friday in October of each year.

Reference

1. Tex. Government Code §531.1132
2. Medicaid and CHIP Managed Care Services Contract Section 8.1.19.5 (6)
3. CHIP Rural Service Area Managed Care Services Contract Section 8.1.19.5 (6)
4. Dental Managed Care Services Contract Section 8.1.13.5 (6)
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 8.1.25.5 (6)
8. STAR Kids Managed Care Services Contract Section 8.1.21.5 (6)



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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 copy of the notification letter from HHSC OIG to the provider,
- 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
- 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 T.A.C. §371.1701
2. UMCC section 8.1.19(3)