Recoveries Accountability Report

As directed by
Rider 153, Article II, 85th Texas Legislature

Texas Health and Human Services
Inspector General

February 1, 2018

OFFICE OF INSPECTOR GENERAL

TEXAS HEALTH & HUMAN SERVICES COMMISSION

SYLVIA HERNANDEZ KAUFFMAN
INSPECTOR GENERAL

February 1, 2018

Ursula Parks
Director
Legislative Budget Board
P.O. Box 12666
Austin, Texas 78711

Dear Ms. Parks,

As directed in SB 1, Article II, Rider 153, 85th Legislature, Regular Session, 2017, the Office of Inspector General submits the methodology it uses to collect and validate funds recovered through investigations, audits, utilization reviews, and inspections which offset funds which would otherwise be expended by the state.

This report contains supporting details of the methodology used to confirm the reported Dollars Recovered (OP-5), a key Inspector General performance measure. If you have questions regarding the report, please contact Kenny McLeskey, IG Director of Finance, at 512-491-2899 or Kenny.Mcleskey@hhsc.state.tx.us.

Sincerely,
Sylvia Hernandez Kauffman
Inspector General

Executive Summary

The Office of Inspector General produced this report as directed in Rider 153 of the 2018-19 General Appropriations Act (Article II, HHSC, 85th Legislature, Regular Session) which required the IG to "develop a methodology to validate the funds recovered through investigations, audits, utilization reviews, and inspections which offset funds which would otherwise be expended by the state." The IG was created to strengthen the Health and Human Services Commission's capacity to combat fraud, waste, and abuse in publicly funded Health and Human Services programs. The IG's primary tools for identifying, detecting, deterring, and preventing fraud, waste, and abuse are audits, investigations, inspections, and reviews. This report outlines the steps the IG takes to process and report its recoveries.

What is considered a recovery?

When payments are made in an amount greater than allowed under Medicaid and other social service program policies, an overpayment occurs. When an overpayment is discovered, the IG takes action to recoup the overpayment amount. These recoupments are reported as recoveries under performance measure Dollars Recovered (OP-5). The IG includes two sources as part of this performance measure:

- Cash payments received from clients and providers.
- Reduction of future payments to clients and providers (offsets).

Table A: FY 2017 recoveries

Division	Recoveries
Investigations	$32,536,769
Medicaid Program Integrity	$4,880,011
Audit	$23,171,847
Medical Services	$37,700,400
Inspections	$22,849
Total	**$98,311,876**

Source: IG Performance Data Compiler

How is a recovery processed and tracked?

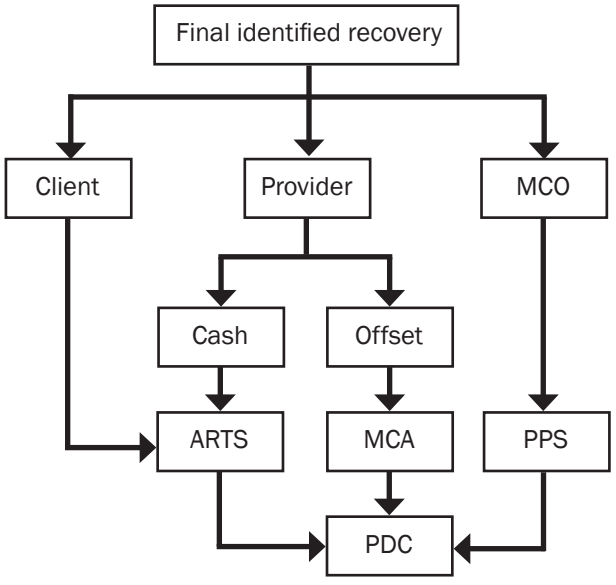
How payments are processed depends on two variables:

- The source of the payment: client, provider or managed care organization (MCO).
- The form of the payment: cash or offset.

Payments are tracked using three primary systems or processes:

- **Accounts Receivable Tracking System (ARTS).** ARTS is the Health and Human Services Commission (HHSC) system for processing all client recoveries and cash payments by providers.
- **Medicaid Claims Administrator (MCA).** The MCA processes fee-for-service (FFS) future billing offsets from providers. These MCO offsets are processed through the Premium Payment System.
- **Premium Payment System (PPS).** PPS collects overpayments from MCOs by making adjustments to future payments to an MCO

Figure A: Recoveries process flow



Recoveries process flow

Client payments are all processed through the ARTS system, regardless of whether the payment is collected by cash or as an offset. The process through which a provider recovery is identified may vary (investigation, audit, or utilization review), but the payment type is what determines how the recovery is processed.

Executive Summary

Figure B: Recovery source, type, and process by division

Division	Type of recovery	Cash or offset	Processing mechanism
Chief Counsel	Provider	Both	ARTS and MCA
Medicaid Program Integrity	Provider	Cash	ARTS
Investigations	Client	Cash	ARTS
Audit	Provider	Both	ARTS and MCA
Medical Services (Utilization Reviews)	Provider	Both	ARTS and MCA
Inspections	MCO and Provider	Both	PPS and ARTS

While other supplemental documentation and tracking systems may be used for reporting, each division uses information from ARTS, the MCA, or PPS to validate and record its recoveries in the IG's Performance Data Compiler (PDC) tracking database, which is used to compile recoveries data for the IG performance measure.

Section 1: Introduction

In 2003, the 78th Texas Legislature created the Office of Inspector General to strengthen the Health and Human Services Commission's capacity to combat fraud, waste, and abuse in publicly funded Health and Human Services programs. The IG's primary tools for identifying, detecting, deterring, and preventing fraud, waste, and abuse are audits, investigations, inspections, and reviews.

The Inspector General produced this report at the direction of Rider 153 of the 2018-19 General Appropriations Act (Article II, HHSC, 85th Legislature, Regular Session):

> 153. Office of Inspector General Accountability. In order to establish accountability of how funds appropriated to Office of Inspector General in Strategy K.1.1, Client and Provider accountability, are expended to combat fraud, waste, and abuse throughout the health and human services system, the Office of Inspector General shall develop a methodology to validate the funds recovered through investigations, audits, utilization reviews, and inspections which offset funds which would otherwise be expended by the state.

This report contains supporting details regarding the methodology used in confirming the reported Dollars Recovered (OP-5), a key Inspector General performance measure. In FY 17, the IG reported $98 million in recoveries under OP-5.

Table 1.1: Fiscal year 2017 IG recoveries

	IG division recoveries	Chief Counsel assisted recoveries	Total recoveries	Cash portion	Bill offset portion
Audit					
IG Audit	$829,300	$315,524	$1,144,824	$1,144,824	
CMS Medicaid Integrity Contractor	$734,705	$753,430	$1,488,135	$1,238,135	$250,000
Recovery Audit Contractor	$20,538,888		$20,538,888		$20,538,888
Audit total	**$22,102,893**	**$1,068,954**	**$23,171,847**	**$2,382,959**	**$20,788,888**
Inspections					
WIC Vendor Monitoring	$22,849		$22,849	$22,849	
Inspections total	**$22,849**		**$22,849**	**$22,849**	
Investigations					
GI CHIP	$2,349		$2,349	$2,349	
GI Medicaid	$1,161,453		$1,161,453	$1,161,453	
GI SNAP	$31,051,607		$31,051,607	$31,051,607	
GI TANF	$255,288		$255,288	$255,288	
GI WIC investigations	$7,394		$7,394	$7,394	
EBT Trafficking	$58,678		$58,678	$58,678	
Investigations total	**$32,536,769**		**$32,536,769**	**$32,536,769**	
Medicaid Program Integrity					
Provider overpayments and penalties		$4,880,011	$4,880,011	$991,314	$3,888,697
MPI total		**$4,880,011**	**$4,880,011**	**$991,314**	**$3,888,697**
Medical Services					
Acute Care Surveillance	$5,696,320	$248,382	$5,994,702		$5,944,702
UR (Hospitals)	$27,549,491		$27,549,491		$27,549,491
UR (Nursing homes)	$3,961,925		$3,961,925	$933,819	$3,028,106
Voluntary repayments		$244,282	$244,282		$244,282
Medical Services total	**$37,207,736**	**$492,664**	**$37,700,400**	**$933,819**	**$36,766,581**
Dollars recovered total	**$91,870,247**	**$6,441,629**	**$98,311,876**	**$36,867,710**	**$61,444,166**

Source: IG Performance Data Compiler

Section 1: Introduction

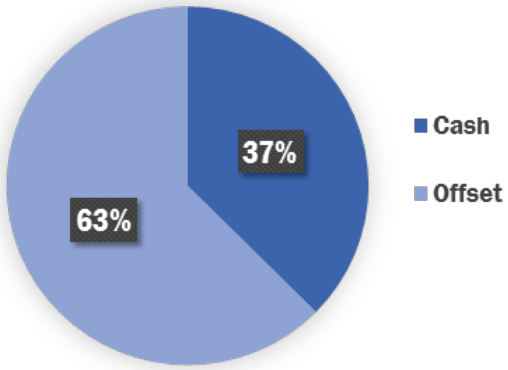
Background

When payments are made in an amount greater than allowed under Medicaid and other social service program policies, an overpayment occurs. When an overpayment is discovered, the IG takes action to recoup the overpayment amount. These recoupments are reported as recoveries under performance measure Dollars Recovered (OP-5). The IG includes two sources as part of this performance measure:

- Payments received from clients and providers. These recoveries are cash payments received by the state.
- Reduction of future payments to clients and providers. Bill offsets are recoveries where the state does not reimburse a contractor for services rendered to the state or adjusts the payments a contractor would receive to offset past payments. Future client benefits may also be reduced in order to recover an overpayment.

Payments are tracked using the following systems or processes. How these systems are specifically used in the recovery and recoupment process are explained in the division sections that follow in this report.

Table 1.2: FY 2017 recoveries



Source: IG Performance Data Compiler

- **Accounts Receivable Tracking System (ARTS).** All client recoveries are processed, reported, and documented by the Health and Human Services Commission's (HHSC) ARTS. Provider cash payments are also processed through ARTS. However, the processes for collecting client recoveries using ARTS is different than the processes for collecting provider recoveries.
- **Automated System for Office of Inspector General (ASOIG).** ASOIG is a tool used by General Investigations to track the stages of a referral through the investigations process. ASOIG provides an automated platform for assigning referrals, calculating overpayment amounts based on client eligibility information at particular points in time, generating correspondence, tracking the final outcome of investigation activities, providing overpayment claim data to the ARTS system via interface, and producing reports on General Investigations case activities.
- **Hospital Utilization Review (HUR) System:** HUR is the data application for hospital utilization reviews. The HUR system exchanges data with HHSC and the MCA systems related to paid acute care claims reimbursed as fee-for-service for inpatient hospital Medicaid services. This includes claim recoupments and adjustments for admission denials and coding errors associated with overpayments and underpayments.
- **Medicaid Fraud and Abuse Detection System PI Case Tracker (Case Tracker).** Case Tracker is a tool used by the Medicaid Program Integrity and Chief Counsel divisions to track provider referrals through the investigations process. Chief Counsel uses Case Tracker to document and track provider recoveries.
- **Medicaid/CHIP Administrative Tracking System (MCATS).** MCATS is a tracking system for monitoring the Medicaid Claims Administrator contract. MCATS includes a platform for documenting correspondence and requests for action between the State and the Medicaid Claims Administrator.
- **Medicaid Claims Administrator (MCA).** The MCA processes fee-for-service (FFS) claims for Texas Medicaid

and other state health care programs. The MCA processes FFS recoveries and billing offsets from providers for the IG. Recoveries may be related to specific claims which are then adjusted or may be for non-specific claims when a settlement is reached between a provider and the state. The current MCA for Texas is Accenture, which leads a group of contractors also known as the Texas Medicaid & Healthcare Partnership (TMHP).

- **Nursing Facility Utilization Review (NFUR) System.** NFUR is the data application for nursing facility utilization reviews. The NFUR system exchanges data with HHSC and the MCA systems related to long-term care facilities and clients, including RUG changes, associated overpayments, and claims recoupments.

- **Performance Data Compiler (PDC).** PDC is a SharePoint Excel file that serves as the tracking mechanism for collecting and reporting IG performance measure data, which originates from a variety of different systems across the IG. Monthly, each division manually enters the information for its performance measures into the PDC. The data entered by each division into the PDC is then aggregated into its respective IG performance measure and reported to HHSC Budget quarterly.

- **Premium Payment System (PPS).** PPS is the payment system for Managed Care Organizations (MCOs) for HHSC. PPS collects overpayments from MCOs by making adjustments to future payments to an MCO.

Section 2: Chief Counsel Division

Background

Among other functions, the IG's Chief Counsel Division receives referrals from Medicaid Program Integrity (MPI), Medical Services, and Audit divisions and pursues any overpayment and sanctions that can be pursued in a case. These cases are either settled by agreement or resolved by hearing before a State Office of Administrative Hearings Administrative Law Judge. Audits are either settled by agreement or resolved by a hearing before an HHSC appeals hearing officer. IG Chief Counsel also works with providers when they want to self-report a potential Medicaid violation. The IG's Chief Counsel Division includes staff who process all payments received by the IG from fraud, waste and abuse activities, such as provider overpayments, restitution recoveries from criminal cases, and the Voluntary Repayment Plan (VRP). The Department of Homeland Security Immigration and Customs Enforcement sometimes requests that individuals repay money previously expended on their behalf in the Medicaid program. In those instances, individuals will contact VRP and repay those funds on a purely voluntary basis. Chief Counsel produces a monthly report for each division so they can track recoveries.

Recoveries process

IG Chief Counsel receives referrals regarding provider overpayments and penalties from the MPI, Medical Services, and Audit divisions, and from the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU), and processes recoupments from these sources. Chief Counsel also processes the payments received from the VRP, which are credited to Medical Services in performance measure reporting. When all legal remedies are exhausted, Chief Counsel enters the final recovery amount in Case Tracker in the "estimated recovery" field, either by creating a new case or updating an existing case. If the funds will be recovered through an offset, Chief Counsel notifies the MCA through a State Action Request (SAR) to establish an accounts receivable in their system.

Chief Counsel typically receives between 130 and 230 checks a month as a form of payment from a variety of sources:

Criminal restitution

- County courts
- Office of the Attorney General
- Texas Department of Corrections
- U.S. Department of the Treasury

Overpayment

- Providers/provider's counsel
- Office of the Comptroller
- MCA (for agency transfer)

Once the check is received, it is transferred to HHSC Accounts Receivable (AR) to be deposited and entered in to ARTS. Payments are placed in a suspense account until the IG determines how the funds are allocated. The suspense account holds funds until HHSC receives direction from the IG on distribution.

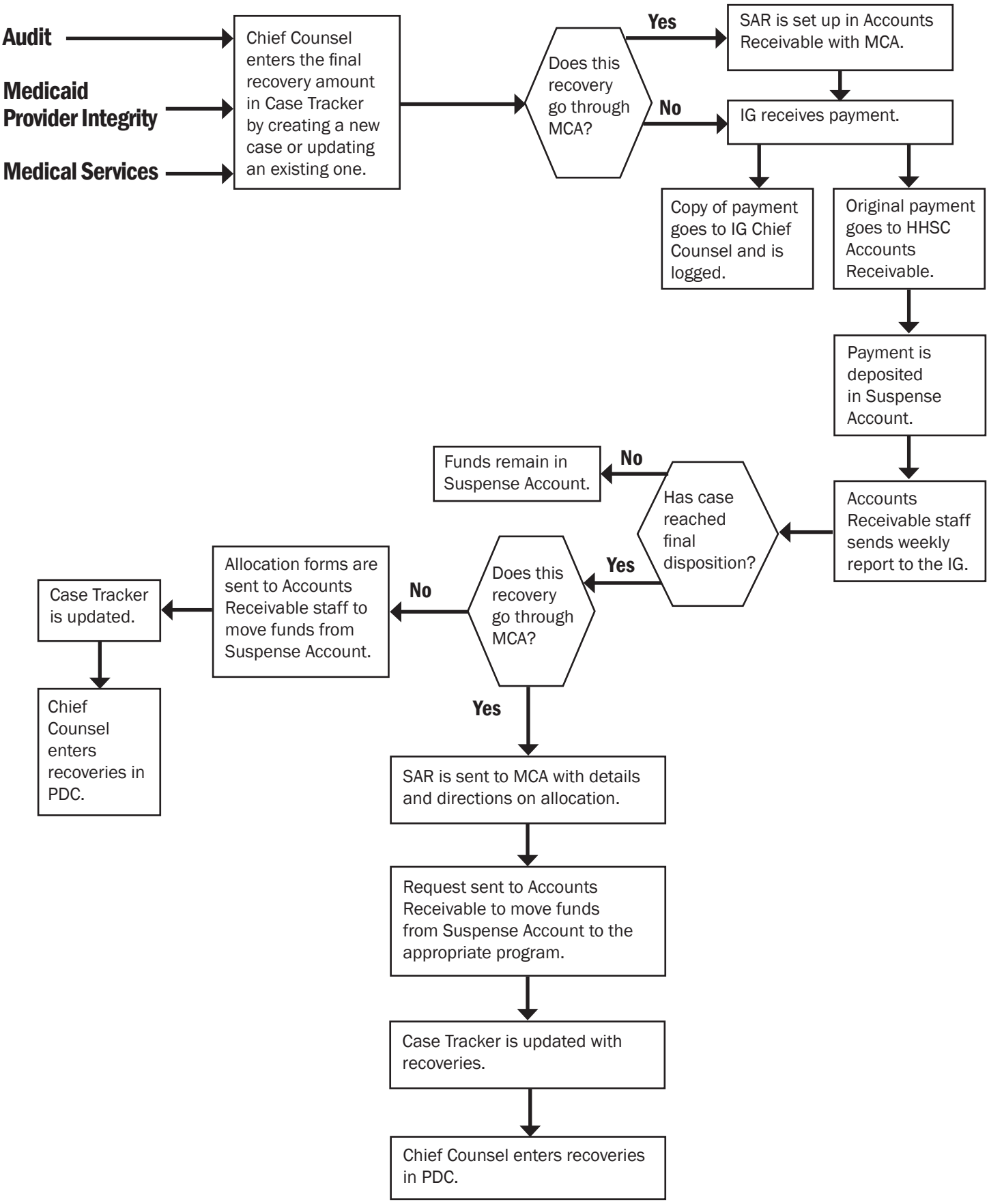
Weekly, HHSC AR staff sends IG Chief Counsel a file from the suspense account out of CAPPS Financials, the HHSC accounting system. Chief Counsel researches each payment to determine which have a final disposition and determines the appropriate process to use for each payment in the monthly distribution. Recoveries will either be transferred back to the HHSC program or sent to the MCA.

For funds that are to be sent to the MCA, Chief Counsel prepares a file requesting HHSC AR staff to issue a state warrant from the suspense account. The state warrant is sent to the MCA to apply to an accounts receivable the MCA initially established for the overpayment claim. Cash payment may be made instead of offset for many reasons, such as a provider is no longer in the program and the MCA cannot reduce future payments, court-ordered restitution, or the provider chooses to make a cash payment. For program transfers, Chief Counsel sends an allocation fund table to the HHSC AR staff requesting that they enter the coding into CAPPS Financials, and those funds are transferred from the suspense account to the appropriate program.

All recoveries are entered by Chief Counsel into Case Tracker for tracking and reporting purposes. Chief Counsel also enters the recoveries into the PDC monthly.

Section 2: Chief Counsel Division

Figure 2.1: Chief Counsel recoveries process



Section 3: Medicaid Program Integrity Division

Background

The Medicaid Program Integrity Division (MPI) investigates allegations of fraud, waste, and abuse by Medicaid providers. Once an investigation is complete, the case is transferred to the IG's Chief Counsel Division or the Civil Medicaid Fraud Unit (CMF) for pursuit of recoupment of overpayments or assessment of penalties, or to the Office of Attorney General's MFCU for criminal prosecution, which may require a provider to pay restitution to Medicaid. MPI recoveries collected by the IG Chief Counsel Division, or restitution resulting from MFCU cases, are credited back to MPI in performance measure reporting. Another source of recoveries credited to MPI are provider self-reported overpayments.

When a case is closed, it means no further action will be taken by the IG. A closed case could have resulted in a referral to a regulatory agency, MFCU, or a licensing board. A single case can result in multiple referrals.

Recoveries process

When potential program violations are identified by an investigator, MPI staff transfers the case to Chief Counsel. Chief Counsel pursue the amount of any overpayment as well as whether any other sanctions. Payments received by Chief Counsel are handled through the process discussed in the Chief Counsel section (see Figure 2.1, page 7).

Table 3.1: MPI recoveries FY 2017

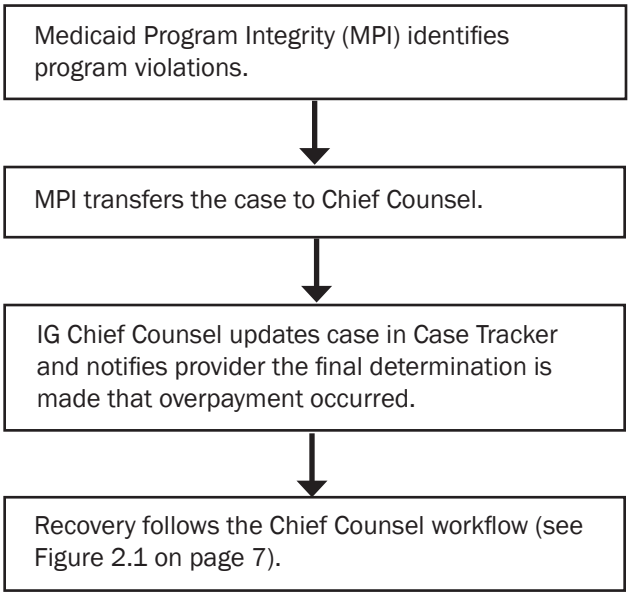
	All Funds	General Revenue (est.)
Provider investigations	$4,880,011	$2,138,421

Table 3.2: MPI case volume FY 2017

Preliminary investigations closed	1,536
Full-scale investigations closed	243
Cases transferred to Chief Counsel	41
Referrals to Medicaid Fraud Control Unit	587
Referrals to other entities	1,748

Source: IG Performance Data Compiler

Figure 3.1: Medicaid Program Integrity recoveries process



Section 4: Investigations Division

Background

The Investigations Division protects the integrity of HHS programs through investigations of contract and client fraud, waste, and abuse. It refers cases for Administrative Disqualification Hearings and prosecution to appropriate state or federal regulatory and law enforcement authorities. The division also conducts certain personnel investigations at the State Supported Living Centers and state hospitals, as well as within the HHS system.

- **General Investigations (GI)** investigates allegations of fraud, waste, and abuse in health and human services clients in the Temporary Assistance for Needy Families (TANF) program; the Women, Infants, and Children (WIC) Program; Medicaid; the Children's Health Insurance Program (CHIP); and the Supplemental Nutrition Assistance Program (SNAP).

Table 4.1: Investigations recoveries FY 2017

	All Funds	General revenue (est.)
Client investigations	$32,536,769	$6,666,116

Table 4.2: Investigations by type FY 2017

General Investigations (clients)	16,434
Internal Affairs	485
State Centers Investigative Team	1,118
EBT Trafficking (SNAP retailers)	53

Source: IG Performance Data Compiler

- **Internal Affairs (IA)** investigates fraud, waste, abuse by employees and contractors within the HHS System.
- **Law Enforcement (LED)** conducts criminal investigations of employee misconduct at State Supported Living Centers and state hospitals, and Electronic Benefits Transfers misuse. The two units in this directorate are the State Centers Investigative Team (SCIT) and the Electronic Benefit Transfer (EBT) Trafficking Unit.

Investigations Recoveries are generated by GI and EBT Trafficking Unit investigations.

General Investigations recoveries process

When fraud is established in a client case, the case may be handled through the Administrative Disqualification Hearing (ADH) process, or by a local district attorney for prosecution. When the amount of the overpayment is determined, the client is given several payment options: make a one-time payment, establish a payment plan, or have future benefits reduced to pay back the money owed. Cash payments may made by check, money order, cash, or credit card.

When an overpayment is identified, the investigator enters the overpayment claim information into ASOIG. Client overpayments for SNAP, TANF, and Medicaid are processed by ASOIG when it sends an automated claim notification to ARTS. For WIC and CHIP, the investigator submits the claim manually to the HHSC AR team because there are no interfaces available for those programs. The investigator then sends a notice to the client with the overpayment amount.

HHSC is responsible for the collection of client recoveries. If the client does not respond to the investigator's initial overpayment notice, HHSC AR staff sends another notice to the client and works with the client on how to make remuneration. When a payment is received, it is posted to the claim listed in ARTS. The deposit information for recoveries is automatically interfaced from ARTS to CAPPS Financials, but is manually entered by HHSC staff into the Uniform Statewide Accounting System. The physical checks received by HHSC are sent to the Texas Comptroller's Office for final deposit.

HHSC AR staff sends a monthly ARTS report listing recoveries to Investigations. The report includes detailed claim information, summaries by program, and a summary overview. Investigations enters recovery information into the PDC based on the reports from ARTS.

Section 4: Investigations Division

Electronic Benefits Transfer Trafficking Unit Investigations

The Electronic Benefits Transfer (EBT) Trafficking Unit investigates SNAP retailers. IG retailer surveillance operations can result in fraud recoveries from the retailer and/or client. The IG does not report dollars recovered from SNAP retailers. All retailer recovery activity is credited to the U.S. Department of Agriculture's Food and Nutrition Service (FNS).

The IG tracks EBT client recoveries from trafficking investigations and can produce a report related specifically to this activity. However, the IG reports these recoveries as part of the overall SNAP client recoveries. EBT investigations use the same process GI uses, including entering claims information into ASOIG, receiving the monthly ARTS recovery reports, and entering recovery information into the PDC.

Treasury Offset Program (TOP)

The IG also receives recoveries through the Treasury Offset Program (TOP), which is a partnership with the FNS and U.S. Department of Treasury to collect delinquent SNAP claims by offsetting federal payments.

HHSC AR manages the TOP process through ARTS. Clients who become 60 days delinquent on their agreements are sent written notices. If payment is not received within an additional 60 days, the SNAP claims are referred to TOP. Federal income tax returns payments are withheld to recover the debt. When TOP collections are received by HHSC, collections are allocated to the appropriate claims, and balances are adjusted accordingly, which will be reflected in the monthly ARTS report. TOP collections related to IG cases are reported by the IG as part of client recoveries.

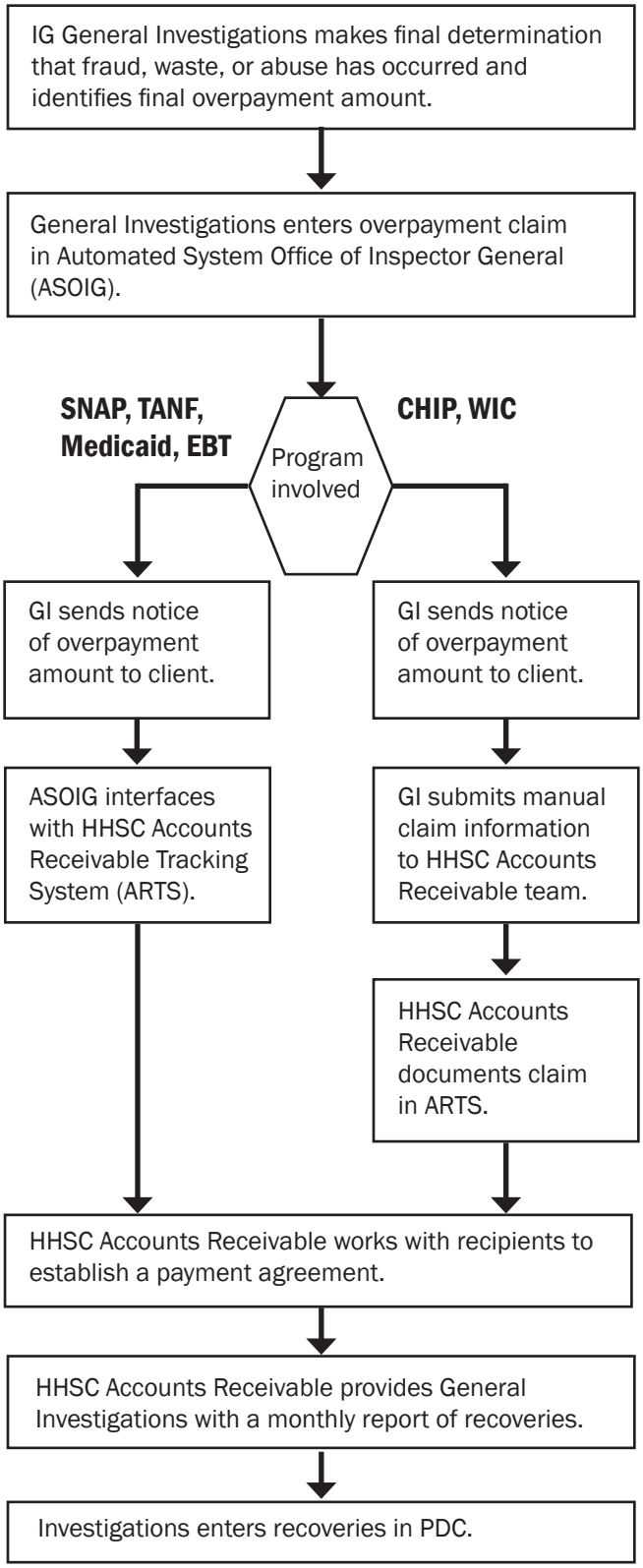
Other recovery sources

The state may also collect delinquent recoveries through two other sources:

- **Lottery offset.** State lottery winnings are withheld to collect on delinquent claims.
- **Driver's license suspension.** A client's Texas driver's license may be suspended if they fail to respond to a request for payment.

Collections related to IG cases are reported by the IG as part of client recoveries.

Figure 4.1: Investigations recoveries process



Section 5: Audit Division

Background

The IG Audit Division conducts risk-based performance, provider, and information technology audits, which sometimes identify overpayments that result in recoveries or recoupments. Audit processes include reviewing the (a) accuracy of medical provider payments; (b) performance of HHS System and the Department of Family and Protective Services (DFPS) contractors; and (c) effectiveness of programs, functions, processes, and information technology within the HHS System and DFPS. The types of audits the Audit Division performs are:

- **Performance Audits.** Review the effectiveness and efficiency of HHS System and DFPS program performance and operations. These audits may identify questioned costs or unsupported costs, which may be recovered or recouped, or may make recommendations that result in the assessment of liquidated damages by responsible program areas.
- **Provider Audits.** Evaluate contractor or provider compliance with criteria contained in legislation, rules, guidance, or contracts, and determine whether funds were used as intended. These audits may identify questioned costs or unsupported costs, which may be recovered or recouped.
- **Information Technology Audits.** Assess compliance with applicable information technology requirements and examine the effectiveness of selected security controls for systems that support HHS System and DFPS programs, or are used by contractors or business partners who process and store information on behalf of HHS and DFPS programs. These audits may make recommendations that result in the assessment of liquidated damages by responsible program areas.

Table 5.1: Audit recoveries FY 2017

	All Funds	General Revenue (est.)
IG Audit	$1,144,824	$501,662
MIC Audit	$1,488,135	$652,101
RAC	$20,538,888	$9,000,141
Total	**$23,171,847**	**$10,153,904**

Table 5.2: Audit performance FY 2017

IG Audit reports issued	24
CMS MIC Audit reports issued	17
RAC claims reviewed	6,143

Source: IG Performance Data Compiler

The Audit Division also coordinates all federal government audits and manages the Recovery Audit Contractor (RAC) contract. The division is the single point of contact with the Centers for Medicare and Medicaid Services (CMS) for Medicaid Integrity Contractor (MIC) audits and Payment Error Rate Measurement (PERM) activities.

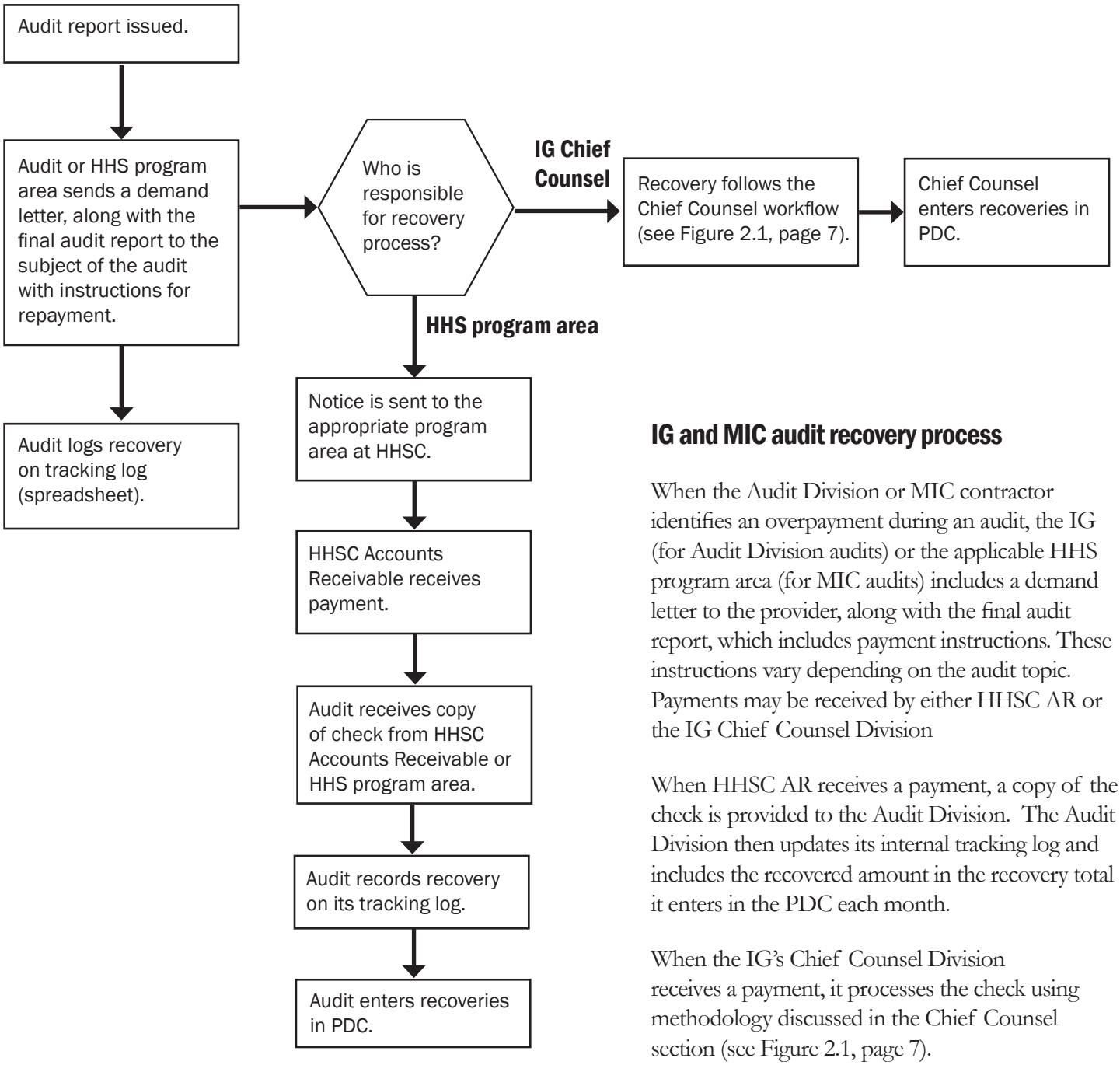
The MIC conducts post-payment audits of Medicaid providers to determine whether Medicaid payments were for covered services that were delivered to eligible clients and were properly billed and documented. These audits may identify questioned costs or unsupported costs, which may be recovered or recouped.

The RAC addresses a federal requirement for states to identify and reduce overpayments in the Medicaid program. The RAC reviews Medicaid paid claims to determine if services were provided according to federal and state laws, rules, and regulations. The RAC uses data mining algorithms to develop various reviews to identify specific types of Medicaid claims where the potential exists for overpayments. HHSC pays the RAC based on a percentage of the total dollars collected from the overpayments the RAC identifies. The MCA recoups overpayments identified by the RAC.

The RAC contract provides for additional services under which the contractor began conducting provider audits on behalf of the IG in fiscal year 2017. These audits may identify questioned costs or unsupported costs, which may be recovered or recouped.

Section 5: Audit Division

Figure 5.1: Audit and MIC Audit recoveries process



IG and MIC audit recovery process

When the Audit Division or MIC contractor identifies an overpayment during an audit, the IG (for Audit Division audits) or the applicable HHS program area (for MIC audits) includes a demand letter to the provider, along with the final audit report, which includes payment instructions. These instructions vary depending on the audit topic. Payments may be received by either HHSC AR or the IG Chief Counsel Division

When HHSC AR receives a payment, a copy of the check is provided to the Audit Division. The Audit Division then updates its internal tracking log and includes the recovered amount in the recovery total it enters in the PDC each month.

When the IG's Chief Counsel Division receives a payment, it processes the check using methodology discussed in the Chief Counsel section (see Figure 2.1, page 7).

Section 5: Audit Division

RAC audit recovery process

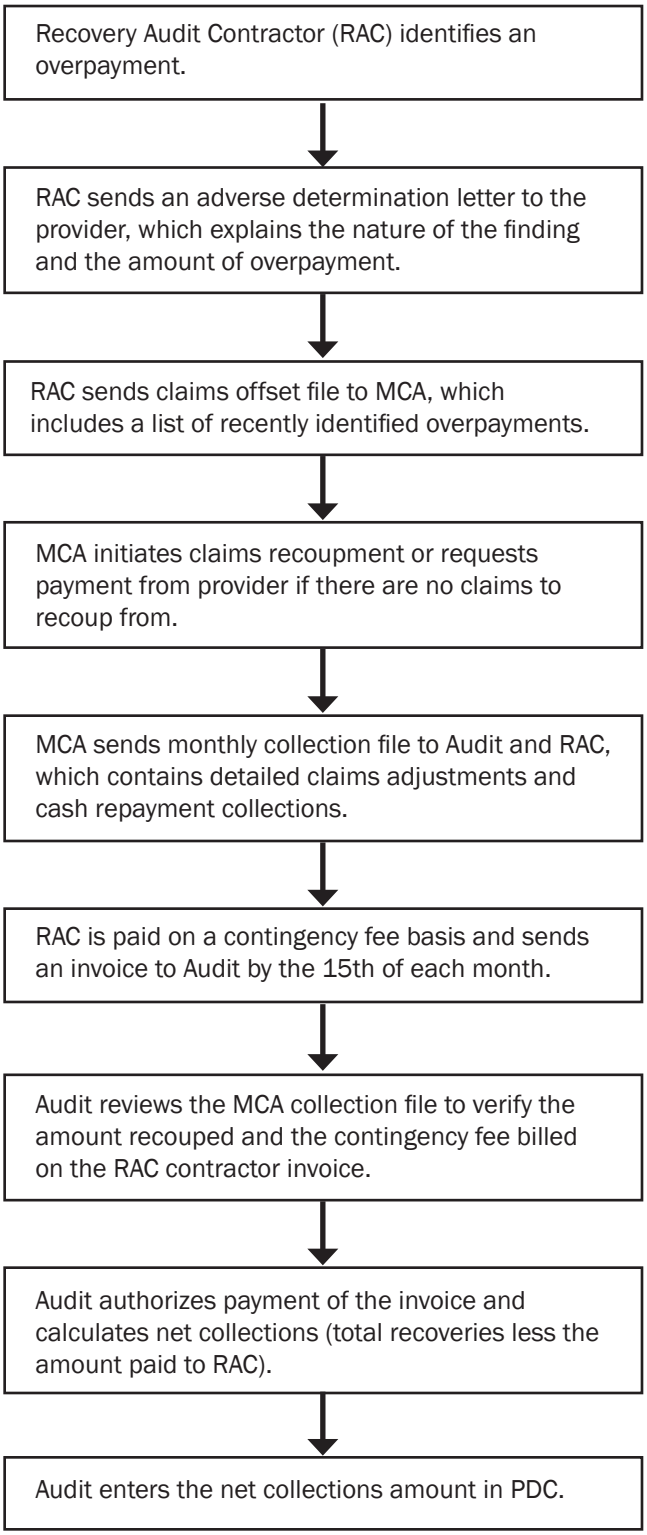
When the RAC identifies an overpayment to a provider, the RAC sends an adverse determination letter to the provider, which explains the nature and the amount of the overpayment. The RAC periodically submits a claims recoupment file to the MCA, which includes a list of recently identified overpayments. The MCA establishes an accounts receivable and initiates claims recoupments. If a provider does not have future payments to offset, the MCA sends a notice to the provider requesting payment.

The MCA sends a monthly collection file to the RAC and the Audit Division. The file contains detailed claims adjustments and cash repayment collections.

The RAC is paid on a contingency fee basis and submits an invoice to the Audit Division by the 15th of each month. The invoice includes the dollars collected in the prior month and the amount due to the RAC. The amount due is calculated using percentages defined in the RAC contract. Percentages vary based on the type of review performed.

Audit Division staff reviews the collection file provided by the MCA to verify the amount recouped and the contingency fee amount billed on the RAC invoice. Audit Division staff then authorizes payment of the invoice, calculates net collections (total recoveries less the amount paid to the RAC), and includes the net collections amount in the recovery total it enters in the PDC each month.

Figure 5.2: Recovery Audit Contractor recoveries process



Section 6: Division of Medical Services

Background

The Division of Medical Services (DMS) conducts claims and medical record reviews of acute care, hospital, and nursing facility utilization; research and detection; and the Pharmacy Lock-in Program. The division also provides clinical consultation to the Investigations, Audit, and Inspections divisions on dental, medical, nursing, and pharmacy services.

- **Clinical Subject Matter Expert (CSME) Team.** Provides clinical expertise to IG investigations, audits, and inspections; special collaborative initiatives; and Chief Counsel staff. The CSME team also works with MCO and Dental Management Organization (DMO) compliance departments on clinical documentation and medical/dental policy interpretation.
- **Acute Care Surveillance (ACS) Team.** Identifies patterns of irregular billing, performs Surveillance Utilization Reviews required by the Centers for Medicare and Medicaid Services (CMS), develops and runs targeted data queries to identify acute care billing outliers, and collects Medicaid overpayments.
- **Quality Review Team.** Conducts retrospective utilization reviews (UR) of hospitals and nursing facilities, and administers the Pharmacy Lock-in Program. The Utilization Review team performs on-site and desk reviews of hospital claims and nursing facility Minimum Data Set forms for appropriate billing. Pharmacy Lock-in Program staff works with MCOs to monitor client use of prescription medications and acute care services.

Hospital and Acute Care recoveries process

Hospital and acute care recoupments are handled through the MCA. When a medical records review reveals an overpayment, DMS staff sends an overpayment notice informing the provider of the overpayment amount and instructions to repay or appeal (or, in the case of inpatient hospital utilization review, only the instructions to appeal). DMS staff then submit a State Action Request (SAR) in MCATS instructing the MCA to conduct a claims recoupment to recover the overpayment. The MCA researches the claim and responds to the SAR in MCATS when the adjustment has been made.

With hospital utilization reviews and recoupments, DMS receives the recoupment data through an interface with the HUR system. With acute care claims and recoupments, nurses manually enter the claims and recoupments into Case Tracker.

Table 6.1: DMS recoveries FY 2017

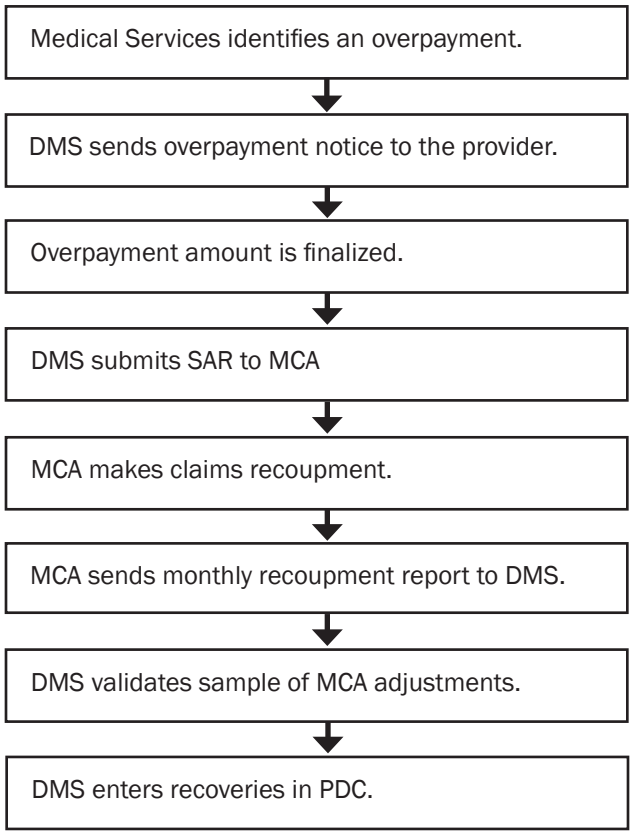
	All Funds	General Revenue (est.)
ACS	$5,944,702	$2,604,968
UR (Hospitals)	$27,549,491	$12,072,187
UR (Nursing homes)	$3,961,925	$1,736,116
Voluntary repayments	$244,282	$107,044
Total	**$37,700,400**	**$16,520,315**

Table 6.2: DMS performance FY 2017

Audit type	Reviews
ACS reviews	1,405
Hospital claim reviews completed	50,360
Nursing facility onsite reviews completed	434

Source: IG Performance Data Compiler

Figure 6.1: DMS hospital and acute care services recoveries process



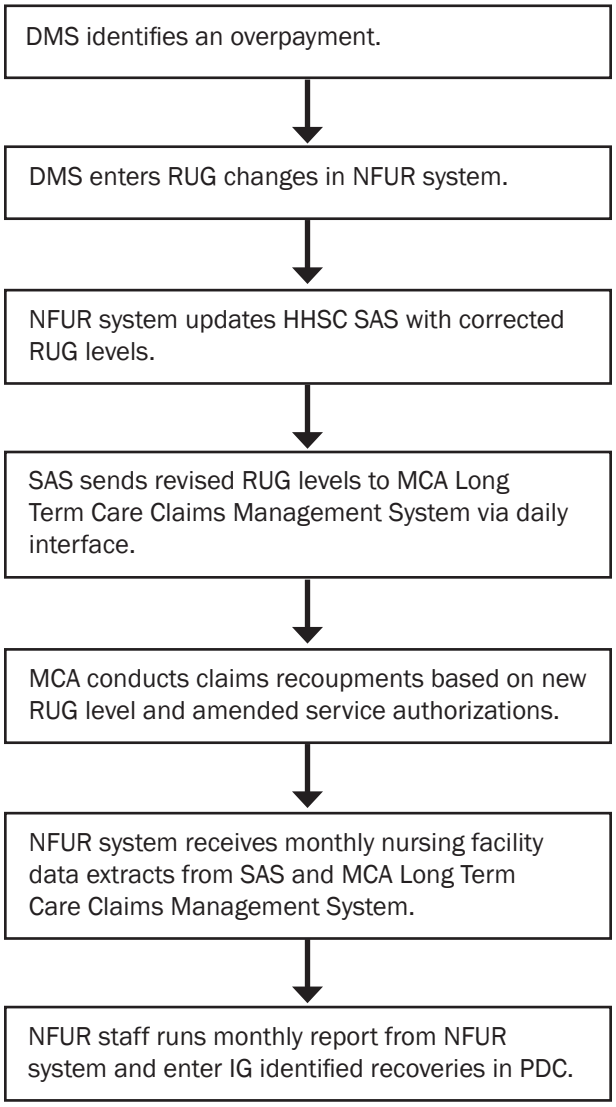
DMS then enters the aggregate recovery value into the PDC monthly.

Nursing Facilities recoveries process

When DMS Nursing Facility Utilization Review (NFUR) staff identifies a nursing facility overpayment and it is finalized through the appeals process, they enter Resource Utilization Group (RUG) changes into the IG's NFUR system. Information from the NFUR system is then sent via file transfer to HHSC's Service Authorization System (SAS). The SAS serves as the source of record for the authorized services for a particular long-term care Medicaid client. RUG updates from the SAS are sent to the MCA's Long Term Care Claims Management System on a daily basis, which is part of what determines the amount that a provider can bill for client services. When NFUR staff changes a client's RUG level, the service authorizations for that client are changed accordingly in all downstream systems, and the MCA conducts nursing facility claims recoupments based on the amended service authorizations. The MCA then sends a file of the adjusted claims to HHSC AR staff, who processes the claims payments through the Comptroller's Office. Each month, claims information from the SAS and Long Term Care Claims Management Systems related to nursing facilities is populated in the NFUR system, and NFUR staff then runs a Business Objects report from the NFUR system that identifies all recoveries that are the result of NFUR identified overpayments or underpayments from the previous month. NFUR staff enters the aggregate value into the PDC.

If the dates of service to which the RUG changes apply are more than three years old (current state fiscal year and two prior years), instead of the claims recoupment process, a credit collection process is initiated by HHSC. When collections are eventually recovered, they are captured in the NFUR system, as well, and are included by NFUR in the PDC entry.

Figure 6.2: DMS nursing facilities recoveries process



Section 7: Inspections Division

Background

The Inspections Division conducts inspections of Texas Health and Human Services programs, systems, and functions. Inspections are designed to be expeditious, targeted examinations into specific programmatic areas to identify systemic trends of fraud, waste, and abuse. Inspections typically result in recommendations to strengthen program effectiveness and efficiency.

The Inspections Division also oversees the state's WIC Vendor Monitoring Unit. This unit conducts in-store evaluations, compliance buys, and invoice audits to monitor vendors participating in the WIC program.

Table 7.1: Inspections recoveries FY 2017

	All Funds	General Revenue (est.)
WIC recoveries	$22,849	$0

Table 7.2: Inspections performance FY 2017

Inspections	2
WIC Invoice Audits	6
WIC compliance buys	269

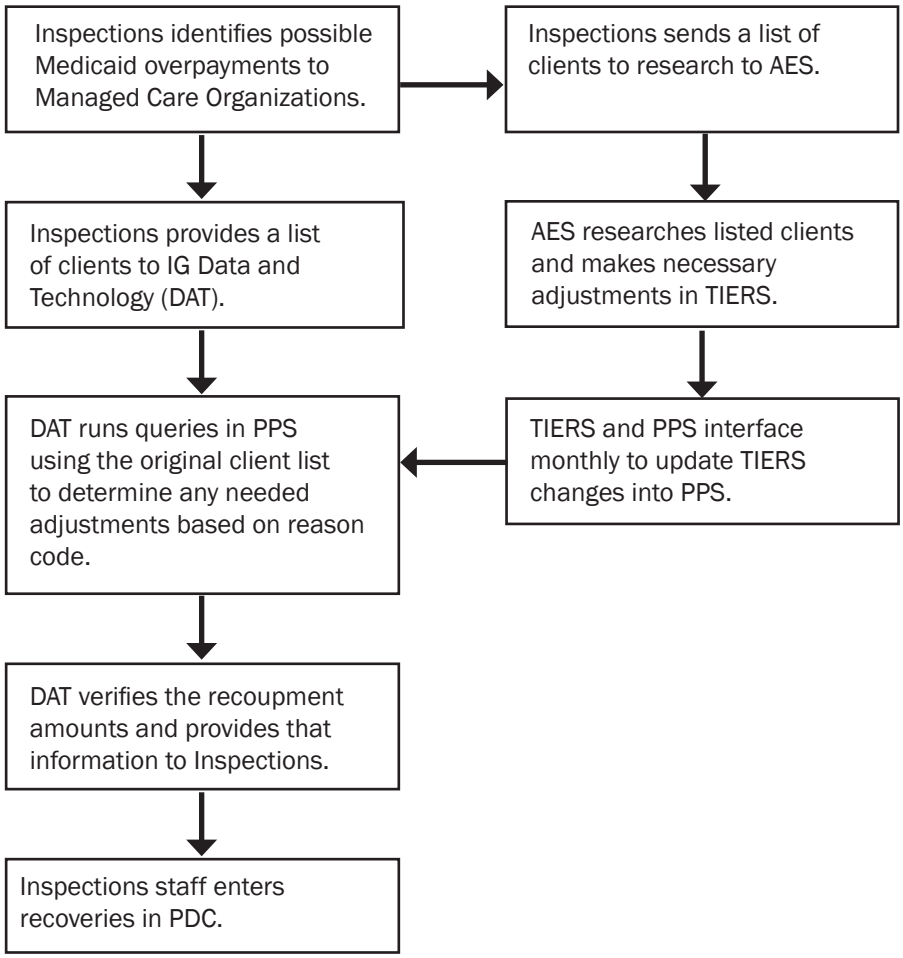
Source: IG Performance Data Compiler

Inspections recoveries process

Not every inspection will result in a recovery. The Inspections Division has two inspections in progress that have identified recoveries from MCOs, which will be reported in fiscal year 2018. Inspections is working with HHSC Access and Eligibility Services (AES) to identify and recover MCO capitation payments made in error to MCOs for deceased clients and clients with multiple Medicaid identifiers. The process described below is particular to the current inspections that are in progress. Given that inspections can be conducted on a variety of HHS programs and services, future recovery processes will depend upon the program or service upon which the inspection focuses.

When an inspection reveals a potential overpayment to an MCO, Inspections staff provides AES with a list of the associated clients related to the potential overpayment. AES researches the information from Inspections and, when approved, makes changes to the client records in the Texas Integrated Eligibility Redesign System (TIERS) to reflect the updated eligibility and enrollment information provided by Inspections. Inspections verifies the data and actions taken. Any discrepancies are then sent to AES for verification and action. Monthly, the PPS (the system in which MCO capitation rates are maintained) interfaces with TIERS to pull all eligibility and enrollment changes and calculates the net aggregate value

Figure 7.1: Inspections recoveries process



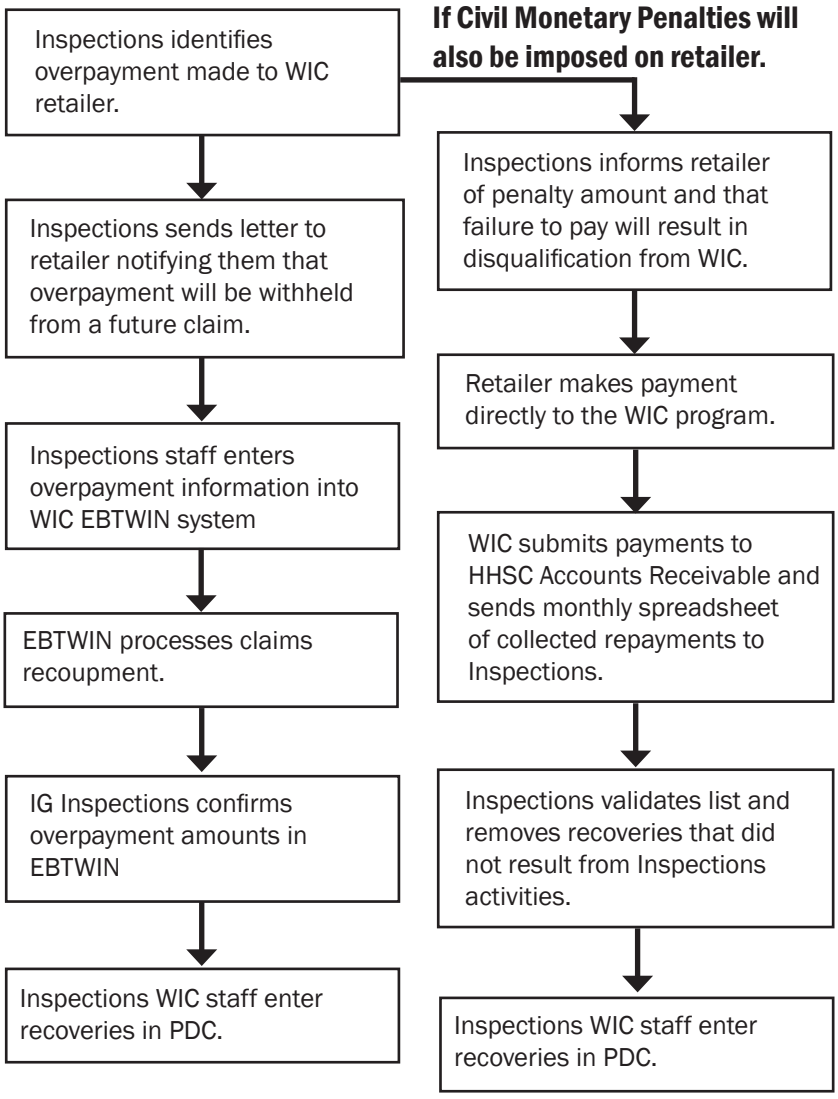
of all eligibility changes (whether identified by the IG or not) for the preceding 23 months and one future month (total of 24 months). Medicaid/CHIP Services then validates and approves the results, sends them to HHSC IT to update in TIERS. HHSC IT sends the TIERS data package to PPS who reviews the data, and creates monthly statements for each MCO. PPS then sends the associated adjustment values to HHSC AR staff, who enter the information into CAPPS Financials in order to adjust future payments to the MCOs. To ensure that the IG only captures recoveries that related to eligibility adjustments that were identified by Inspections, the IG's Data & Technology team runs a report of the PPS adjustments and compares that list to the list of clients, and AES- actioned clients list that Inspections sent to AES. Inspections staff then enter the associated recovery value in the PDC.

WIC Retailers recoveries process

Inspections staff may identify irregularities in the WIC program through the WIC Vendor Monitoring Unit. Inspections staff may find during a compliance buy that a vendor:

- Overcharged for items purchased
- Sold unauthorized items
- Charged for items not received
- Paid cash for benefits

Figure 7.2: Inspections WIC retailer recoveries process



The WIC Vendor Monitoring Unit conducts invoice audits and compliance buys. When an overpayment to a WIC retailer is identified through either method, Inspections staff sends a letter to the retailer notifying them that the amount of the identified overpayment will be withheld from a future claim. Inspections staff then enters the information into the WIC Electronic Benefits Transfer WIC Information Network (EBTWIN) system, which is the database for all WIC client and retailer information, balances, and transactions. Based on data entered by Inspections, the EBTWIN system processes a claims adjustment to reduce the amount of a future WIC payment to the vendor. Each month, Inspections staff confirms the identified overpayment amounts in EBTWIN and then enter the dollar value of the total claims adjustment into the PDC.

Upon completion of a Compliance Buy, Inspections staff may also issue Civil Monetary Penalties (CMP) to the retailer. When a CMP is issued, Inspections notifies the retailer of the CMP amount and informs them that they will be disqualified from the WIC program unless they pay the CMP. The written notice instructs the retailer to remit payment directly to WIC. WIC submits cash recoveries received to HHSC AR staff for deposit and sends a monthly spreadsheet of repayments collected to Inspections. Inspections validates the list, reduces it to only those recoveries that resulted from Inspections activities, and enters the aggregate value of recoveries resulting from Inspections activities into the PDC.

Section 8: Federal reporting

HHSC is responsible for federal reporting and calculation of federal funds that are returned based on IG recoveries. The federal portion of the recoveries/overpayments are reported along with other program expenses and revenues. IG recoveries are not identified specifically. The report includes the offset of the overpayments and a net amount of revenues and expenditures.

Medicaid

All Medicaid reimbursements are split according to the Federal Medical Assistance Percentages (FMAP) rates. The FMAP rate applied at the time of recovery depends on the claim type determination of either "claim specific" or "non-claim specific." For claim specific recoveries, where there is an adjustment to a specific claim, the federal share is determined by the FMAP rate paid for the specific date of service. The current year FMAP rate is used to determine the federal share of non-claim specific recoveries where the original payment date and rate cannot be determined, usually due to a settlement. Medicaid recoveries are reported to the federal government through the CMS 64 report. Recoveries are returned to the program to provide benefits to other clients.

CHIP

CHIP recoveries are split according to the current CHIP Enhanced FMAP rate. The federal portion in fiscal year 2018 is 92.82 percent. CHIP recoveries are reported quarterly on the CMS-21 report. Recoveries are returned to the program to provide benefits to other clients.

SNAP

SNAP is 100 percent federally funded; however, the state is allowed to keep a percentage of the recovery depending on the type of error that led to the overpayment. There are three types of overpayments in SNAP: Intentional Program Violations (fraud), Inadvertent Household Error (client error) and Agency Error.

The federal share of SNAP recoveries is calculated by ARTS. SNAP reports are submitted on a monthly (FNS46 and FNS388), quarterly (FNS798/SF425), and semi-annual (FNS388A) basis. Recoveries are returned to the program to provide benefits to other clients.

Table 8.1: State share of SNAP recoveries by error type

Error type	State share
Intentional program violations	30%
Inadvertent household error	20%
Agency error	0%

TANF

TANF is a federally funded block grant. Recoveries are returned to the program to provide benefits to other clients. TANF recoveries are reported quarterly on the 196R.

WIC

WIC is 100 percent federally funded. Any recoveries are transferred back to the program to provide benefits to other clients. WIC recoveries are reported monthly on the FNS798 and annually on the FNS798A.

Appendix: Acronyms used in this report

ACS: Acute Care Surveillance

ADH: Administrative Disqualification Hearing

AE: Agency Error

AES: Access and Eligibility Services

AR: Accounts Receivable

ARTS: Accounts Receivable Tracking System

ASOIG: Automated System for Office of Inspector General

CE: Client Error

CHIP: Children's Health Insurance Program

CMF: Civil Medicaid Fraud (Attorney General's Office)

CMP: Civil Monetary Penalty

CMS: Centers for Medicare and Medicaid Services

DFPS: Department of Family and Protective Services

EBT: Electronic Benefits Transfer

EBTWIN: Electronic Benefits Transfer WIC Information Network

FFS: Fee-for-Service

FMAP: Federal Medical Assistance Percentages

FNS: U.S. Department of Agriculture's Food and Nutrition Service

GI: General Investigations

HHS: Texas Health and Human Services

HHSC: Health and Human Services Commission

HUR: Hospital Utilization Review

IA: Internal Affairs

IG: Office of Inspector General

IPV: Intentional Program Violations

MCA: Medicaid Claims Administrator

MCO: Managed Care Organization

MIC: Medicaid Integrity Contractor

MCATS: Medicaid/CHIP Contract Administration Tracking System

MFCU: Medicaid Fraud Control Unit (Attorney General's Office)

MFADS: Medicaid Fraud and Abuse Detection System

MPI: Medicaid Program Integrity

NFUR: Nursing Facility Utilization Review

PDC: Performance Data Compiler

PPS: Premium Payment System

RAC: Recovery Audit Contractor

RUG: Resource Utilization Group

SAR: State Action Request

SAS: Service Authorization System

SNAP: Supplemental Nutrition Assistance Program

TANF: Temporary Assistance for Needy Families

TIERS: Texas Integrated Enrollment Redesign System

TMHP: Texas Medicaid & Healthcare Partnership

TOP: Treasury Offset Program

UR: Utilization Review

VRP: Voluntary Repayment Program

WIC: Women, Infants, and Children Program