Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

TEXAS DID NOT REPORT AND RETURN ALL MEDICAID OVERPAYMENTS FOR THE STATE'S MEDICAID FRAUD CONTROL UNIT CASES

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Amy J. Frontz
Deputy Inspector General
for Audit Services

May 2022
A-06-20-04004

Office of Inspector General

https://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These audits help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at https://oig.hhs.gov

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG website.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief
Date: May 2022
Report No. A-06-20-04004

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Texas Did Not Report and Return All Medicaid Overpayments for the State's Medicaid Fraud Control Unit Cases

Why OIG Did This Audit

This audit is one of a series of audits to determine whether States had recovered, and returned the correct Federal share of, improper provider claim amounts. For this audit, we focused on Texas' Medicaid Fraud Control Unit (MFCU) actions related to the recoveries of Medicaid overpayments through legal judgments and settlements that the State had pursued under relevant Medicaid fraud statutes. Texas is required to report recoveries for these MFCU-determined Medicaid overpayments to the Centers for Medicare & Medicaid Services (CMS) and to refund the Federal share to the Federal Government.

Our objective was to determine whether Texas reported and returned the correct Federal share of MFCU-determined Medicaid overpayments identified during the period October 1, 2016, through September 30, 2018.

How OIG Did This Audit

We determined that there were 217 cases with MFCU-determined Medicaid overpayments for our audit period and that restitution was owed for 65 cases. We reviewed documentation supporting the reporting of the MFCU-determined Medicaid overpayments and reconciled the overpayments with the corresponding Form CMS-64s. We reviewed Texas' payment documentation to determine whether Texas returned the correct Federal share of its recoveries.

What OIG Found

Texas did not correctly report and return the Federal share of all MFCU-determined Medicaid overpayments identified for the period October 1, 2016, through September 30, 2018. We determined that Texas should have reported MFCU-determined Medicaid overpayments totaling $24.3 million (at least $13.9 million Federal share) for the 65 cases with Medicaid restitution during the period that we reviewed. Texas correctly reported $46,369 ($26,982 Federal share) in MFCU-determined Medicaid overpayments for 2 of the 65 cases and did not correctly report the remaining 63 cases. For the 63 cases, Texas did not report and return overpayments totaling $19.0 million ($11.1 million Federal share) for 26 cases for our audit period. (Texas later returned the Federal share on the fiscal year (FY) 2020 and FY 2021 Form CMS-64s as a result of our audit.) In addition, Texas did not report $5.2 million (at least $2.7 million Federal share) for 37 cases within the required timeframe. These issues occurred because Texas did not have adequate internal controls to ensure that it always reported MFCU-determined Medicaid overpayments in accordance with Federal requirements.

What OIG Recommends and Texas Comments

We recommend that Texas (1) report and return the Federal share for the 26 cases, totaling $19.0 million ($11.1 million Federal share); (2) strengthen internal controls by developing written policies and procedures, including procedures for recording MFCU-determined Medicaid overpayments, and reconciling case files received from the MFCU with the overpayments recorded in the State agency's accounting system; (3) ensure that it reports all MFCU-determined Medicaid overpayments in accordance with Federal regulations and within regulatory timeframes; and (4) review the MFCU-determined Medicaid overpayments for cases after our audit period to ensure that all overpayments were reported on the Form CMS-64.

In written comments on our draft report, Texas concurred with all of our recommendations. Texas stated that, during the course of our audit, it reported and returned the Federal share of overpayments for the 26 cases, totaling $19.0 million ($11.1 million Federal share). In addition, Texas described steps it has taken to address our procedural recommendations.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS AUDIT

This audit is one of a series of audits to determine whether States had recovered, and returned the correct Federal share of, improper provider claim amounts. A previous Office of Inspector General (OIG) audit[1] found that a State Medicaid agency did not report and refund the correct Federal share of Medicaid-related overpayments for 76 percent of the State's Medicaid Fraud Control Unit (MFCU) cases.[2] For this audit, we focused on Texas' MFCU actions related to the recoveries of Medicaid overpayments through legal judgments and settlements that the State had pursued under relevant Medicaid fraud statutes. We refer to these recoveries as "MFCU-determined Medicaid overpayments." The Texas Health and Human Services Commission (State agency) is required to report these recoveries to the Centers for Medicare & Medicaid Services (CMS) on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) and to refund the Federal share of those recoveries to the Federal Government.

OBJECTIVE

Our objective was to determine whether the State agency reported and returned the correct Federal share of MFCU-determined Medicaid overpayments identified during the period October 1, 2016, through September 30, 2018 (Federal fiscal years (FYs) 2017 through 2018).

BACKGROUND

Medicaid Program and Medicaid Fraud Control Units

The Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. The State plan establishes which services the Medicaid program will cover. Although a State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements.

The Federal Government pays its share of a State's medical assistance costs (Federal share) under the Medicaid program on the basis of the Federal medical assistance percentage (FMAP),

[1] *Nebraska Did Not Report and Refund the Correct Federal Share of Medicaid-Related Overpayments for 76 Percent of the State's Medicaid Fraud Control Unit Cases,* A-07-18-02814 (June 2021). Available online at https://www.oig.hhs.gov/oas/reports/region7/71802814.pdf.

[2] MFCUs, which are required by Federal statue, investigate and prosecute Medicaid provider fraud and patient abuse and neglect in health care facilities and board and care facilities.

which changes each FY and varies depending on the State's relative per capita income. The State agency is responsible for computing and reporting the Federal share, which is based on the total computable amount multiplied by the FMAP.[3] The total computable amount and the Federal share are both reported on the Form CMS-64. During our audit period, Texas' FMAP ranged from 56.18 percent to 56.88 percent.

Section 1902(a)(61) of the Act requires each State to operate a MFCU or receive a waiver. The Act, section 1903(q), specifies that the function of State MFCUs is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect in facility settings. The Texas MFCU was established in 1979 as a division of the Office of the Attorney General.

Federal Requirements Concerning Reporting of Medicaid Overpayments

Federal regulations implement sections 1903(d)(2) and (3) of the Act and specify that State agencies have 1 year from the date of discovery to recover Medicaid overpayments before the Federal share must be reported to CMS.[4] These regulations generally direct State agencies to make adjustments for the overpayments after 1 year if recovery is not made, unless the overpayments are fraud-related and are being determined in the courts.

Federal regulations also state that for cases involving fraud in which a State is unable to recover a Medicaid overpayment because the relevant court has not determined the overpayment amount, the State is not required to report the Federal share of the overpayment until 30 days after the date of the final judgment. Once the court has determined the overpayment amount (that is, reached a final judgment, including, if applicable, a final judgment that has been appealed), the State then has 30 days to collect the overpayment from the provider before reporting that amount on the Form CMS-64 for adjustment (42 CFR § 433.316(d)(2) and *Medicaid Program Integrity Manual,* chapter 11, § 11005).[5]

Reporting of Fraud-Related Medicaid Overpayments

States use the Form CMS-64 to report actual Medicaid expenditures for each quarter. In turn, CMS uses the Form CMS-64 to reimburse States for the Federal share of Medicaid expenditures. The amounts that States report on the Form CMS-64 and its attachments must be actual expenditures with supporting documentation (42 CFR § 430.30).

[3] CMS's *2018 Payment Error Rate Measurement Manual* defines the Form CMS-64 "total computable amount" as the Federal share plus the State share of Medicaid costs.

[4] Under 42 CFR § 433.316(d)(1), an overpayment that results from fraud is discovered on the date of the final written notice, as defined under 42 CFR § 433.304, of the State's overpayment determination.

[5] The *Medicaid Program Integrity Manual* was revised into only two chapters, effective Apr. 3, 2018. Chapter 11 no longer exists in the current *Medicaid Program Integrity Manual*; however, it was in effect for most of our audit period.

CMS's *Medicaid Program Integrity Manual*, Pub. No 100-15, instructs State agencies to report MFCU-determined Medicaid overpayments on line 2 of the Form CMS-64.9C1 feeder form[6] (Form CMS-64.9C1), if collected, or, for overpayments identified but not yet collected within regulatory timelines, on the Form CMS-64.9O feeder form[7] (Form CMS-64.9O) (chapter 11, §§ 11005 and 11035).[8]

CMS's *State Medicaid Manual*, Pub. No. 45, instructs State agencies to apply the FMAP rate at which the original expenditure was matched when reporting recoveries (chapter 2, §§ 2500 (D)(2) and 2500.6(B)). If the expenditure cannot be immediately tied to a specific period, State agencies are to compute the Federal share at the FMAP rate in effect at the time the refund was received.

According to CMS officials:

- In FY 2011, CMS revised the Form CMS-64.9O so that State agencies should report only Medicaid overpayments not resulting from fraud, waste, and abuse on that form.

- At the same time, CMS introduced the Form CMS-64.9OFWA feeder form (Form CMS-64.9OFWA) to separately track uncollected Medicaid overpayments resulting from fraud, waste, and abuse (including MFCU-determined Medicaid overpayments).

- The Form CMS-64.9OFWA is formatted similarly to the Form CMS-64.9C1 but includes a separate line for State agencies to report amounts reclaimed for cases in which the State agencies subsequently determine that the providers in question are bankrupt or out of business. The Form CMS-64.9OFWA was available in the Medicaid Budget and Expenditures System beginning with FY 2011.[9, 10]

[6] The Form CMS-64.9C1 feeder form is used to provide detailed information about fraud, waste, and abuse collection efforts. The total from this feeder form carries over to the Form CMS-64 Summary sheet, line 9c.

[7] Before it was revised (as discussed below), the Form CMS-64.9O feeder form was used to provide detailed information about overpayments identified but not yet collected, including overpayments concerning fraud, waste, and abuse. The total from this feeder form carried over to the Form CMS-64 Summary sheet, line 10c.

[8] CMS's *State Medicaid Manual*, chapter 2, § 2500.1(B), sets forth detailed instructions for the Form CMS-64 and states that collections identified through fraud, waste, and abuse efforts should be reported on line 9c.

[9] The Medicaid Budget and Expenditures System is a Web-based application that Medicaid and Children's Health Insurance Program (CHIP) State agencies use to report budgeted and actual expenditures for Medicaid and CHIP for each fiscal period in addition to the actual quarterly expenditures that occur. Summarized statistical data are available for download.

[10] The *Medicaid Program Integrity Manual* in effect for most of our audit period did not include guidance for the preparation of the Form CMS-64.9OFWA. CMS updated this manual in FY 2018, the last year of our audit period; this update eliminated guidance for the preparation of the Form CMS-64.9C1. Information for the Form CMS-64 and its feeder forms and subsidiary schedules is available at https://www.medicaid.gov/medicaid/finance/state-expenditure-reporting/index.html (accessed Sept. 8, 2021).

State Agency Policies and Procedures for Reporting Medicaid Fraud Control Unit-Determined Overpayments

The State agency has written procedures concerning preparation and submission of the Form CMS-64, which include procedures for reporting Medicaid overpayments. The State agency receives final case files from the MFCU and records the Medicaid restitution owed according to the final judgment or settlement. In response to our questions regarding reporting timelines for MFCU-determined Medicaid overpayments, State agency officials explained to us that these overpayments are reported after the provider has paid either all or part of the overpayment, or after 1 year from the date of final determination if all or some of the overpayments have not been collected.

HOW WE CONDUCTED THIS AUDIT

We determined that there were 217 cases with MFCU-determined Medicaid overpayments for our audit period (October 1, 2016, through September 30, 2018). We reviewed all 217 case files from the State agency and determined that Medicaid restitution was owed for 65 cases.[11] We reviewed the State agency's documentation supporting its reporting of the MFCU-determined Medicaid overpayments and reconciled the overpayments to the corresponding Form CMS-64s. We reviewed State agency payment documentation to determine whether the State agency returned the correct Federal share of its recoveries.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

See Appendix A for details on our audit scope and methodology.

FINDINGS

The State agency did not correctly report and return the Federal share of all MFCU-determined Medicaid overpayments identified for the period October 1, 2016, through September 30, 2018. We determined that the State agency should have reported MFCU-determined Medicaid overpayments totaling $24,327,152 (at least $13,932,365 Federal share) for the 65 cases with Medicaid restitution during the period that we reviewed. However, the State agency correctly reported $46,369 ($26,982 Federal share) in MFCU-determined Medicaid overpayments for 2 of the 65 cases and did not correctly report the remaining 63 cases.

[11] The State agency reported that these were final judgments; we did not determine whether any judgments were on appeal.

Specifically, for the 63 cases with MFCU-determined Medicaid overpayments that the State agency did not correctly report and return, the State agency:

- did not report and return overpayments totaling $19,034,192 ($11,122,401 Federal share) for 26 cases for our audit period and

- did not report $5,246,591 (at least $2,782,982 Federal share) for 37 cases within the required timeframe.

This occurred because the State agency did not have adequate internal controls to ensure that it always reported MFCU-determined Medicaid overpayments in accordance with Federal requirements. Specifically, the State agency did not have written policies and procedures for recording MFCU-determined Medicaid overpayments in its accounting system or reconciling case files received from the MFCU to the MFCU-determined Medicaid overpayments recorded in its accounting system.

FEDERAL REQUIREMENTS AND GUIDANCE REGARDING THE REPORTING OF MEDICAID FRAUD CONTROL UNIT-DETERMINED MEDICAID OVERPAYMENTS

Federal regulations implementing sections 1903(d)(2)(C) and (D) of the Act state:

> [A] State has 1 year from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 1-year period, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable (42 CFR § 433.300(b)).

Federal regulations also state that for cases involving fraud in which a State is unable to recover a Medicaid overpayment because the relevant court has not determined the overpayment amount, the State is not required to return the Federal share of the overpayment until 30 days after the date of the final judgment. Once the court has determined the overpayment amount (that is, has reached a final judgment, including, if applicable, a final judgment that has been appealed), the State then has 30 days to collect the overpayment from the provider before reporting that amount on the Form CMS-64 for adjustment (42 CFR § 433.316(d)(2) and *Medicaid Program Integrity Manual* § 11005).

The *Medicaid Program Integrity Manual*, Pub. No. 100-15, instructs State agencies to report MFCU-determined Medicaid overpayments on line 2 of the Form CMS-64.9C1, if collected, or,

for overpayments identified but not yet collected on the Form CMS-64.9O (chapter 11 § 11035).[12]

Appendix B contains the Federal requirements and guidance related to the reporting of MFCU-determined Medicaid overpayments.

THE STATE AGENCY DID NOT REPORT AND RETURN THE FEDERAL SHARE OF ALL MEDICAID FRAUD CONTROL UNIT-DETERMINED MEDICAID OVERPAYMENTS

The State agency did not report and return the Federal share of MFCU-determined Medicaid overpayments for 26 cases, totaling $19,034,192 ($11,122,401 Federal share), until after our audit identified them. The State agency did not report and return the Federal share of the MFCU-determined Medicaid overpayments because it did not always record the restitution owed in its accounting system and did not have adequate internal controls. Specifically, the State agency did not have a process for reconciling case files received from the MFCU to the MFCU-determined Medicaid overpayments recorded in its accounting system to ensure that all cases were recorded. As a result, the State agency did not return $11,122,401 to the Federal Government during the audit period. However, as a result of our audit, the State agency later reported and returned the Federal share for these cases on FY 2020 and FY 2021 Form CMS-64s.

THE STATE AGENCY DID NOT REPORT MEDICAID FRAUD CONTROL UNIT-DETERMINED MEDICAID OVERPAYMENTS WITHIN THE REQUIRED TIMEFRAME

The State agency was late in reporting and returning $5,246,591 (at least $2,782,982 Federal share) of MFCU-determined Medicaid overpayments for 37 cases:

- Overpayments associated with 14 cases involving managed care organizations (MCOs), totaling $2,547,149 ($1,433,261 Federal share), were reported late because the State agency did not modify its reporting process to address a change in State legislation regarding MCO overpayments that was introduced in 2017 until FY 2020.[13]

- Overpayments associated with 23 cases, totaling $2,699,442 (at least $1,349,721 Federal share), were reported late because State agency officials believed that once the court had made its final determination, the State agency had an additional 1 year to

[12] Beginning in FY 2010, CMS implemented the Form CMS-64.9OFWA feeder form (Form CMS-64.9OFWA) to separately track uncollected Medicaid overpayments resulting from fraud, waste, and abuse (including MFCU-determined Medicaid overpayments).

[13] In 2017, the Texas Legislature passed HB 2379, which amended Texas Government Code § 531.1131 by specifying how the MCOs and Texas Health and Human Services Commission Inspector General should split monies recovered in fraud and abuse cases discovered by the MCOs or Commission's Inspector General. The State agency indicated that this change caused it to analyze the effect, if any, of that law on cases involving payments to providers from MCOs and caused delays in reporting the overpayments identified in this audit.

report MFCU-determined Medicaid overpayments. However, the specified timeframe for these cases is 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made (42 CFR § 433.316(d)(2) and *Medicaid Program Integrity Manual* § 11005).

The table shows how late the State agency was in reporting the 37 cases.

Table: MCFU-Determined Medicaid Overpayment Reporting

Overpayments Reported on the Form CMS-64	Number of Cases
Less Than 1 Year Late*	6
1 to Less Than 2 Years Late	21
2 to Less than 3 Years Late	9
3 to Less than 4 Years Late	1
Total Cases	37

* The timeframe starts 30 days after the final judgement is made.

As a result, the Federal Government did not receive its share of the MFCU-determined Medicaid overpayments in a timely manner.

RECOMMENDATIONS

We recommend that the Texas Health and Human Services Commission:

- report and return the Federal share for the 26 cases, totaling $19,034,192 ($11,122,401 Federal share);[14]

- strengthen internal controls by developing written policies and procedures, including procedures for recording MFCU-determined Medicaid overpayments, and reconciling case files received from the MFCU with the overpayments recorded in the State agency's accounting system;

- ensure that it reports all MFCU-determined Medicaid overpayments in accordance with Federal regulations and within regulatory timeframes; and

- review the MFCU-determined Medicaid overpayments for cases after our audit period to ensure that all overpayments were reported on the Form CMS-64.

[14] After our audit identified the missing payments, the State agency reported and returned the Federal share for these 26 cases. We reviewed documentation to confirm that this amount was reported and returned.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and described the corrective actions that it has taken to address them.

In response to our recommendation to report and return the Federal share for the 26 cases, totaling $19,034,192 ($11,122,401 Federal share), the State agency responded that the funds were returned during the course of the audit, as noted in the report.

In response to our second and third recommendations to strengthen internal controls and report all overpayments in accordance with Federal requirements, the State agency stated that its procedures have been updated to include requirements for (1) the reconciliation of all MFCU cases; (2) a second-level review to ensure that overpayments are accurate and documented; (3) appropriate processing and documentation of cases involving MCOs; and (4) payments of judgments within 30 days, when applicable.

In response to our recommendation that it should review the MFCU-determined Medicaid overpayments for cases after our audit period to ensure that all overpayments were reported on the Form CMS-64, the State agency responded that it had completed reconciliations for FYs 2019, 2020, and 2021.

The State agency's comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

According to information provided by the State agency, during our audit period (October 1, 2016, through September 30, 2018) the Texas MFCU received final determinations for 217 cases. We reviewed the 217 case files and determined that 65 cases had Medicaid restitution that was owed. This audit covers the 65 MFCU cases with associated MFCU-determined Medicaid overpayments totaling $24,327,152.

We did not audit the State agency's overall internal control structure. Rather, we reviewed only those internal controls related to our audit objective. To evaluate these internal controls, we interviewed State agency officials to determine policies and procedures related to collecting, recording, and returning MFCU-determined Medicaid overpayments.

We performed our audit work from February 2020 to March 2022.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal law, regulations, and guidance;
- conducted interviews with State agency staff to determine the policies and procedures for collecting, recording, and returning MFCU-determined Medicaid overpayments;
- evaluated policies and procedures for recording the MFCU-determined Medicaid overpayments and determined how the overpayments flowed through the State's accounting system and were reported on the Form CMS-64;
- obtained the amount the State agency reported for MFCU-determined Medicaid overpayments on the Form CMS-64;
- obtained a list from the State agency of all MFCU-related recoveries collected during our audit period;
- obtained a list from the MFCU of finalized fraud cases for our audit period;
- reconciled the MFCU case list to State records;
- obtained the case files for the judgments and settlements that the MFCU finalized during our audit period;

- reviewed case files to identify the amount the State agency should have reported on the Form CMS-64;

- reconciled State agency payment records to Medicaid overpayments reported on the Form CMS-64 to determine whether all payments were reported in accordance with Federal requirements; and

- discussed the results of our audit with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: FEDERAL REQUIREMENTS AND GUIDANCE

FEDERAL LAWS

Section 1903(d)(2)(A) of the Social Security Act (the Act) provides that "[t]he Secretary [of Health and Human Services (HHS)] shall . . . pay to the State, in such installments as he may determine, the amount so estimated, reduced, or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection."

Section 1903(d)(3)(A) of the Act provides that "[t]he pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection."

FEDERAL REGULATIONS

Federal regulations (42 CFR § 433.300(b)) state:

> Section 1903(d)(2)(C) and (D) of the Act . . . provides that a State has 1 year from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 1-year period, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.

Federal regulations state: "The date on which an overpayment is discovered is the beginning date of the 1-year period allowed for a State to recover or seek to recover an overpayment before a refund of the Federal share of an overpayment must be made to CMS" (42 CFR § 433.316(a)).

Under 42 CFR § 433.316(d)(1), an overpayment that results from fraud is discovered on the date of the final written notice, as defined under 42 CFR § 433.304, of the State's overpayment determination.

Federal regulations (42 CFR § 433.316(d)(2)) state:

> When the State is unable to recover a debt which represents an overpayment (or any portion thereof) resulting from fraud within 1 year of discovery because no final determination of the amount of the overpayment has been made under an administrative or judicial process (as applicable), including as a result of a

judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or any portion thereof) until 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

CMS GUIDANCE

The *Medicaid Program Integrity Manual*, September 23, 2011, states: "The Form CMS-64.9C1 feeder form is used to provide detail about the fraud, waste, and abuse collection efforts and flows into line 9c of the Form CMS-64" (chapter 11, § 11035).

This manual also provides instructions for reporting MFCU-determined Medicaid overpayments on the Form CMS-64.9C1: "Line 2—MFCU Investigations [:] Used to report overpayment amounts collected from investigations conducted by the State's MFCU" (chapter 11, § 11035).

APPENDIX C: STATE AGENCY COMMENTS

HHSC Management Responses to
U.S. Department of Health and Human Services Office of Inspector General
Draft Report date March 29, 2022 - A-06-20-04004 and Titled
"Texas Did Not Report and Return All Medicaid Overpayments For The State's Medicaid Fraud Control Unit Cases"

Recommendation 1: The Texas Health and Human Services Commission (HHSC) report and return the Federal share for the 26 cases, totaling $19,034,192 ($11,122,401).

Management Response

Statement of concurrence/nonconcurrence

Concur. The funds were repaid during the course of the audit. Specifically, the auditors reviewed documentation to confirm that money was reported and returned as noted in footnotes 13 and 15.

Action Plan

As noted in the report, all the funds at issue were returned during the course of the audit. While a number of process changes were underway when the audit began, the processes were further refined during the course of the audit to ensure timely reporting. All issues have been addressed through procedure changes and the annual reconciliations. These reconciliations have also taken place for the years subsequent to the audit.

Responsible Manager

Erik Cary, Interim OIG Chief Counsel

Target Implementation Date

Complete.

Recommendation 2: The Texas HHSC should strengthen internal controls by developing written policies and procedures, including procedures for recording MFCU-determined Medicaid overpayments, and reconciling case files received from the MFCU with the overpayments recorded in the State agency's accounting system.

HHSC Management Responses to
U.S. Department of Health and Human Services Office of Inspector General
Draft Report date March 29, 2022 - A-06-20-04004 and Titled
"Texas Did Not Report and Return All Medicaid Overpayments For The State's Medicaid Fraud Control Unit Cases"

Management Response

Statement of concurrence/nonconcurrence

Concur

Action Plan

OIG procedures have been updated to highlight requirements for:

- reconciliation of all MFCU referrals against the report MFCU sends to Federal OIG Office of Evaluations and Inspections;
- second-level review to ensure accuracy and to ensure overpayments were documented;
- appropriate processing and documentation when MCOs may be entitled to a portion of the settlement; and
- payments of judgments within 30 days when applicable.

Responsible Manager

Erik Cary, Interim OIG Chief Counsel

Target Implementation Date

Complete

Recommendation 3: The Texas HHSC should ensure that it reports all MFCU-determined Medicaid overpayments in accordance with Federal regulations and within regulatory timeframes

HHSC Management Responses to
U.S. Department of Health and Human Services Office of Inspector General
Draft Report date March 29, 2022 - A-06-20-04004 and Titled
"Texas Did Not Report and Return All Medicaid Overpayments For The State's Medicaid Fraud Control Unit Cases"

Management Response

Statement of concurrence/nonconcurrence

Concur

Action Plan

OIG procedures have been updated to highlight requirements for:

- reconciliation of all MFCU referrals against the report MFCU sends to Federal OIG Office of Evaluations and Inspections;
- second-level review to ensure accuracy and to ensure overpayments were documented;
- appropriate processing and documentation when MCOs may be entitled to a portion of the settlement; and
- payments of judgments within 30 days when applicable.

Responsible Manager

Erik Cary, Interim OIG Chief Counsel

Target Implementation Date

Complete

Recommendation 4: The Texas HHSC should review the MFCU-determined Medicaid overpayments for cases after our audit period to ensure that all overpayments were reported on the Form CMS-64.

HHSC Management Responses to
U.S. Department of Health and Human Services Office of Inspector General
Draft Report date March 29, 2022 - A-06-20-04004 and Titled
"Texas Did Not Report and Return All Medicaid Overpayments For The State's Medicaid Fraud Control Unit Cases"

Management Response

Statement of concurrence/nonconcurrence

Concur

Action Plan

The OIG has reconciled MFCU referrals against the report MFCU sends to Federal OAG Office of Inspections and Division for FY 2019 and 2020, and 2021.

OIG procedures have been updated to highlight requirements for:

- reconciliation of all MFCU referrals against the report MFCU sends to Federal OIG Office of Evaluations and Inspections;
- second-level review to ensure accuracy and to ensure overpayments were documented;
- appropriate processing and documentation when MCOs may be entitled to a portion of the settlement; and
- payments of judgments within 30 days when applicable.

Responsible Manager

Erik Cary, Interim OIG Chief Counsel

Target Implementation Date

Complete