Fraud, Waste, and Abuse

Office of Inspector General
&
Medicaid and CHIP Services Department

November 2016
Objectives

• Identify state and federal agencies involved in fraud, waste, and abuse (FWA) and pertinent federal regulations.

• Review the FWA referral process.

• Discuss possible consequences of FWA.

• Discuss the importance of identifying and reporting fraud, waste, and abuse.

• Review Managed Care Organization (MCO) responsibilities.
Lesson 1

AGENCIES AND FEDERAL REGULATIONS
Overview

- State and Federal laws require each state’s Medicaid program to prevent, detect, and pursue cases of fraud, waste, and abuse.

- In Texas, the Health and Human Services Commission Inspector General (HHSC-IG) has this responsibility.
State and Federal Medicaid Enforcement Agencies (1)

• Texas Health and Human Services (HHSC)
  • Inspector General (IG)
    https://oig.hhsc.texas.gov/
  • State Exclusions List
    https://oig.hhsc.state.tx.us/oigportal/EXCLUSIONS.aspx

• Texas Office of Attorney General (OAG)
  • Medicaid Fraud Control Unit (MFCU)
    https://www.texasattorneygeneral.gov/cj/medicaid-fraud-control-unit-field-offices
  • Civil Medicaid Fraud (CMF) Division
    https://texasattorneygeneral.gov/cmf/civil-medicaid-fraud
State and Federal Medicaid Enforcement Agencies (2)

- Federal Agencies
  - United States Department of Justice
    https://www.justice.gov/
  - United States Department of Health & Human Services, Office of Inspector General
    https://oig.hhs.gov/

- Federal Exclusions
  https://exclusions.oig.hhs.gov/
  List of Excluded Individuals and Entities (LEIE) Downloadable Databases
  https://oig.hhs.gov/exclusions/exclusions_list.asp
HHSC-IG

- **History**
  - Created by the 78th Legislative Session in 2003
  - Began operation on September 1, 2004

- **Focus on administrative enforcement**
  - Providers
  - Recipients

- **Resources**
  - 761 FTEs (full time employees, not including vacancies)
  - 30 field offices (including Austin)
    - 8 Medicaid Provider Investigations (MPI) field offices
Office of Attorney General: Medicaid Fraud Control Unit (MFCU)

- Focus on criminal enforcement
  - Medicaid fraud by providers
  - Physical abuse and financial exploitation of nursing home residents

- Resources
  - 196 employees
    - Including 18 special prosecutors
  - 9 field offices (including Austin)

- How HHSC-IG and MFCU interact
  - HHSC-IG refers suspected fraud to MFCU
  - May run parallel criminal and administrative investigations
  - Monthly meetings to coordinate cases
Office of Attorney General: Civil Medical Fraud Division (CMF)

- Focus on civil litigation
  - Texas and multistate litigation
  - Often combined with Medicare claims

- Resources
  - 52 employees
    - Including 36 attorneys

- How HHSC-IG and CMF interact
  - Attorney-client relationship
  - CMF represents HHSC
  - Coordination with IG to avoid overlap
Federal Agencies

- U.S. Department of Health & Human Services
  - Centers for Medicare and Medicaid Services (CMS)
    https://www.cms.gov/
  - CMS Medicaid Integrity Program
  - Office of Inspector General

- U.S. Department of Justice
  - Federal Bureau of Investigation (FBI)
    https://www.fbi.gov/
  - United States Attorneys
  - Civil Division
  - Criminal Division
Federal Regulations

• Investigating referrals
  • HHSC-IG must conduct integrity review on every complaint received
    • If warranted, must conduct a full-scale investigation

• Repayment of federal funds
  • Federal law generally requires repayment within one year of the date the provider receives notice of an overpayment
  • Must typically be made whether recovered from provider or not
    • Exceptions to the rule include an out of business or bankrupt provider
Lesson 2
HOW TO IDENTIFY AND REPORT FRAUD, WASTE, AND ABUSE
Fraud, Waste, and Abuse (FWA)

• Fraud
  • Intentional deception or misrepresentation made in order to gain a benefit to which the person or another person is not entitled

• Waste
  • Careless, inefficient, or unnecessary use of public resources, items, or services

• Abuse
  • Any practice inconsistent with sound fiscal, business, or medical practices
  • May result in unnecessary program cost
Why Report FAW (1)

- It cheats everybody
  - FWA activities cost taxpayers and providers
  - Siphons money from patient care
  - Increases state, federal, and managed care oversight and investigative costs

- Hurts Medicaid clients
  - Individuals do not receive medically necessary care
  - Individuals may receive unnecessary and harmful care
Why Report FAW (2)

• Violates the law
  • Results in civil or criminal liability
  • All individuals who knowingly falsify records or claims and anyone who knew or should reasonably have known of FWA activities are responsible

• Recovered Funds
  • Returned to the program providing services
Most Frequent Schemes (1)

• Altered documentation
  • Information is added/deleted from medical and other records to obtain a higher reimbursement rate
    • Includes false information to secure unauthorized benefits

• Billing for services not rendered
  • Includes, but not limited to:
    • Medications, lab tests, and fictitious office visits
Most Frequent Schemes (2)

• Billing for unnecessary services
  • Includes, but not limited to:
    • Excessive diagnostic testing, medications, therapy or office visits, or duplicate services

• Billing outpatient services as inpatient services
  • Allows a facility to bill at a higher rate
Most Frequent Schemes (3)

• Durable Medical Equipment (DME)
  • Medicaid may be charged for inferior or substandard medical equipment
    • A wheelchair that does not work properly
    • Delivery of excessive quantities of supplies that a client’s condition does not warrant
      • Delivery of unnecessary incontinence supplies or a customized wheelchair when a standard wheelchair is sufficient
Most Frequent Schemes (4)

• Kickbacks
  • In facilitating a client’s access to services, there can be no inducements to use any particular provider, product, or service

• Overtreatment
  • Services not medically necessary or that do not have adequate medical documentation to support medical necessity
Most Frequent Schemes (5)

• Supplies not delivered
  • Medicaid is charged for supplies clients did not receive

• Upcoding or unsubstantiated diagnoses
  • Medicaid charged for procedures, services, or office visits at a higher rate than is appropriate or actually took place
Always report suspected recipient or provider Medicaid fraud, waste, or abuse to:

**MCO Special Investigative Unit (SIU)**

HHSC-IG toll-free Integrity Line

1-800-436-6184

Texas Office of Inspector General

https://oig.hhsc.texas.gov/
Reporting (2)

- Required information:
  - Name and address of the provider, facility, or recipient
  - Summary of what happened
  - Date of occurrence whenever possible
• Other information required:
  • Medicaid Provider Number (state-issued ID or national ID; tax identification number or other identifier) or the client’s Medicaid number
  • Type of provider being reported, i.e. Dentist, Physician, Physical Therapist, etc.
  • Copies of any available documentation
    • Such as records, bills, x-rays, photos, notes
  • Witness names and their contact information
Lesson 3

REFERRALS
MCO Referrals (1)

• The MCO SIU must make a referral to HHSC-IG and MCFU if there is an indication of fraud, regardless of the estimated overpayment.

• Referrals to the HHSC-IG are submitted online through the waste, abuse, fraud referral system (WAFERS).
MCO Referrals (2)

- An expedited referral is required when the MCO has reason to believe that a delay may result in:
  - Harm or death to patients
  - The loss, destruction, or alteration of valuable evidence
  - A potential for significant monetary loss that may not be recoverable
  - Hindrance of an investigation or criminal prosecution of the alleged offense
MCO Referrals (3)

- MCO SIU makes a referral to HHSC-IG
  - SIU provides HHSC-IG with complete investigation file
  - HHSC-IG opens a case and assigns it to an intake investigator for a preliminary investigation
  - The intake investigator contacts SIU if additional information is needed
MCO Referrals (4)

• Each preliminary investigation results in one or more of the following:
  • Case closure
  • Provider education
  • Referral to a licensure board
  • Payment hold (suspension)
  • Referral to the Texas Office of Attorney General Medicaid Fraud Control Unit
  • Full-scale investigation
Open Case List Report

- MCO must send a list of all investigations opened by the SIU to the HHSC-IG and OAG Medicaid Fraud Control Unit each month
  - Report includes:
    - Investigations that were referred
    - Investigations not referred, closed with no findings
    - Referred to HHSC-IG but returned for the SIU to take action
    - Information on providers on payment hold
HHSC-IG Investigations (1)

• Full-Scale Investigation
  • Investigator:
    • Reviews complaint and identifies all entities reimbursing the provider with Medicaid funds
    • Obtains provider’s contract with each entity and the amount paid by the entity during the investigated timeframe
    • Determines which claims to include, obtains detailed paid claims data and identifies any record of prior education or recoupment for the provider
HHSC-IG Investigations (2)

- **HHSC-IG**
  - MCOs must provide HHSC-IG with all documents necessary to conduct an investigation
  - Investigation may include a review by consulting experts, as well as interviews of recipients and other potential witnesses
  - HHSC-IG Litigation works in tandem with investigations and audit to develop cases
HHSC-IG Investigations (3)

• Investigative Report
  • Investigator produces a final report that includes the investigative findings and the evidence in support of those findings
  • When these findings include program violations, the case is referred to HHSC-IG’s Litigation Division
  • Litigation takes action if an identified overpayment is appealed or a provider needs to be terminated or excluded from the program
Lesson 4

CONSEQUENCES
Exclusions and Terminations

• Exclusion is the suspension of a provider’s ability to request reimbursement from the Medicaid program for items or services provided to Medicaid beneficiaries. 1 Texas Administration Code §§ 371.1705, .1707

• Termination is the revocation of a provider’s enrollment in the Medicaid program, after all appeal rights have expired. 1 Texas Administration Code §371.1703

• Lists of individuals or entities excluded or terminated are maintained on federal and state websites and databases
Consequences

• Payment Suspension (Hold), when warranted:
  • Federal rules require HHSC-IG to place a provider on payment suspension when the agency determines there is credible allegation of fraud for which an investigation is pending
    • 42 C.F.R. §455.23
  • HHSC-IG initiated suspensions:
    • HHSC-IG sends notice to MCO that payments to a provider have been suspended
    • MCO must suspend payments to the provider within one business day
    • MCO must respond to the notice within three business days and inform HHSC-IG of whether the MCO has implemented the suspension
Consequences

• Payment Suspensions (Holds) Initiated by MCO
  • The MCO must submit the following information to HHSC-IG:
    • Nature of suspected fraud
    • Basis for suspension
    • Date suspension was imposed
    • Date suspension was discontinued
    • Reason for discontinuing suspension
    • Outcome of any appeals
    • Amount of payments held
    • The percentage of the hold
    • Good cause rationale for imposing a partial payment suspension, if applicable
Report Fraud, Waste, or Abuse

Texas Inspector General Integrity Line
1-800-436-6184

Texas Office of Inspector General
https://oig.hhsc.texas.gov/

Texas Attorney General
https://www.texasattorneygeneral.gov/cj/criminal-medicaid-fraud#report
Lesson 5

MCO RESPONSIBILITIES
Federal Laws and Regulations

• MCOs are subject to all state and federal laws and regulations relating to fraud, waste, and abuse.
  • MCOs are subject to and must meet all requirements in:
    • Texas Government Code § 531.113
    • Texas Government Code § 533.012
    • 1 Tex. Admin. Code §§ 353.501-353.505
    • 1 Tex. Admin Code §§ 370.501-370.505
Special Investigative Units (1)

- Texas Government Code, Section 531.113
  - MCOs must:
    - Establish and maintain a special investigative unit (SIU) to investigate fraudulent claims and other types of program abuse by recipients and service providers
    - Adopt a plan to prevent and reduce fraud and abuse
    - File their contract with the Commission’s Office of Inspector General if they contract with another entity to investigate fraudulent claims and other types of program abuse
Special Investigative Unit (2)

- MCOs must establish and maintain an SIU to facilitate cooperation with IG.
  - Does not have to be physically located in Texas, but must be adequately staffed to handle Texas volume

- Texas Administrative Code, Sections 353.501
  - MCOs may choose to:
    - Establish and maintain the special investigative unit within the MCO
    - Contract with another entity for the investigation of FWA
Contracting

• Texas Administrative Code, Section 353.501
  • MCOs who choose to contract another entity to investigate fraudulent claims and other types of program abuse by the member or the provider, must:
    • Comply with all requirements of Title 42, §438.230 of the Code of Federal Regulations (CFR)
Filing Contract Information

• Texas Administrative Code, Section 353.503
  • MCO must file these items with the HHSC-OIG within **10 business days** of executing the contract:
    • Copy of the written contract, including any attachments
    • Contact information and description of qualifications of the principals of the entity with which the MCO contracted
# MCO Deliverable: Fraud and Abuse Subcontractors

<table>
<thead>
<tr>
<th>#</th>
<th>Functional Component</th>
<th>Deliverable Name</th>
<th>Deliverable Description</th>
<th>Contract Ref</th>
<th>Report Timing</th>
<th>Submitted to</th>
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</thead>
</table>
| 28. | Fraud               | Fraud and Abuse - Subcontractors  | If the MCO contracts for the investigation of allegations of Fraud, Abuse, or Waste and other types of program abuse by Members or Providers, the plan must include a copy of the subcontract; the names, addresses, telephone numbers, electronic mail addresses, and fax numbers of the principals of the subcontracted entity; and a description of the qualifications of the subcontracted entity. Such subcontractors must be held to the requirements stated in this Section. | UMCC Att. B-1 8.1.19  
CHIP RSA Att. B-1 8.1.19  
STAR Health Att. B-1 8.1.25  
STAR+PLUS Exp Att. B-1 8.1.19  
STAR+PLUS MRSA Att. B-1 8.1.21  
STAR Kids Att. B-1 8.1.21  
Medicaid and CHIP Dental Services Att. B-1 8.1.13  
MMDD 2.1.4.5; 2.1.5 | X  
Within 10 business days of execution of subcontract | OIG |
Compliance Plan

• MCOs must develop and submit a written Fraud, Waste, and Abuse compliance plan to OIG for approval each year.

• Texas Administrative Code, Sections 353.501
  • The plan must be submitted **90 days** before the start of the state fiscal year
    • If HHSC-OIG denies the plan, MCOs must resubmit within **15 business days** from the receipt of the denial letter
Compliance Plan Submission (1)

- Texas Administrative Code, Sections 353.502
  - The fraud, waste, and abuse compliance plan submitted to the HHSC-OIG must include:
    - Description of the MCO’s procedures for:
      - **Detecting, investigating, referring, and reporting** possible acts of fraud, waste, and abuse by providers and recipients
      - **Educating** recipients and providers, and **training** personnel to prevent fraud, waste, and abuse
Compliance Plan Submission (2)

• Description of the organizational arrangement of personnel responsible for investigating and reporting possible acts of fraud or abuse
  • Process flow diagram or chart
• Contact information for the person responsible for carrying out the plan
## MCO Deliverable: Compliance Plan

<table>
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<th>Functional Component</th>
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<td>27</td>
<td>Fraud</td>
<td>Fraud and Abuse Compliance Plan</td>
<td>The MCO must submit a written Fraud and Abuse compliance plan to the Office of Inspector General at HHSC for approval each year.</td>
<td>UMCC Att. B-1 8.1.19</td>
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<td>CHIP RSA Att. B-1 8.1.19</td>
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<td>STAR Health Att. B-1 8.1.25</td>
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<td>STAR+PLUS Exp Att. B-1 8.1.19</td>
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<td>STAR+PLUS MRSA Att. B-1 8.1.21</td>
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<td>Medicaid and CHIP Dental Services Att. B-1 8.1.13</td>
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<td>MMDD 2.1.4.3</td>
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Fraud and Abuse Compliance Plan modified by Version 2.1
## Liquidated Damages: Compliance Plan

<table>
<thead>
<tr>
<th>#</th>
<th>Service/Component¹</th>
<th>Performance Standard²</th>
<th>Measurement Period³</th>
<th>Measurement Assessment⁴</th>
<th>Liquidated Damages</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.</td>
<td>Attachment B-1, RFP Sections 7.2.8.1 and 8.1.19</td>
<td>The MCO must submit or comply with the requirements of the HHSC-approved Fraud, Waste, and Abuse Compliance Plan.</td>
<td>Transition, Operations, and Turnover</td>
<td>Each incident of noncompliance, per MCO Program</td>
<td>HHSC may assess up to $1,000 per calendar day for each incident of noncompliance, per MCO Program.</td>
</tr>
</tbody>
</table>

Item 8 modified by Version 2.16
General Requests for Access

- MCOs and their subcontractors must allow access to all premises and provide originals or copies of all records and information requested by:
  - HHSC-OIG or its authorized agent(s),
  - Centers for Medicare and Medicaid Services (CMS),
  - U.S. Department of Health and Human Services (DHHS),
  - Federal Bureau of Investigation
  - OAG
  - Texas Department of Insurance (TDI)
  - Other units of state government
• MCOs must:
  • Designate a primary and secondary contact person for all HHSC-OIG record requests
  • Respond to the request within the designated timeframe
  • Fill in all data fields on the request
    • Provide an explanation when leaving data fields blank
    • Not add or delete any additional data fields
  • Provide data in the order and format requested
  • Include a notarized Business Records Affidavit, unless otherwise indicated in the request
Request for Information (2)

- Texas Administrative Code, Sections 353.504
  - MCOs must provide the records requested within 24 hours of receiving the request
    - Exception: When OIG or another state or federal agency representative reasonably believes that the requested records are about to be altered or destroyed or that the request may be completed at the time of the request
  - Failure to provide records may result in:
    - HHSC imposing contractual remedies and sanctions
Liquidated Damages: Request for Information

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<thead>
<tr>
<th>#</th>
<th>Service/Component</th>
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<tbody>
<tr>
<td>24</td>
<td>Attachment B-1, RFP Section 8.1.19</td>
<td>The MCO must respond to Office of Inspector General request for information in the manner and format requested.</td>
<td>Transition, Operations, and Turnover</td>
<td>Each calendar day of noncompliance, per MCO Program.</td>
<td>HHSC may assess up to $1,000 per calendar day, per MCO Program, that the report is not submitted, late, inaccurate, or incomplete. This amount will increase to $5,000 per day per MCO program for the fourth and each subsequent occurrence within a 12-month period.</td>
</tr>
</tbody>
</table>

Item 24 modified by Versions 2.6 and 2.16
## Common Record Requests

<table>
<thead>
<tr>
<th>Information Requested</th>
<th>Timeframe to Provide</th>
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<tbody>
<tr>
<td>1099 data and other financial information</td>
<td>3 business days</td>
</tr>
<tr>
<td>Claims data for sampling and recipient investigations</td>
<td>5 business days</td>
</tr>
<tr>
<td>Urgent claims data requests</td>
<td>3 business days (with OIG manager’s approval)</td>
</tr>
<tr>
<td>Provider education information</td>
<td>10 business days</td>
</tr>
<tr>
<td>Files associated with an investigation conducted by an MCO</td>
<td>15 business days</td>
</tr>
<tr>
<td>Provider profile, UR summary reports, and associated provider education activities and outcomes</td>
<td>As indicated in the request</td>
</tr>
<tr>
<td>Member and/or pharmacy data</td>
<td>As required by OIG</td>
</tr>
</tbody>
</table>
Recovery of Funds (1)

• Texas Administrative Code, Sections 353.505

  • When suspecting fraud, waste, or abuse, the MCOs must:
    • Immediately notify HHSC-OIG and OAG
    • Begin payment recovery efforts
      • Exception: if the amount is over $100,000 and the MCO receives notice from the HHSC-OIG or OAG indicating that the MCO is not authorized to proceed with recovery effort
    • Ensure that any payment recovery efforts in which the MCO engages are in accordance with Texas Administrative Code, Chapter 353, Subchapter F
Recovery of Funds (2)

• If HHSC-OIG or the OAG assumes responsibility for completion of the investigation, the HHSC-OIG or OAG will determine and direct the collection of any overpayment.
  • HHSC-OIG will distribute amounts collected to the MCO, minus investigation and collection proceeding costs.

• MCOs may retain any money they recover.
  • Recoveries are reported on the monthly Open Case List Report.
### MCO Deliverable: MCO Open Case List Report

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<tr>
<th>#</th>
<th>Functional Component</th>
<th>Deliverable Name</th>
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</table>
| 52. | Fraud                | MCO Open Case List Report                 | The MCO must submit, using the prescribed OIG template, a monthly open case list report electronically to OIG-Medicaid Provider Integrity and the Office of Attorney General Medicaid Fraud Control Unit (MFCU). The prescribed fields must not be changed or reformatted. The monthly report will include a report of all overpayment and other recoupments by the MCO. The monthly report will include all open and recently completed cases that:  
- are completed within the month;  
- are not completed;  
- did not result in a finding;  
- resulted in a recoupment of any overpayments;  
- resulted in the suspension of payments to the provider based upon a credible allegation of fraud;  
- not accepted by OIG; or  
- were referred directly to OIG Sanctions within the month. | UMCM Att. B-1 8.1.20.2  
CHIP RSA Att. B-1 8.1.20.2  
STAR Health Att. B-1 8.1.26.2  
STAR+PLUS Exp Att. B-1 8.1.20.2  
STAR+PLUS MRSA Att. B-1 8.1.22.2  
STAR Kids Att. B-1 8.1.21  
Medicaid and CHIP Dental Services Att. B-18.1.14.2  
MMDD 2.1.5  
UMCM Chapter 5.5.1 | X | | | | | By close of business on the first business day following the 14th day of the month after the month being reported. | OIG-Medicaid Provider Integrity and OAG Medicaid Fraud Control Unit (MFCU) |
Open Case List Report Template

• UMCM Chapter 5.5 – Fraud Deliverable/Report Format
  • Cases up to $100,000
  • Cases Over $100,000 to OIG
  • Cases Pending
  • Cases OIG Did Not Accept
  • No Findings
  • All Member Referrals
  • Payment Holds
HHSC-OIG’s Fraud Referral Form

- MCOs must report and refer possible fraud, waste, and abuse to the HHSC-OIG within **30 business days** of receiving the reports from the SIU.

- The MCO’s assigned officer or director completes the Fraud Referral form (WAFERS), accompanied by a Fraudulent Practices report.
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<tbody>
<tr>
<td>29.</td>
<td>Fraud</td>
<td>Fraudulent Practices Report</td>
<td>Utilizing the HHSC-Office of Inspector General (OIG) fraud referral form, the MCO’s assigned officer or director must report and refer all possible acts of waste, abuse or fraud to the HHSC-OIG within 30 business days of receiving the reports of possible acts of waste, abuse or fraud from the MCO’s Special Investigative Unit (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 the 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. This requirement applies to all reports of possible acts of waste, abuse and fraud.</td>
<td>UMCC Att. B-1 8.1.20.2</td>
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<td>X</td>
<td>Within 30 days of notification by the MCO’s SIU of the possible acts of waste, abuse, or fraud</td>
<td>OIG</td>
</tr>
</tbody>
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## Liquidated Damages: Fraudulent Practices Report

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<td>25.</td>
<td>Attachment B-1, RFP Section 8.1.20.2, UMCN Chapter 5.5</td>
<td>The MCO must submit a Fraudulent Practices Report to the HHSC-OIG within 30 Business Days of receiving a report of possible Waste, Abuse, or Fraud from the MCO’s Special Investigative Unit (SIU). The MCO must submit quarterly MCO Open Case List Reports.</td>
<td>Transition, Operations, and Turnover</td>
<td>Each calendar day of noncompliance, per MCO Program.</td>
<td>HHSC may assess up to $1,000 per calendar day, per MCO Program, that the report is not submitted, late, inaccurate, or incomplete. This amount will increase to $5,000 per day per MCO program for the fourth and each subsequent occurrence within a 12-month period.</td>
</tr>
</tbody>
</table>

Item 25 modified by Versions 2.6 and 2.16

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## Liquidated Damages: Payment Hold

<table>
<thead>
<tr>
<th>#</th>
<th>Service/Component¹</th>
<th>Performance Standard²</th>
<th>Measurement Period³</th>
<th>Measurement Assessment⁴</th>
<th>Liquidated Damages</th>
</tr>
</thead>
<tbody>
<tr>
<td>24.1</td>
<td>Attachment B-1, RFP Section 8.1.19</td>
<td>The MCO must respond to Office of Inspector General request for payment hold amounts accurately and in the manner and format requested.</td>
<td>Transition, Operations, and Turnover</td>
<td>Per instance of noncompliance, per MCO Program.</td>
<td>HHSC may assess up to the difference between the amount required to be reported by the MCO under Chapter 5.5 of the UMCM and the amount received by HHSC OIG.</td>
</tr>
</tbody>
</table>
Additional MCO Responsibilities (1)

- MCOs must require all employees and subcontractors who process Medicaid claims to attend the annual Fraud, Waste, and Abuse training provided by HHSC.

- MCOs must perform pre-payment reviews for identified providers as directed by OIG.
Additional MCO Responsibilities (2)

• When requested by HHSC-OIG, the MCOs will be required to provide employees to participate in administrative proceedings.

• MCOs must comply with sections 8.1.19 and 8.1.20.2(c) and (d) of the UMCC or may be subject to:
  • Liquidated damages
  • Administrative enforcement pursuant to 1 Tex. Administrative Code Chapter 371 Subchapter G, in addition to any other legal remedy
Resources

- Texas Government Code, Chapter 531, Subchapter C
- Texas Government Code, Section 531.113
- Texas Human Resources Code, Chapter 32
- 1 Texas Administrative Code, Chapter 371
- 1 Texas Administrative Code, Sections 353.501-353.505
- Uniformed Managed Care Contract Attachment B-1, Section 4.3.15, 8.1.18.2, 8.1.18.4, & 8.1.19
- 42 CFR Section 455.23
Questions?

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