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

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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.

Understanding Health Care FWA #’s

- **The 10% Benchmark:** Historically, 3% to 10% cited by the FBI and NHCAA.
  - The high end (10%) is a legacy figure from 1990s GAO reports used to describe unmanaged Fee-for-Service (FFS) systems.
  - In the 90’s, these numbers were a “call to action” to modernize and “manage” health care. The data justified the transition to Managed Care.
- **Waste is the Larger Problem:** Newer research shows that waste and inappropriate care (23%) is nearly 10x larger than the cost of fraud (1.8%)
  - Systemic Waste (~23%): Redundant testing and inappropriate care settings.
  - Administrative/Billing Errors (~7%): Coding mistakes and unintentional errors.
  - Criminal Fraud (~1.8%): A narrow fraction of total spend.
- **Medicaid Billing Errors :** The national FY 2025 Medicaid improper payment rate was 6.12% (Medicaid FFS)
  - MCOs billing error rate is substantially smaller, almost zero
  - Texas FFS PERM is also lower than national rates 1.31%

The Move to Managed Care

Managed Care moved the state from "pay-and-chase": Texas successfully moved away from the **10% waste inherent in 1990s Fee-for-Service** (FFS) to MCO managing fraud, waste, and abuse risk through:

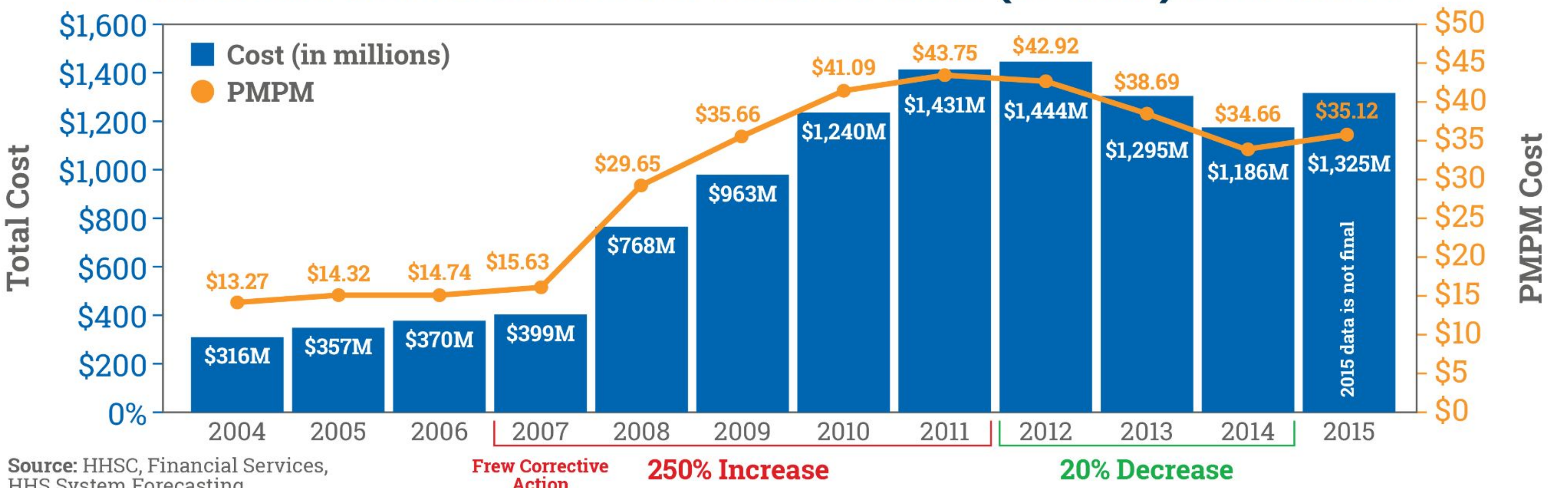
- ✓ **Utilization Monitoring:** Reducing "Waste" and redundant testing via Prior Authorizations.
- ✓ **Risk-sharing:** MCOs lose money if they don't catch waste or billing errors.
- ✓ **Coordinated care:** More appropriate site of service or preventive care.
- ✓ **Network Management:** Keeping out "wasteful" or high-risk providers.
- ✓ **Negotiating Rates:** Preventing "pricing failures" common in FFS.

$13.9 Billion Saved
via Managed Care (2009-2017)

Source: Texas HHSC, Rider 61 Study

Dental Managed Care: Successfully Curbing Systemic Abuse

- **DMOs Decreased Medicaid Costs by 20% in 2 Years:** Prior to dental managed care, Medicaid dental costs ⬆️ more than 250% in five years and orthodontia costs nearly doubled. Within the first six months, DMOs dramatically reduced inappropriate utilization including reducing orthodontia by a 72% ⬇️.



Why Managed Care Works To Reduce FWA

- ✓ **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, the **rates are certified by an independent actuary,** and certified again by CMS.
- ✓ **MCOs take on full financial risk**—MCOs responsible for all costs exceeding premiums, including FWA.—**Gives state budget certainty.**
- ✓ **Texas caps admin and profits and requires health plans to share savings** back to the state (called the experience rebate).
- ✓ **MCOs use benefit design tools to reduce waste and incentivize appropriate care,** including thought utilization review (PAs) and network management.
- ✓ **Partnership with OIG:** Identify and report suspected FWA to OIG; conduct pre-payment reviews and assist investigations (mainly Fraud & Abuse).

MCO Fraud, Waste, and Abuse (FWA) Requirements

- **Statutory and Contractual Duties:** MCOs must comply with FWA requirements or face penalties (e.g., liquidated damages).
- **Establish and Maintain SIU:** MCOs are required to create and maintain a Special Investigative Unit to handle FWA.
  - Refer possible acts of FWA to OIG in 30 days.
  - Report all overpayments/underpayments.
  - SIUs meet regularly with the OIG to share techniques for identifying fraud waste and abuse.
- **Formal FWA Plans:** MCOs must develop and submit an annual plan to HHSC OIG.

Payment Recoveries and Payment Holds

MCO & State Recovery Tools

Prepayment Review (MCOs): Allowed, but must pay promptly. No payment holds allowed.

Time Limits

- **MCOs:** 2 years to identify/recoup. Must report overpayments to OIG.
- **HHSC/OIG:** Can recoup indefinitely after 2 years.

Recovery Audit Contractor (RAC): Identifies over/underpayments after 1 year. Must be cost-effective, no duplicate audits.

Extrapolation: OIG & MCOs can use for fraud detection. MCOs prohibited for pharmacy claims.

Referrals & OIG Authority

Fraud Referral: Immediate referral of suspected fraud. OIG may take over cases >$100k (10-day decision).

Recovery Distribution

- **Standard:** MCO keeps 50%, State gets 50%.
- **If OIG finds independently:** 100% to State.

Payment Hold Authority

- **OIG:** Exclusive authority to impose payment holds.
- **MCOs:** Prohibited.

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

The Path Ahead: Protecting Texas Medicaid

- **While Texas has been successful at managing FWA, it is a constant battle:** Success depends on the ability of MCOs to actively manage benefits and respond to new threats in real-time.
- **Bad actors adapt to policy changes quickly:** When oversight tools are weakened or mandates are too broad, waste quickly returns to the system. Always looking for a weakness and the next revenue maximizing opportunity.
- **The model only works if the guardrails stay up:** MCOs can't stop waste if we lose the ability to check medical necessity or vet who is allowed in the network.
- **Sudden increase in utilization:** MCOS will see a provider suddenly expand clinics or upcoding. Utilization is not suddenly increasing because of quality or access. Utilization is growing because they found a code that isn't being scrutinized yet.
- **The "Access" Defense:** This is the most common complaint when an MCO flags a bad actor for a billing audit. The provider immediately calls their Legislator and claims the MCO is "cutting care" or "blocking access."

Benefit Design Matters

Recent Example: States seeing spike in "Applied Behavior Analysis" (ABA) billing.

What made Texas different for ABA:

- **Strong PA criteria:** PA for all services with renewals at 90-180 days
- **Required parental involvement:** 85% Attendance
- **Competitive market reimbursement rates**
- **Required licensed professionals:** Clearly defined roles
- **Capped benefits:** Direct treatment capped at 8 hr/day, with high-intensity therapy (over 20 hours/week) generally restricted to children age 6
- **Exclusions - Only Strict Clinical Services:** Only allows medically necessary, clinical interventions - not duplicating schools or child-care support

Not worth the abuse in Texas: ABA PE providers not entering TX at the same rate - it too hard to abuse the system with our PAs, rates, and licensure requirements.

Guardrails are essential: Without specific medical necessity guidelines, benefit design loopholes can inadvertently trigger a multi-million dollar spending crisis.

Benefit Design Matters

Example – Skills Training and Target Skill Management (BH benefit for kids and adults): Huge spikes in specific codes started in 2017 from non-LMHA providers (no ABA-like guardrails).

- **Provider assessment:** Providers self-assess and MCOs cannot see the assessment on level of care - seeing some members receive 400 hours a months.
- **Rates set above market (other states):** Youtube videos advertising a "get rich quick scheme" based on the Texas rate schedule.
- **Lack of licensure requirement for individuals providing services.**
- **No exclusion protections or benefit hours cap similar to ABA:** For example the only thing that was happening for one client was teaching them basketball to justify billing.

MCOs used benefit design tools to address the problem: MCOs creating PA policies, lowering reimbursement rates for non-LHMA providers, and limiting their network (similar guardrails to ABA). **MCOs don't always have the assessment tools they need:** No access to provider assessment tool/information.

Benefit Design Matters

- **PAs protect foster children:** Before STAR Health, children in foster care were often overmedicated, and received psychotropic drugs without a MH diagnosis.
  - After implementation, used PAs and coordination to reduce the use of 2+ drugs by 71% (to <1.5%) and 5+ drugs by 73% (to <0.5%). Psychiatric hospital readmissions decreased by 66%.
- **MCO PA reviews cut waste:** One MCO required a Physician Statement of Need (PSON) PA requirement for attendant services (PAS/CFC) to ensure appropriate level of care and hours.
  - Saved the MCO $42 million, so HHSC adopted it as a statewide standard for all MCOs to reduce waste.
- **NEMT benefit design lacks the guardrails needed:** MCOs are required to cover all pharmacy transportation trips. MCOs currently seeing a need for new guardrails — members take multiple trips per day or every day.
  - Ex. 27 pharmacy rides per month for one member, 669 rides in one year

Benefit Design Matters

- **Another Example - DME abuse has always been a threat in Texas:** The Texas OIG's FY 2026 Audit Plan explicitly identifies "Durable Medical Equipment suppliers" as a top priority due to an "elevated risk for fraud, waste, or abuse."
  - DME fraud, waste, and abuse was one of the main reasons managed care was expanded to South Texas.
  - MCOs use benefit design tools like preferred provider arrangements to address fraud, waste, and abuse, but it can be a challenge to establish these types of arrangements in Texas.
- **Reminder - Weakened guardrails invite abuse:** Restricting tools such as PAs, mandating "any willing provider," and limiting rate negotiations creates loopholes for bad actors while making it harder for MCOs to stop the waste. MCOs need UR, network, and rate flexibility.
- **MCOs need flexibility to develop common sense UR and FWA policies.**

Necessary Tools to Stop Waste: EVV

- **What's EVV?** Verification system for Medicaid personal care and in-home care services. Ensures Medicaid services provided in homes are delivered and prevents fraud through confirmation of: visit type, provider, recipient, location, and time.
- **Why it's needed:** Home-based services are at high-risk of fraud. Community attendant services cost 2.75 billion (all funds) in the SFY26-27 budget.
- **Recent Reforms:** Rider 29 (89th) directed stricter compliance with EVV requirements to avoid lengthy grace periods.
- **What opportunities are there to expand the use of EVV?**
  - Require task documentation for all EVV mandated services
  - Require EVV for in home nursing services, speech therapy, and BH Skills Training
  - Require nurse license and modifiers to match EVV/Claims (i.e. RN vs LVN)
  - Clarify if MCOs can use EVV geolocation data for FWA review
  - Tighten EVV visit maintenance time frame
- **MCOs need EVV flexibility:** Build on the EVV system to include more detail required for visits, more in-home services subject to EVV, and more scrutiny through geolocation data.

Necessary Tools to Stop Waste: Preventing Upcoding

- **Background:** Upcoding is the practice of assigning higher severity level codes and other billing practices to inappropriately inflate billing. The AG, FBI, and others classify upcoding as fraud.
- **More on Upcoding:** ERs have used upcoding for years to assign higher severity ER codes to gain higher payments. The problem is worsening and expanding beyond the ER with AI.
  - AI tools are furthering upcoding through **"ambient listening" tools** that listen in on patient/doctor conversations to identify diagnosis codes and billing justification.
  - New study shows that hospital upcoding increased by up to 20% with these AI tools.
- **Why it matters:** Upcoding adds significant costs to public and private payers. Level 5 ER codes are reimbursed at six times higher than level 1 ER codes.
- **MCOs use tools to monitor and stop upcoding:** AI, Extrapolation.

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Necessary Tools to Stop Waste: Prepayment Prevention

Background: Prepayment prevention is the most effective tool for combating fraud, while post-payment recovery—often described as "pay and chase." While Texas has a robust system for post-payment recoveries, Texas laws and regulations are limited for fraud, waste and abuse prevention.

- MCOs limited to prepayment reviews and subject to prompt pay timelines.
- Other states have options for payment holds, prepayment investigations, and prevention data collection.
- CMS recommends MCO-initiated payment holds.

Possible Prevention Tools:

- **Prepayment Referrals:** Creating prepayment investigations.
- **Payment Holds:** Permitting payment holds if MCOs suspect FWA or when a provider refuses to comply with SIU investigations.
- **Prompt Pay Exceptions:** Pausing payment timelines & penalties should pause during an investigation.
- **FWA Prevention Savings Reporting**

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Medicaid FWA Recommendations

#1 **Fiscal analysis of any policy change that involves benefit design or care coordination/management**

#2 **Study and make recommendations to promote more FWA prevention, including** investigating prepayment reviews, MCO directed payments holds, appropriate prompt pay pauses, and cost avoidance reporting aimed at prevention

#3 **Day one managed care to ensure consistent utilization management and billing accuracy**

#4 **Full review of existing policies and MCO flexibility/limitations on UR, FWA tools, and network management:**

- Create a task force to review benefit design and make recommendations to incentivize appropriate care and reduce waste
- Make recommendations on where MCOs need more flexibility to use tools and PAs that will reduce FWA
- Ensure that MCOs have flexibility to use tools such as EVV or other claims monitoring tools to detect FWA

Medicaid Managed
Care History
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When Did Managed Care Begin in Texas?

- **1967:** Medicaid fee for service (FFS) begins in Texas
  - **FFS has no provider networks** and Medicaid members often have no way to find doctors that will accept Medicaid
  - **FFS mainly treats and pays for care after people are sick** - strong focus on paying for hospital care - no medical home and overutilization of costly emergent care
  - Medicaid FFS enrollees are limited to 3 prescriptions
  - State contracts out to a private company (TMHP) to pay providers FFS payments based on the volume and not the value of those services and **there are no accountability quality measures**
- **1993:** LoneSTAR managed care pilot implemented through a 1115 waiver type (renamed STAR) - **Texas begins to see savings from care coordination and reduced ER visits**
  - STAR **MCOs emphasize preventative health care**, establish PCPs as medical homes, no limits on prescriptions, create care coordination, and enroll members in value-added services like vision and transportation service and 24-hour nurse lines
- **1998:** STAR+PLUS pilot implemented - Texas is 1st in the nation to combine acute and long-term care - **Provides alternatives to costly long-term institutionalization not available through FFS Medicaid** - Increased access to community based services and supports by 32% for a vulnerable population
- **2002: HHSC studies on managed care demonstrate favorable outcomes regarding access, cost savings, and member satisfaction** - STAR+Plus reduced costs by 17% ($123 million or $91.67 PMPM), increased community care by 70%, and reduced ER visits by 40% compared to FFS

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- **2003:** HB 2292 directs HHSC to provide Medicaid through the most cost effective model of managed care
- **2005:** Managed care expansion is implemented using a variety of models and **all fail except the current managed care model** because they did not provide the same quality of care and were not as cost efficient
  - STAR+Plus expansion saves over $161M AF ($69.2M GR), including $42.5M in premium tax revenue - recognized as a national model that integrates acute and long-term care
- **2008:** STAR Health launched statewide, provides Health Passport to foster care kids — use of two or more psychotropic drugs is cut by by 71% (to less than 1.5%) and the number on five or more such drugs by 73% (to less than 0.5%) and the readmission rate of psychiatric hospitalizations decreases by 66%
- **2011:** Amends 1115 Waiver to expand managed care mandatory statewide - **1115 Waiver uses managed care savings (budget neutrality) to provide supplemental payments to hospitals** (now called Directed Payment Programs or DPPs)
- **2012-2015:** Pharmacy benefits, children's dental, individuals with IDD, nursing facility benefits, and hospital benefits all carved in in; STAR+PLUS expanded statewide; dual demonstration implemented - saved $263.3M in GR and $645.3M in AF, while increasing state revenue collections by $200M for '12-13
- **2016:** STAR Kids launched statewide - reduced ER visits by 6% in the first year
- **2018:** HHSC directs an **independent study of managed care showing MCOs have saved Texas $5.3 to $13.9 billion since 2009**
- **2019-2026:** Transportation and Healthy Texas Women carved in, 1115 Waiver approved until 2030, continuous eligibility for children, expansion of postpartum women benefits from 2 to 12 months becomes law

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