Senate Health & Human Services: Medicaid Fraud, Waste and Abuse

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History of Texas Medicaid

1964 – Over 50 years ago, U.S. created the Medicaid Program - Partnership between the federal and state governments

- Federal Government: Sets Guidelines (60/40 match)
- State Governments: Operate the program
- Medicaid is an entitlement program - open ended
- Texas largely covers only federally mandatory populations

1967 – Texas adopted Medicaid - the Texas Medical Assistance Program

1993 – Texas began shifting to a health insurance model - Managed Care

1999 – CHIP implemented in Texas

2011 – Texas expanded Medicaid managed care statewide and carved in most populations and services through an 1115 waiver

Today 97% of Medicaid clients are in Medicaid managed care

2022 Total Medicaid Spending: $57.8 billion

2022 Total MCO Spending: $37.5 billion - 65% of Medicaid spending

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Texas Uses Health Insurance Model for Medicaid

- **Managed care works just like insurance—every month, HHSC pays a health care premium to the MCO for each person** they cover (called the PMPM, per member per month) and in return the MCOs accept all financial risk
- **HHSC actuaries set the premium** every year based on historical claims and the **rates are certified by an independent actuary** and certified a third time by CMS
- **MCOs are obligated to pay for all medically necessary services** for their members, even if it means the rates they receive from HHSC will not fully cover their costs
- **MCOs take on full financial risk**—if in any given year a plan incurs losses, that plan absorbs those losses—**Gives State budget certainty**
- **Texas caps profits and requires health plans to share savings** back to the state (called the experience rebate)
- **Texas also caps administrative spending** resulting in Texas having some of the lowest administrative costs in the country

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What Does Medicaid Managed Care Cover?

Acute Care Services	**Preventative care, diagnostics and medical treatments** Ex: Physician, inpatient and outpatient hospital services, laboratory, x-ray services
Long-Term Services and Supports	**Support with ongoing, daily activities for individuals with disabilities and older adults** Ex: Community-based care, personal assistance with activities of daily living (cleaning, cooking), nursing facility services
Behavioral Health Services	**Screening and treatment for mental health conditions and substance use disorders (SUD)** Ex: Mental health rehabilitation, medication assisted therapy for SUD, psychological and neuropsychological testing
Medical Transport Services	**Non-emergency medical transportation (NEMT)** Ex: Rides to a doctor's office or pharmacy and money for gas to drive to an appointment
Pharmacy Services	**Coverage for prescription drugs**

What is Fraud, Waste and Abuse?

Fraud Intentional	Abuse Improper Actions Leading to Extra Costs	Waste Overuse or Misuse
A provider deliberately deceives or gives false information to gain unauthorized benefits.	Providers overcharging or billing for services that are not needed or do not meet accepted medical standards, or member actions that lead to unnecessary costs.	Overutilization or inappropriate utilization of services or resources
Example: Billing Medicaid for services that were never provided.	**Example:** Charging for unnecessary services or submitting claims with errors that result in overpayment.	**Example:** Ordering too many tests or procedures that do not improve patient outcomes.

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MCOs Partner with the State to Reduce FWA

- **Partnership with OIG:** Identify and report suspected FWA to OIG; conduct pre-payment reviews and assist investigations (mainly Fraud & Abuse).
- **Budget Certainty and Cost Containment:** Fixed annual premiums; MCOs assume full financial risk for care delivery, limiting state exposure.
- **Full Financial Risk for FWA:** MCOs responsible for all costs exceeding premiums, including FWA.
- **Quality and Care Management:** Value-based payment (VBP) programs and alternative payment models (APMs) to address Waste.
- **Utilization Review:** Ongoing assessment of medical necessity and appropriateness of services to prevent overuse and reduce Waste.
- **Experience Rebates:** MCOs must share savings achieved from reduced costs back with the state.
- **Focus on Preventable Events:** Reduce potentially preventable events that increase costs.

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MCO Fraud, Waste, and Abuse (FWA) Requirements

- **Statutory and Contractual Duties:** MCOs must comply with FWA requirements or face penalties (e.g., liquidated damages).
- **Special Investigative Units (SIUs):** Required to investigate and report fraudulent claims and abuse.
- **Formal FWA Plans:** MCOs must develop and submit an annual plan to HHSC OIG, including:
  - Audits, hotlines, payment reviews, data validation, and verification of services billed.
  - Procedures for investigating provider FWA, description of responsible staff, and internal controls.

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Designated Personnel and Reporting Responsibilities

- **Designated Personnel:** Specific staff must oversee FWA activities, attend OIG training, and supervise areas like data collection, provider enrollment, claims processing, utilization review, and quality assurance.
- **Investigation and Reporting:** MCOs investigate all FWA cases and report to OIG within 30 days.
- **Required Reports to OIG:**
  - Fraudulent Practices Referrals: Report all suspected FWA within 30 days.
  - FWA Compliance Plan: Submit annually.
  - Open Case List: Monthly updates on all FWA investigations.
  - Lock-In Actions: Annual report on compliance with lock-in policies.
  - Overpayment Recoveries: Annual report on overpayment recoveries.
  - Pre-payment Review: Monthly report for providers on pre-payment review.
  - Fraud and Abuse Recoveries: Annual data on recoveries and SIU efforts.
  - Quarterly Reports: Detail recovered amounts to HHSC/OIG.

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MCO Special Investigative Units (SIUs) Responsibilities

- **Establish and Maintain SIU:** MCOs are required to create and maintain a Special Investigative Unit to handle FWA.
- **SIUS are required to:**
  - Identify, investigate and report possible acts of FWA to the OIG within 30 days.
  - Report to the OIG any provider payment suspensions initiated by the MCO.
  - Refer cases with an identified estimated overpayment of $100,000 or more or cases under $100,000 that have a clear indication of fraud.
- **Coordinate with OIG:** SIUs meet regularly with the OIG to share techniques for identifying fraud waste and abuse.

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FWA Recoveries in Managed Care

- **MCO Role in Recovery Efforts:** MCOs report suspected fraud, waste, and abuse to OIG, conduct investigations, and refer cases.
- **Tracking and Reporting of Recoveries:** All FWA recoveries must be included in quarterly Financial Statistical Reports (FSRs) as cost reductions.
- **Financial Impact of Recoveries:** Recoveries reduce reported medical costs and are factored into the gross margin and pre-tax net income.
- **Oversight and Accountability:** FSRs are audited by HHSC's external firms and the data is used for experience rebate calculations.
- **State Share of MCO Recoveries:** MCOs must return 50% of all FWA recoveries they collect to the state (HB 2379, 85R).
- **Premium Rate Adjustments:** Premium rates paid to MCOs must be adjusted to reflect FWA cost reductions and recoveries.

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Provider Termination & Exclusion

- **OIG Authority:** OIG can terminate or exclude providers for program violations, including cases required by federal law (e.g., Medicare exclusion, license revocation).
- **MCO Network Updates:** MCOs must regularly update their provider networks using the HHSC TMHP provider master file or by checking the OIG exclusions database.
- **Reporting Exclusions to OIG:** MCOs are required to notify OIG about providers excluded due to fraud, waste, or abuse.

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MCO Strategies to Reduce FWA: Focus on Prevention

- **Shifting to Prevention:** MCOs are moving from a “pay and chase” model to prevention-focused strategies.
- **Reducing Improper Payments:** Emphasis on real-time detection and cost avoidance to prevent inappropriate payments.
- **Cost Containment & Cost Avoidance:** Avoid unnecessary expenditures, reducing medical costs rather than pay and chase overpayment recoupments.
- **Utilization Monitoring:** Ensuring appropriate service use to minimize waste and control costs.
- **Aligning with CMS Practices:** CMS is prioritizing prevention over “pay and chase,” saving an estimated $2.6 billion in FY 2022.

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MCOs Contain Cost by Preventing FWA

- **Training and Education:** Conduct regular training for providers and staff on standards, procedures, and FWA detection.
- **Pre-Review Processes:** Include prepayment claims review, high-dollar claims review, and reviews for providers with high utilization patterns.
- **Prior Authorization:** Enforce prior authorization requirements to control unnecessary services.
- **Post-Payment Analysis:** Conduct post-payment reviews, data analysis, and duplicate payment detection.
- **Monitoring and Auditing:** Perform ongoing internal monitoring and auditing.
- **Fraud Analytics and Detection:** Collaborate with fraud analytics vendors; use modeling to compare provider behaviors within peer groups.
- **Claim Edits:** Develop claim edits to flag suspicious behaviors (e.g., duplicate services, incorrect procedure codes).
- **Specialized Units:** Maintain dedicated Special Units and Compliance Departments.
- **Value-Based Purchasing:** Implement value-based purchasing initiatives to incentivize proper care.

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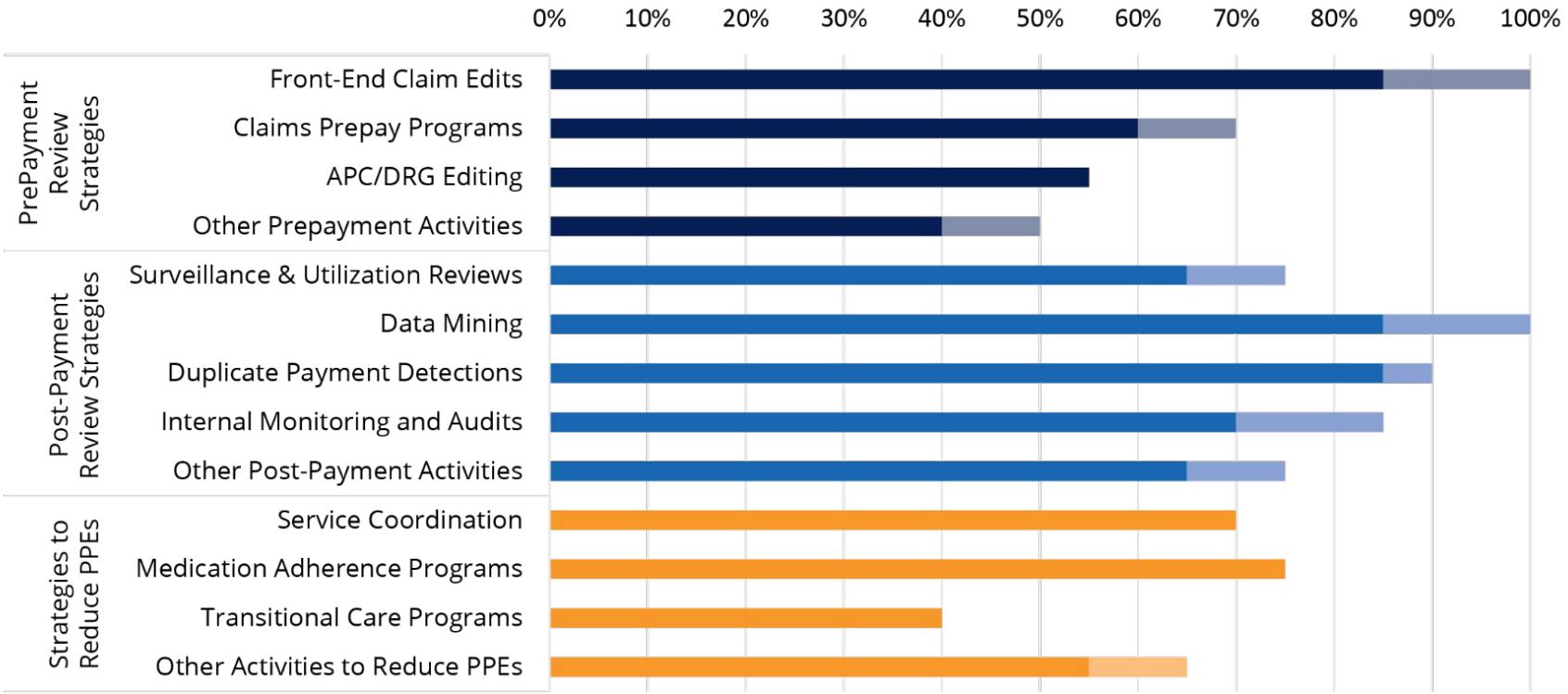
MCO Cost Avoidance Strategies



Note: DMO responses are indicated by the lighter color segments at the end of each bar. Because of the nature of the benefits DMOs are contracted to administer, certain strategies may not be indicated. For instance, ambulatory payment classification (APC) and diagnosis-related group (DRG) reimbursement methodologies are relevant to hospital reimbursement and do not apply to DMOs. Strategies to reduce the number of PPEs are generally unnecessary for DMOs to incorporate in cost avoidance. This contributes a portion of the depiction of decreased utilization of certain activities relative to other activities.

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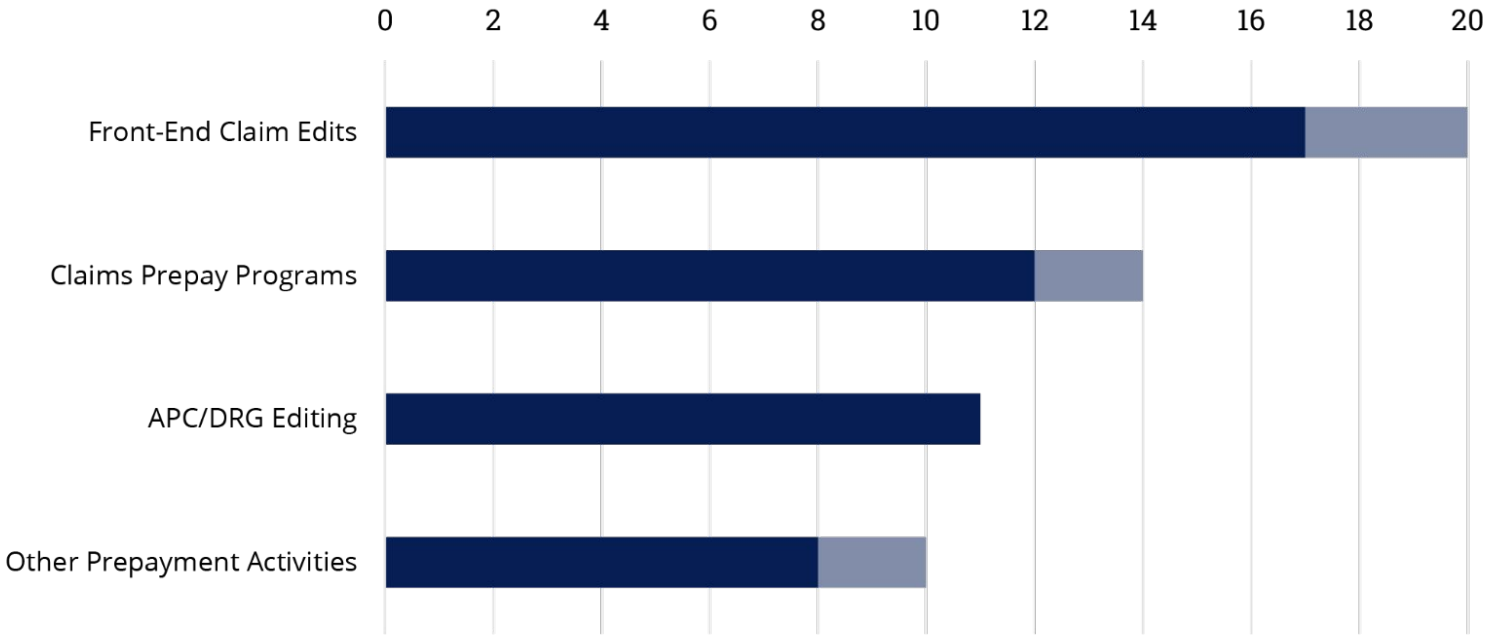
MCO Prepayment Review Activities



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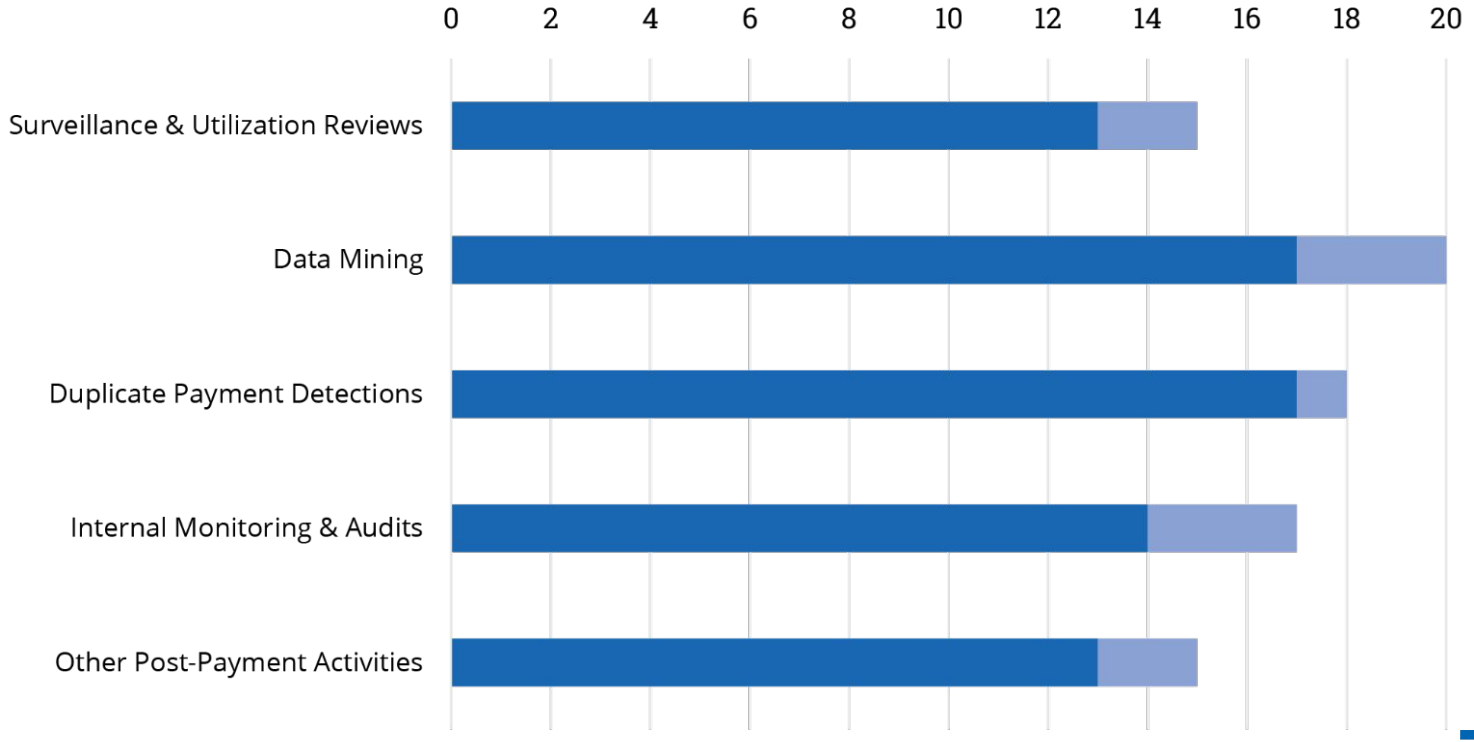
MCO Post Payment Review Activities



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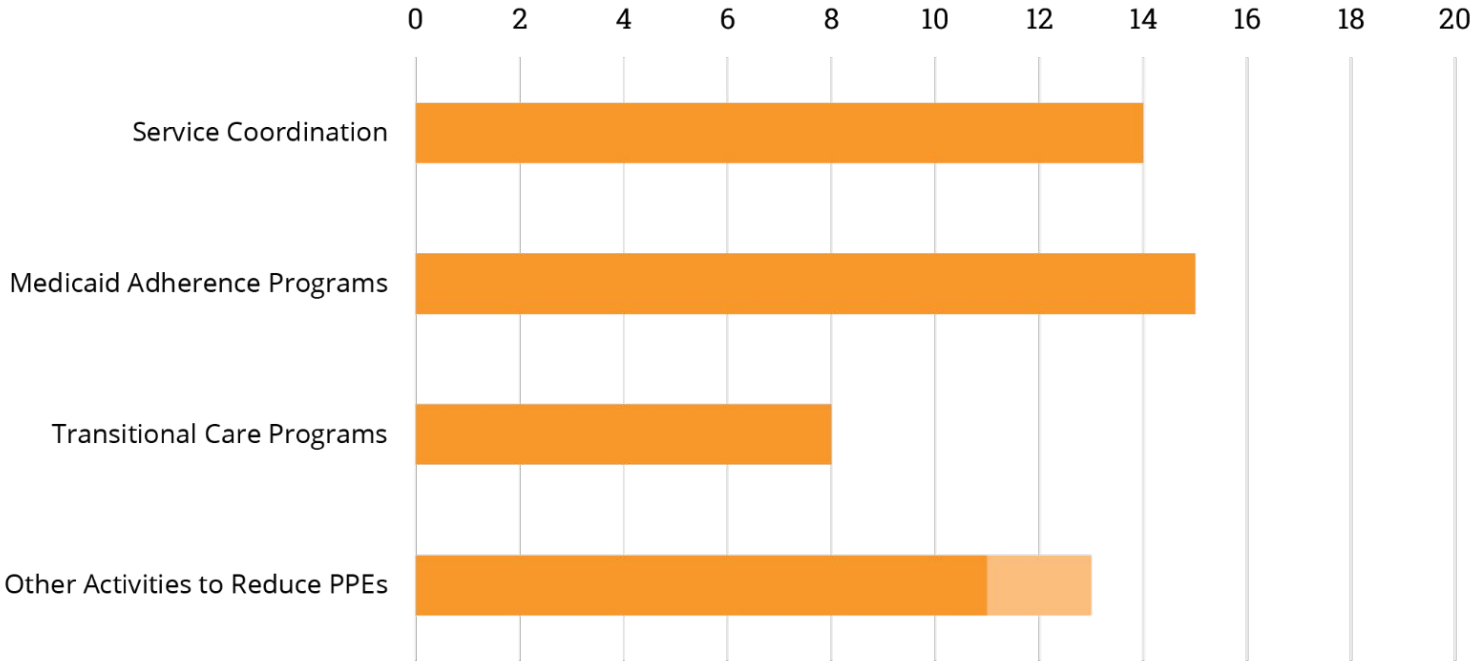
Strategies to Reduce Potentially Preventable Events



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MCO Fraud, Waste and Abuse Activities

Prepayment Review Strategies & Utilization Management	Claims Payment	Post Payment Review	FWA Detection Activities	Recoveries
• Prior Authorization • Front end claims edits • Claims prepay programs • APC/DRG Editing		• Surveillance & utilization reviews • Data mining • Duplicate payment detections • Internal monitoring and audits	• Conduct investigations • Lock in program • Provider termination & exclusion	• Collect recoveries • Return half of the recoveries to the state

Ongoing Activities

Staff Training | Regular Auditing and Reporting | Coordination with OIG | Care management

APC: Ambulatory payment classification (APC)
DRG: Diagnosis-related group (DRG)
Lock in Program: limits a Medicaid client to one provider/pharmacy for services if there is a history of misuse of Medicaid services

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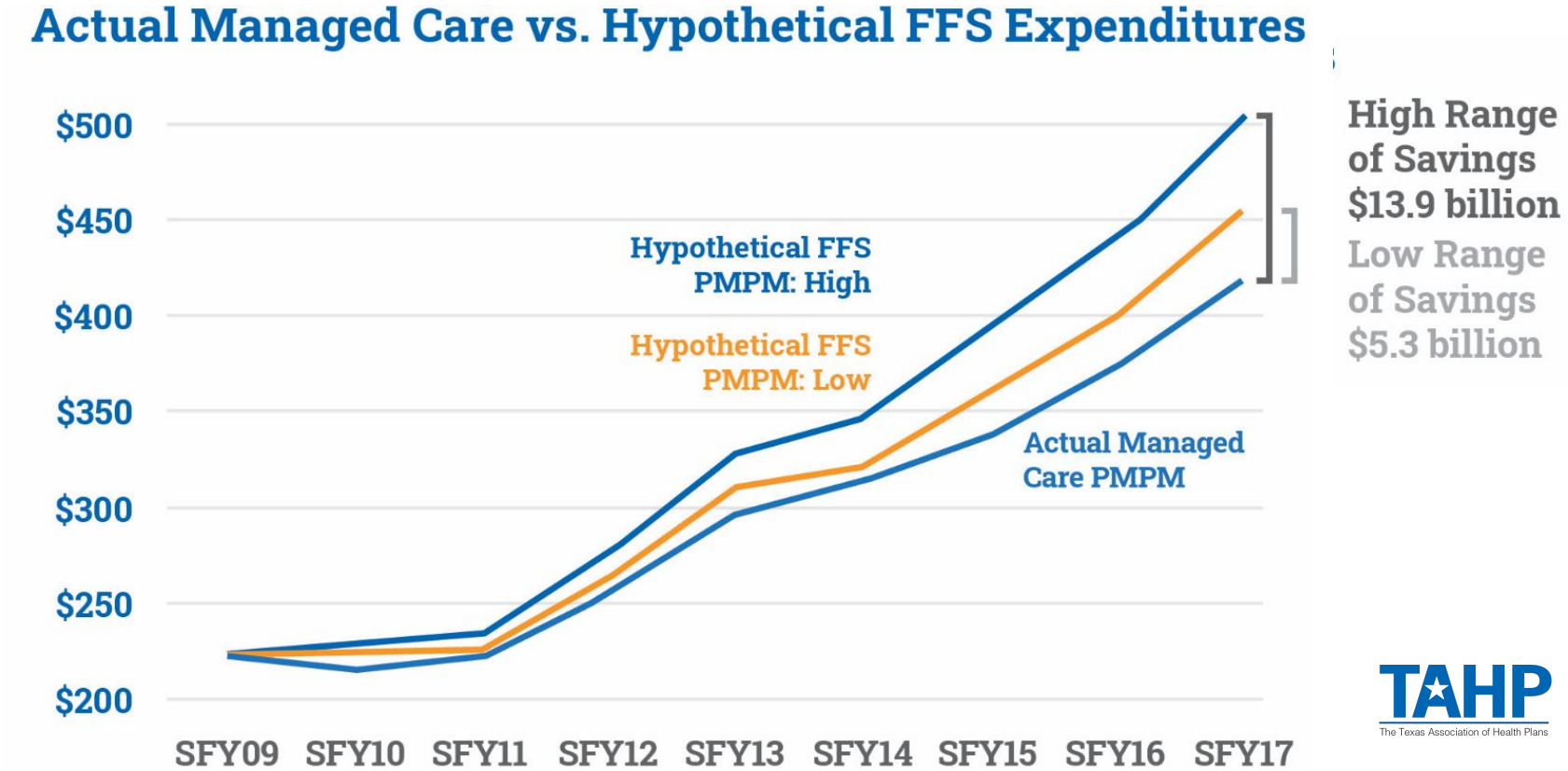
Managed Care Produces Savings for the State - Rider 61 Study

The Texas Medicaid and CHIP managed care programs have generated a **cost savings** of 4.7% - 11.5%, or **$5.3 billion - $13.9 billion** for the state



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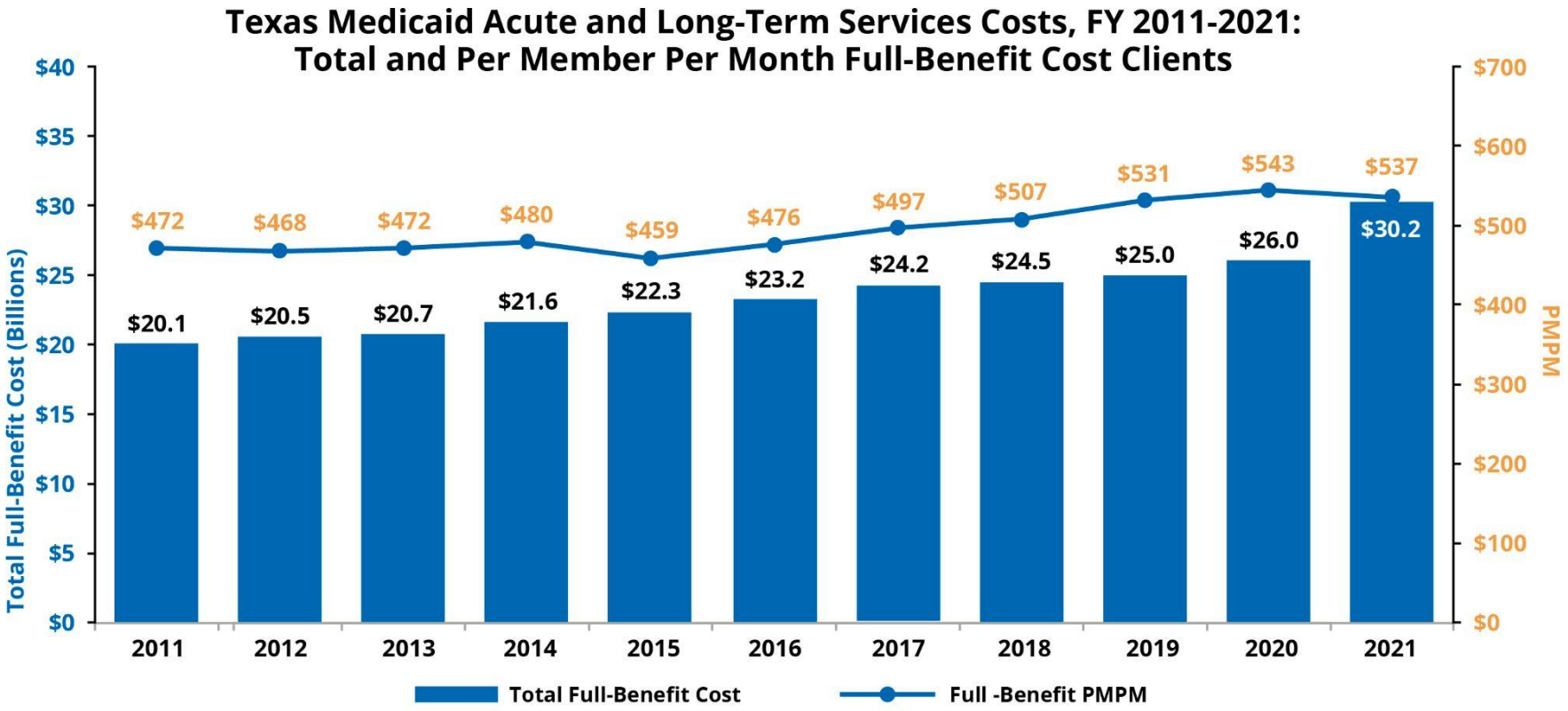
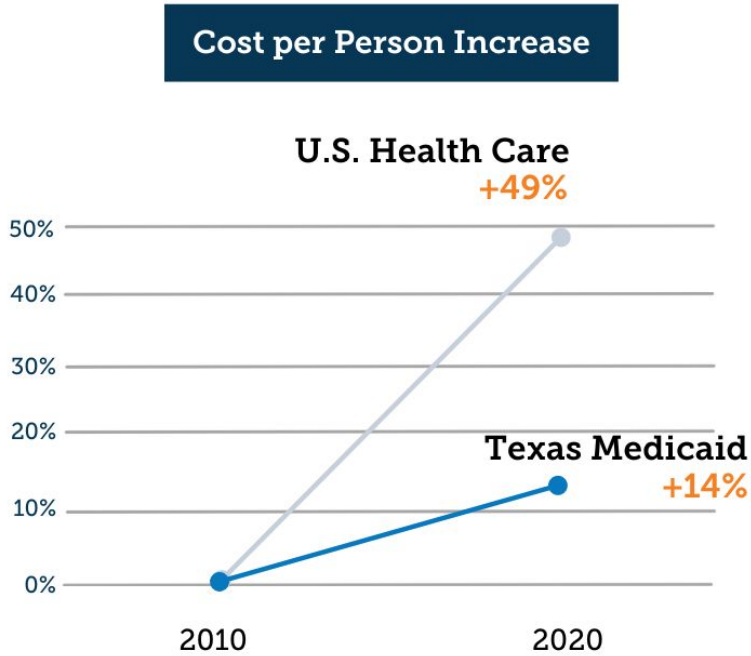
Medicaid Cost Growth



Medicaid MCOs Produce Savings

- Texas Medicaid managed care **saved taxpayers over $5 billion from 2009 to 2017**
- As a result of managed care, Texas Medicaid is more efficient and costs less than U.S health care spending—**35% lower than the national average**—and has the lowest administrative costs in the country—90% of every dollar is invested in direct care



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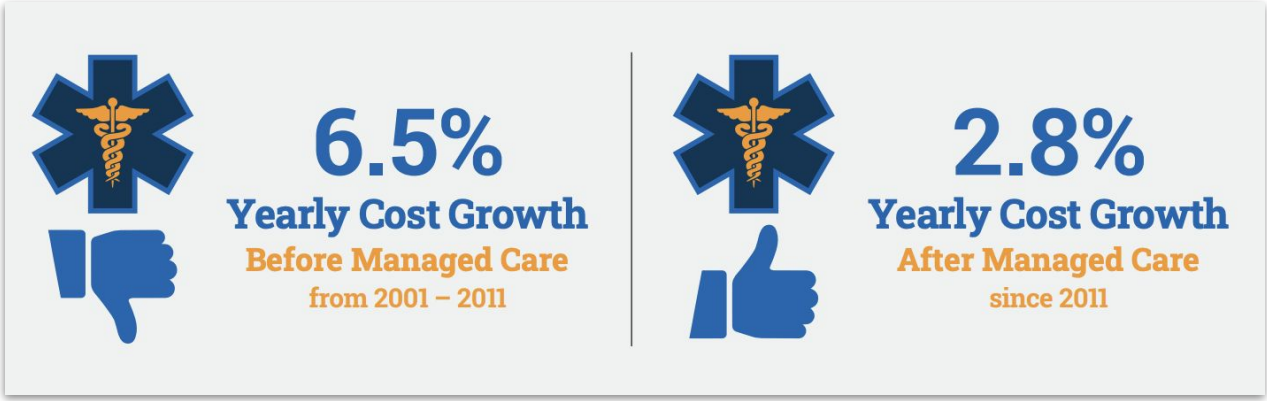
Medicaid MCOs Produce Savings

- As a result of Medicaid managed care, prescription **drug cost growth dropped by 50%** and is now three times better than the national average



- **Texas' managed care 1115 waiver savings creates the federal match for the hospital supplemental payment programs** and provides financial stability to hospitals and the state's health care safety net

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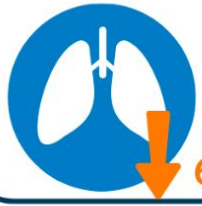
MCOs Improve Access and Outcomes Compared to FFS



Childhood Asthma
Reduced hospital stays for children with asthma
65% reduction

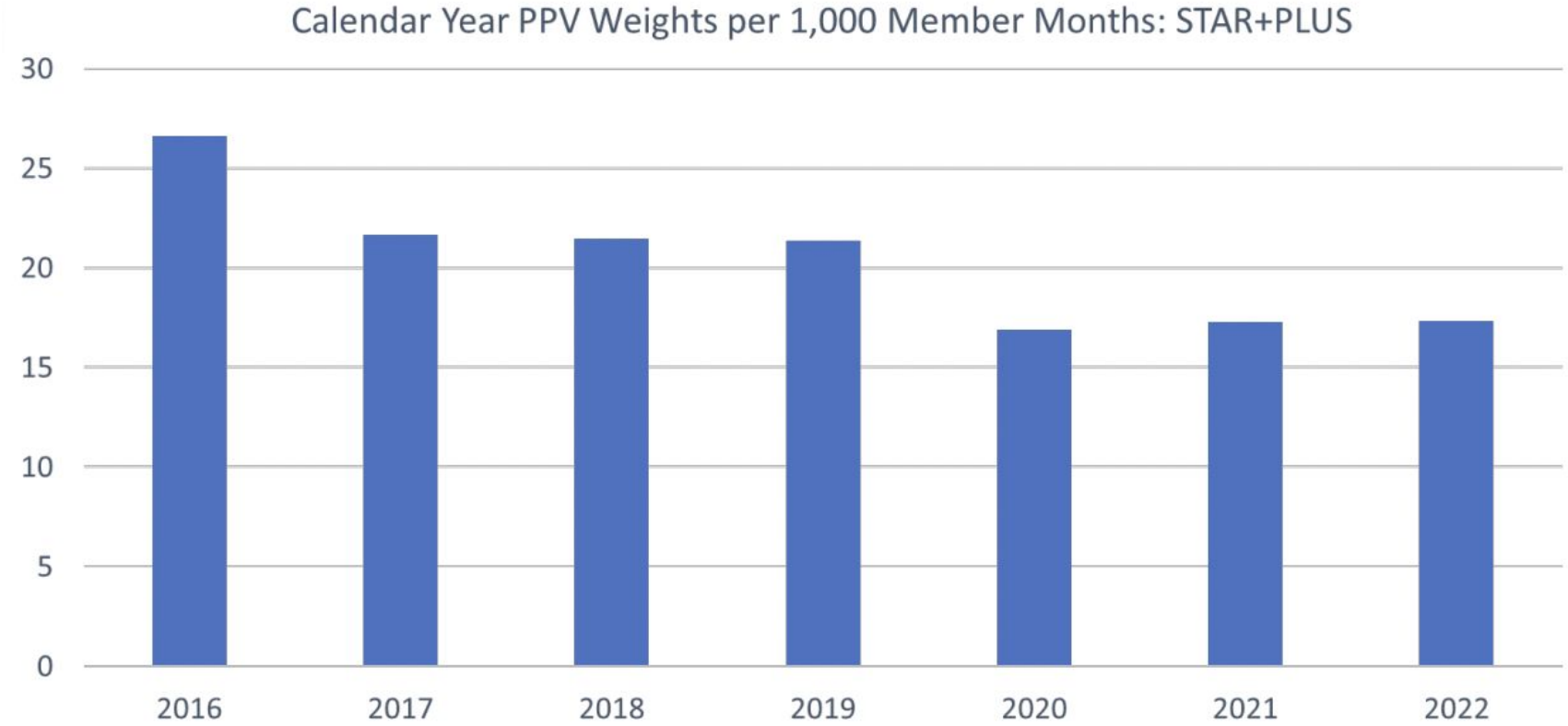
Diabetes in Adults
Reduced hospital stays for adults with complex diabetes
48% reduction

ER Visits
Reduced preventable ER visits
16% reduction

Pregnant Moms
Timely access to prenatal care
7x better

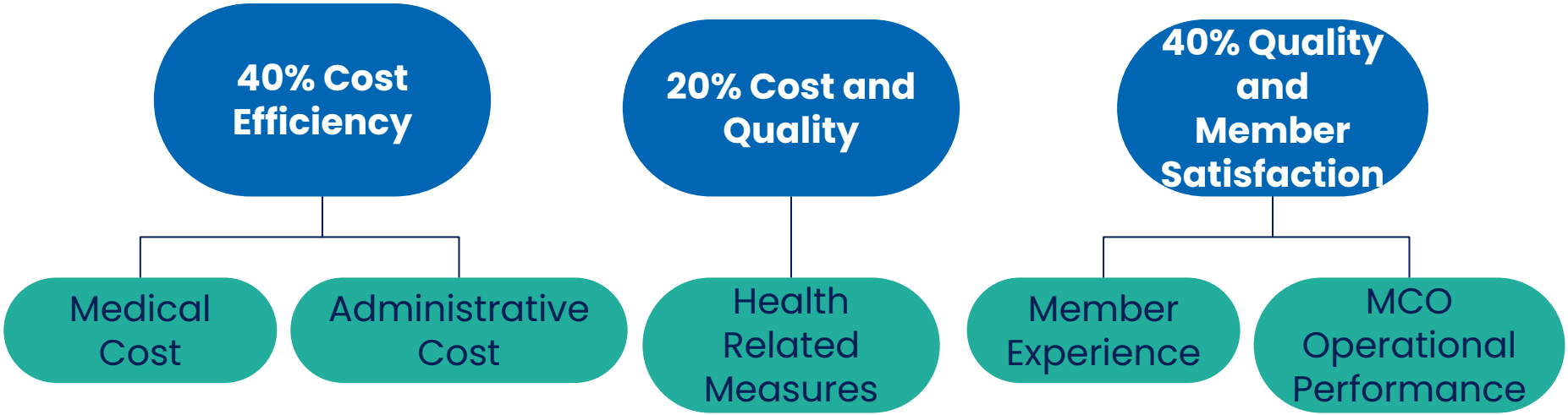
Annual Doctors Appointments for Children
4x better

Trends in Potentially Preventable Events:
Potentially Preventable Emergency Department Visits



State Incentivizes MCO Efficiency Outcomes

How it Works? MCOs with better performance than others on the factors listed below receive a higher share of default enrollments (Medicaid recipients that do not choose a health plan) than under the previous methodology



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Recommendations: Opportunities to Further Reduce FWA

1. **Evaluate and expand existing and innovative FWA strategies**, including the use of AI, enhanced data analysis, or other technology strategies.
    - **Including focus on prevention:** Cost avoidance results in Medicaid savings to the state and is more efficient and easier to recoup than post-payment recovery efforts ("pay & chase").
2. **Continue to strengthen partnership and information sharing with OIG**, including through the Texas Fraud Prevention Partnership, to proactively disrupt fraud trends, identify effective mitigation strategies, and contribute to cost savings.
    - Review the federal Heathcare Fraud Prevention Partnership model for best practices.
    - Expand membership to both public and private payers, law enforcement agencies, and other experts.
    - Meet and exchange information and research including fraud analytics, quantitative study results, qualitative white papers, fraud scheme alerts.

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