Texas Medicaid - 4 Million Texans

- Medicaid managed care is safety net health insurance that protects Texans who need it most, including children, mothers, grandparents, and Texans with disabilities.
- Texas partners with private health insurers to cover **4 million Texans**, roughly 14% of the state's population. **97% of Medicaid in Texas is managed care.**

14% of all Texans

51% of all Texas births

47% of all Texas children

58% of nursing home residents

25% of all Texans on Medicare

50K Veterans

45K Texas children in foster care

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The Move to Managed Care in Texas

- **Preventing and rooting out fraud, unnecessary utilization, and wasteful spending** in Medicaid and other parts of the health care system are core to the mission of TAHP's member health plans.
- **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 in Texas.
- **Managed Care moved the state from "pay-and-chase" to prevention:** Texas successfully moved away from the 10% waste inherent in 1990s Fee-for-Service (FFS) to MCO managing fraud, waste, and abuse risk
- **Newer research shows that Criminal Fraud Is much lower now (~1.8%):** A narrow fraction of total spend.
- MCOs billing error rate is substantially smaller than FFS, almost zero

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Why Managed Care Works To Contain Costs

✓ **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 spending, 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 thorough 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).

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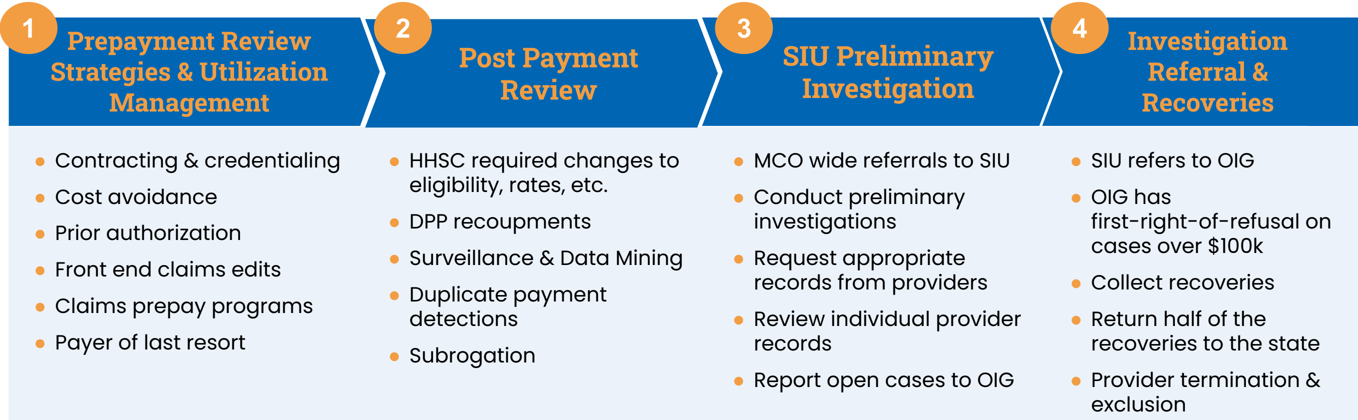
Medicaid MCO Cost Containment



Ongoing Activities

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

"Pay Right the First Time" - Bulk of MCO Savings

Before Money Goes Out: Ensuring care is only paid for when it is safe, appropriate, and accurately billed. Checking claims for errors before paying them. Making sure the diagnosis matches the service. Reviewing severity coding to correct "upcoding." Making sure the right payer is billed first and that Medicaid is the payer of last resort.

- ✓ **Contracting & Credentialing:** Selecting high quality, affordable providers and checking for a history of safe care, no FWA, and required credentials.
- ✓ **Care Management:** Using service coordination and care management for cost avoidance - ie. avoiding unnecessary ER visits, ensuring wellness checkups.
- ✓ **Utilization Management:** Making sure care is safe, medically necessary, and appropriate before it happens (ie prior authorization, medical necessity review).
- ✓ **Claims Payment Integrity:** Providers with a history of inappropriate billing may be placed on a prepayment review where more info is requested before payment.

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

11.7% Total Program Savings

Source: Texas HHSC, Rider 61 Study

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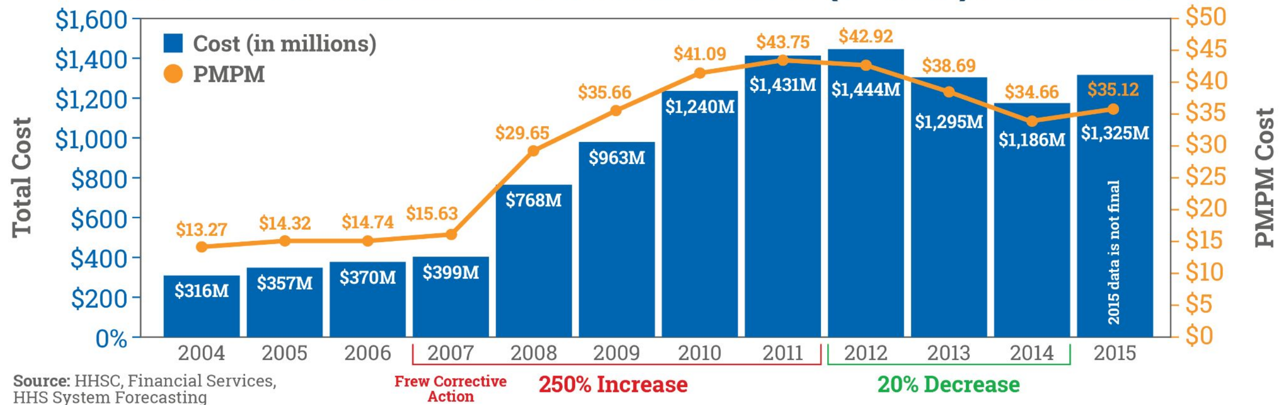
Successful Cost Containment

⬇️ **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, managed care dramatically reduced inappropriate utilization including reducing orthodontia by a 72% ⬇️.

THSteps Dental Total Cost and Cost per Recipient Month, Medicaid Dental Services SFYs 2005-2015 (to date) DMO & FSS



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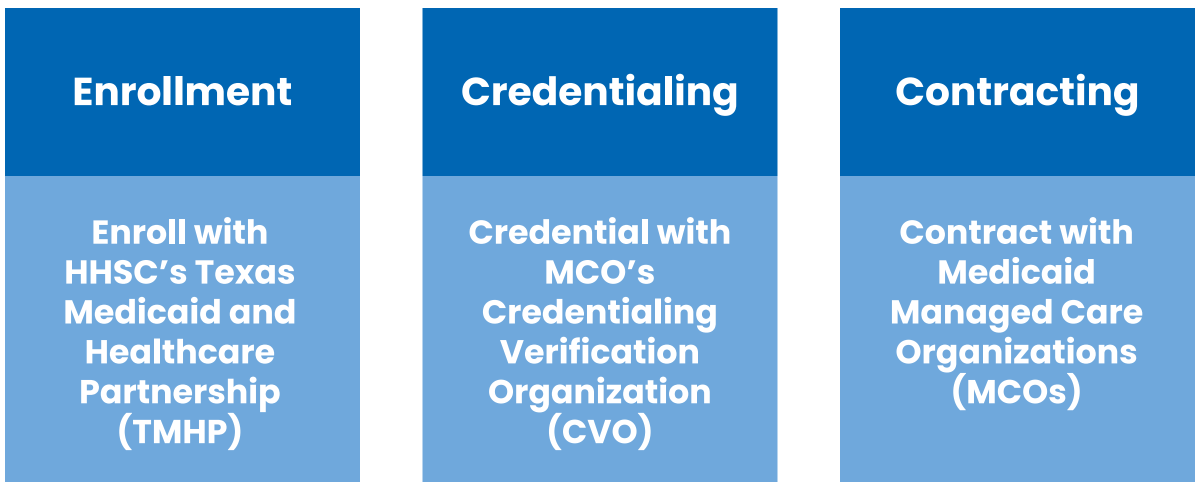
Becoming a Medicaid Provider



Providers must complete enrollment, credentialing, and contracting to participate in the Texas Medicaid program

Payment Integrity – Overpayment Recoveries

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The vast majority of what MCOs recover through payment integrity operations are not fraud. They are billing errors, coding mistakes, duplicate payments, subrogation, documentation deficiencies, and state-directed recoveries such as DPP removal adjustments.

- ✓ **Timeline for Recovery:** MCOs have 2 years to audit claims, HHSC has no limit. The state's Recovery Audit Contractor (RAC) may begin audits after one year if not duplicative
- ✓ **Understanding Overpayments:** According to CMS, 77% of recoveries are for "services where documentation was insufficient to support the services billed" and are **"generally not indicative of fraud or abuse."**
- ✓ **Overpayment Recoveries Report:** Federal & State required report that includes all MCO reported recoveries—from billing errors to fraud settlements.
- ✓ **MCO Rates Account for MCO Overpayment Recoveries:** Overpayment recoveries, including improper coding, must be adjusted or removed from the MCO's medical claims history, encounter data, and financial records, so that they are not included for capitation rate setting.

#3 SIU

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Understanding Overpayment Recoveries

MCOs Recovered 1.1 Billion in Overpayments in FY 2025.

- Monthly Overpayment Reports begin soon, with overpayments categorized into 14 reason code descriptions.
- **Majority is HHSC Directed Changes:** Supplemental payment program required recoveries, retroactive rate changes, provider or member eligibility corrections, etc. - **More than half of overpayment recoveries.**
- For example for one plan, the DPP recoupments made up 29.93% of total overpayment reported.
- Including DPP, 55% of reported overpayments were a result of Agency upstream systems and rate adjustments.

Referral to MCO's SIU - Suspicious Activity

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- ✓ **Special Investigative Units (SIUs):** MCOs must set up an SIU to "investigate fraudulent claims and other types of program abuse."
- ✓ **Monitoring for Fraud, Waste, and Abuse:** All MCO employees must constantly monitor for and refer to their SIU "possible acts of waste, abuse, or fraud."
- ✓ **Preliminary Investigations:** SIUs are tasked with determining whether "suspicious indicators of possible waste, abuse, or fraud exist"
- ✓ **Open Cases Report:** MCOs must report to OIG all cases under preliminary investigation.
- ✓ **Confirming Suspicion:** SIUs must in 15 days, review at least 30 cases (or 15% & 30 cases), request provider records in the next 15 days, and in 45 days determine if more info is needed.
- ✓ **Confirmed Suspicion:** SIU must then immediately refer to the OIG any confirmed suspicious acts. A smaller sample is allowed if the MCO provides written justification in its referral.

#4 OIG

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SIU-OIG Full Investigations & Recoveries

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- ✓ **Full Investigations:** Confirmed "suspicious activity" is referred immediately to the OIG. OIG may take over cases >$100k and has 10-days to decide.
  - **$152 Million:** Texas is #2 in the nation for total recoveries. *Source: MFCU FY25 Report*
  - **685 Cases:** MCOs referred average of 685 cases per year to OIG. *Source: OIG Report*
  - **6%:** Percentage of MCO referrals accepted by the OIG**, MCO investigates remainder**
- ✓ **Split Recoveries:** Regardless of OIG or SIU full investigation, the MCO and OIG split recoveries 50/50 after remitting the federal share back (60%) to the U.S. Government.
- ✓ **OIG Initiated Investigations:** When the OIG independently identifies fraud or abuse (for example, through a whistleblower), the OIG keeps 100% of recoveries after federal share.
- ✓ **Payment Hold Authority:** OIG has exclusive authority to place an all-MCO, statewide payment hold on a provider. MCOs may not do this if the OIG doesn't accept a referral.

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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."

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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.

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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).

- **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.
- **Provider assessment:** Providers self-assess and MCOs cannot see the assessment on level of care - seeing some members receive 400 hours a month.
- **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.**

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.

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Benefit Design Matters

- **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
- **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.

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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.

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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 payment 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

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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 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; 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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