TITLE 1 ADMINISTRATION

PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 353 MEDICAID MANAGED CARE

SUBCHAPTER F SPECIAL INVESTIGATIVE UNITS

§353.502. Managed Care Organization's Plans and Responsibilities in Preventing and Reducing Waste, Abuse, and Fraud.

(a) - (b) (No change.)

(c) The plan submitted to the HHSC-OIG must include the following information to be considered for approval.

 (1) (No change.)

 (2) A description of the MCO's procedures for investigating possible acts of waste, abuse, and fraud by providers. The procedures must satisfy the requirements in subparagraphs (A) - (C) of this paragraph.

 (A) - (B) (No change.)

 (C) If it is determined that suspicious indicators of possible waste, abuse, or fraud exist, within 15 working days from the conclusion of subparagraphs (A) and (B) of this paragraph, the MCO must select a minimum of 30 [~~sample for further review. The sample must consist of a minimum of 50~~] recipients or 15% of a provider's claims related to the suspected waste, abuse, and fraud; provided, however, that if the MCO selects [~~a sample based upon~~] 15% of the claims, the MCO [~~sample~~] must include claims relating to at least 30 [~~50~~] recipients. The MCO may confirm the suspicious indicators of fraud, waste, and abuse with a review of fewer recipients or claims, provided that the MCO submits a written justification for the decision to substantiate the waste, abuse, or fraud with fewer recipients or claims. The justification will be subject to review and approval by the OIG, who may require the MCO to provide further information. If the MCO selects the recipients or claims for review, the MCO must:

 (i) within 15 working days of the selection of the recipients or claims for review [~~sample~~], request medical or dental records and encounter data [~~for the sample recipients~~]; and must

 (ii) (No change.)

 (3) - (4) (No change.)

 (5) A description of the MCO's internal procedures for referring possible acts of waste, abuse, or fraud to the MCO's Special Investigative Unit (SIU) and the mandatory reporting of possible acts of waste, abuse, or fraud by providers or recipients to the HHSC-OIG. The procedures must satisfy the requirements in subparagraphs (A) - (E) of this paragraph.

 (A) - (C) (No change.)

 (D) Within 30 working days of receiving reports of possible acts of waste, abuse, or fraud from the SIU [~~Utilizing the HHSC-OIG fraud referral form~~], the assigned officer or director must notify [~~report~~] and refer all possible acts of waste, abuse or fraud to the HHSC-OIG [~~within 30 working days of receiving the reports of possible acts of waste, abuse or fraud from the SIU. The report and referral must include an investigative report identifying the allegation, statutes/regulations violated or considered, and the results of the investigation; copies of program rules and regulations violated for the time period in question; the estimated overpayment identified; a summary of interviews conducted; the encounter data submitted by the provider for the time period in question; and all supporting documentation obtained as the result of the investigation.~~] All [~~This requirement applies to all~~] reports and referrals of possible acts of waste, abuse, and fraud, with the exception of an expedited referral, must include the following information:[~~.~~]

 (i) the provider's enrollment/credentialing documents;

 (ii) the complete SIU investigative file on the provider, which must include:

 (I) an investigative report identifying the allegation, statutes/regulations/rules violated or considered, and the results of the investigation;

 (II) the estimated overpayment identified;

 (III) a summary of interviews conducted; and

 (IV) a list of all claims and associated overpayments identified by the preliminary investigation;

 (iii) all past investigations of the provider conducted by the MCO or the MCO’s SIU. The MCO shall provide the complete investigative files or any other information regarding those past investigations to the HHSC-OIG investigator upon request;

 (iv) copies of HHSC program and MCO policy, contract, and other requirements, as well as statutes/regulations/rules alleged to be violated for the time period in question;

 (v) all education letters (including education documents) and/or recoupment letters issued to the provider by the MCO or the MCO’s SIU at any time;

 (vi) all medical records related to the reviewed claims;

 (vii) all clinical review reports/summaries generated by the MCO;

 (viii) any and all correspondence and/or communications between the MCO, the MCO’s subcontractors, and any of their employees, contractors, or agents, and the provider related to the investigation. This should include but not be limited to agents, servants and employees of the MCO. This means there could be MCO employees or MCO subcontractors that are not part of the SIU who had communication with the provider; and

 (ix) copies of all settlement agreements between the MCO and its contractors and the provider.

 (E) (No change.)

 (6) - (9) (No change.)

(d) - (g) (No change.)

§353.505. Recovery of Funds.

(a) If a managed care organization (MCO) discovers [~~suspects~~] fraud or abuse has occurred in the Medicaid or CHIP program, based on information, data, or facts obtained by the MCO, it must:

 (1) immediately notify the Health and Human Services Commission-Office of Inspector General (HHSC-OIG) and the Office of the Attorney General (OAG) through a referral as described in §353.502 of this subchapter (relating to Managed Care Organization’s Plans and Responsibilities in Preventing and Reducing Waste, Abuse, and Fraud), as amended, that includes a detailed description of the fraud or abuse and each payment made to a provider as a result of the fraud or abuse;

 (2) subject to subsection (b) of this section, begin payment recovery efforts [~~following the completion of ordinary due diligence regarding a suspected overpayment as described in this subchapter, begin payment recovery efforts except as provided in subsection (b) of this section~~]; and

 (3) ensure that any payment recovery efforts in which the MCO engages are in accordance with this subchapter.

(b) If the amount sought to be recovered under subsection (a)(2) of this section exceeds $100,000, the MCO may not engage in payment recovery efforts if, not later than the 10th business day after the date the MCO notified HHSC-OIG and the OAG under subsection (a)(1) of this section, the MCO receives a notice from either office indicating that the MCO is not authorized to proceed with recovery efforts. [~~If the amount to be recovered exceeds $100,000, the MCO may not engage in payment recovery efforts if the MCO receives notice from the HHSC-OIG or the OAG indicating that the MCO is not authorized to proceed with recovery effort. Such notice must be supplied no later than the tenth business day after the MCO notifies the HHSC-OIG and OAG of the suspected fraud or abuse.~~]

[~~(c) If the HHSC-OIG or the OAG has assumed responsibility for completion of the investigation and final disposition of any administrative, civil, or criminal action taken by the state or federal government, the HHSC-OIG or the OAG will determine and direct the collection of any overpayment.~~]

(c) [~~(d)~~] To the extent allowed by federal law, an [~~An~~] MCO may retain one-half of any money recovered under subsection (a)(2) of this section by the MCO [~~by the MCO~~]. The MCO shall remit the remaining money recovered under subsection (a)(2) of this section to the OIG.

(d) [~~(e)~~] If the OIG notifies an MCO under subsection (b) of this section, the OIG proceeds with recovery efforts, and the OIG recovers all or part of the payments the MCO identified as required by subsection (a)(1) of this section, the MCO is entitled to one-half of the amount recovered for each payment the MCO identified after any applicable federal share is deducted. The MCO may not receive more than one-half of the total amount of money recovered after any applicable federal share is deducted. [~~The HHSC-OIG will distribute any amounts collected to the MCO, less any costs of investigation and collection proceedings.~~]

(e) [~~(f)~~] An MCO shall [~~must~~] submit a quarterly report to the HHSC-OIG detailing the amount of money recovered under subsection (a)(2) of this section.

(f) Notwithstanding any provision of this section, if the OIG discovers waste, abuse, or fraud in Medicaid or the child health care program in the performance of its duties, the OIG may recover payments made to a provider as a result of the waste, abuse, or fraud. All payments recovered by the OIG shall be deposited to the credit of the general revenue fund.

(g) The OIG shall coordinate with MCOs to ensure that the OIG and the MCOs do not both begin payment recovery efforts under this rule for the same case of waste, abuse, or fraud.