TAHP

The Texas Association of Health Plans

Reducing Fraud, Waste, and Abuse in Medicaid Managed Care

Senate Health and Human Services Hearing
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Medicaid Managed Care in Texas

Goal of Managed Care: To better manage care to improve access, quality, and outcomes while ensuring appropriate utilization, containing costs, and reducing fraud, waste and abuse.

Partnering With MCOs to Reduce Fraud, Waste, and Abuse (FWA):

- **Budget Certainty and Cost Containment:** Premiums set once a year and MCOs assume the full financial risk of care delivery, limiting state exposure to costs
- **Full Financial Risk for FWA:** MCOs must assume the full financial risk for all costs in excess of the premium, including FWA
- **Increased Accountability:** Rigorous oversight including audits, contractual requirements, performance guarantees and penalties, transparency, and quality of care outcomes not found in FFS
- **Partnership with the IG:** Identify and report suspicion of fraud, waste, and abuse to IG and assist with pre-payment reviews and investigations

Medicaid Fraud, Waste & Abuse (FWA)

FRAUD: **Intentional -** An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person

ABUSE: **Not Intentional -** Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Ex: Submitting an erroneous claim for payment

WASTE: **Inappropriate Utilization & Overutilization -** Not defined in federal rules, but is generally understood to encompass the overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act. Ex: Ordering excessive laboratory tests; ordering a group of blood tests when only one test is needed

Prevention vs. "Pay & Chase"

MCOs are transforming their efforts to focus on prevention, reducing inappropriate payment, and finding real-time results and methods to transition from a pay and chase environment

MCO Strategies to Prevent FWA

Conduct internal monitoring and auditing

- Work with fraud analytics vendors to identify suspect behavior
- Use modeling and analysis techniques to compare behaviors of providers to others in peer groups
- Develop claim edits to look for suspicious behavior like billing for duplicate services or using incorrect procedure codes
- Dedicated Special Investigations Units and Compliance Departments

Prepayment claims review

- Pre-review high-dollar claims
- Pre-review providers with high utilization patterns

Develop clear written standards and procedures for providers

Prior Authorization Requirements

Value-Based Purchasing Initiatives

Conduct provider and staff training and education on standards and procedures and how to detect fraud, waste and abuse

Fraud hotlines

Transition Away From Pay & Chase

- CMS has transitioned away from "pay & chase" and shifted to preventing potentially fraudulent and improper payments
- Prevention has been increasingly more effective
- CMS reported $42 billion saved primarily through prevention

"Any bias towards focusing on easily recoverable amounts could potentially skew program integrity efforts away from stopping some of the most egregious fraud. That is because money is notoriously difficult to recover from serious fraudsters, who often are not operating legitimate businesses at all, and take steps to move and conceal the Medicare dollars they are able to obtain." –
Annual Report to Congress on the Medicare and Medicaid Programs: 2013-2014, CMS.

Sources: Department of Health & Human Services, Centers for Medicare & Medicaid Services: *Annual Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Years 2013 and 2014*.

IG and MCO Collaboration

- MCOs are subject to all state and federal laws and regulations relating to fraud, waste and abuse in health care and the Medicaid and CHIP programs
- HHSC can assess liquidated damages against an MCO that does not comply with contractual requirements related to FWA
- MCOs are required to submit a written FWA compliance plan to IG for approval each year
- MCOs must perform pre-payment reviews for identified providers as directed by the IG
- MCOs must submit processed claims data and Electronic Funds Transfer (EFT) data to the IG on a monthly basis

MCO Special Investigation Units

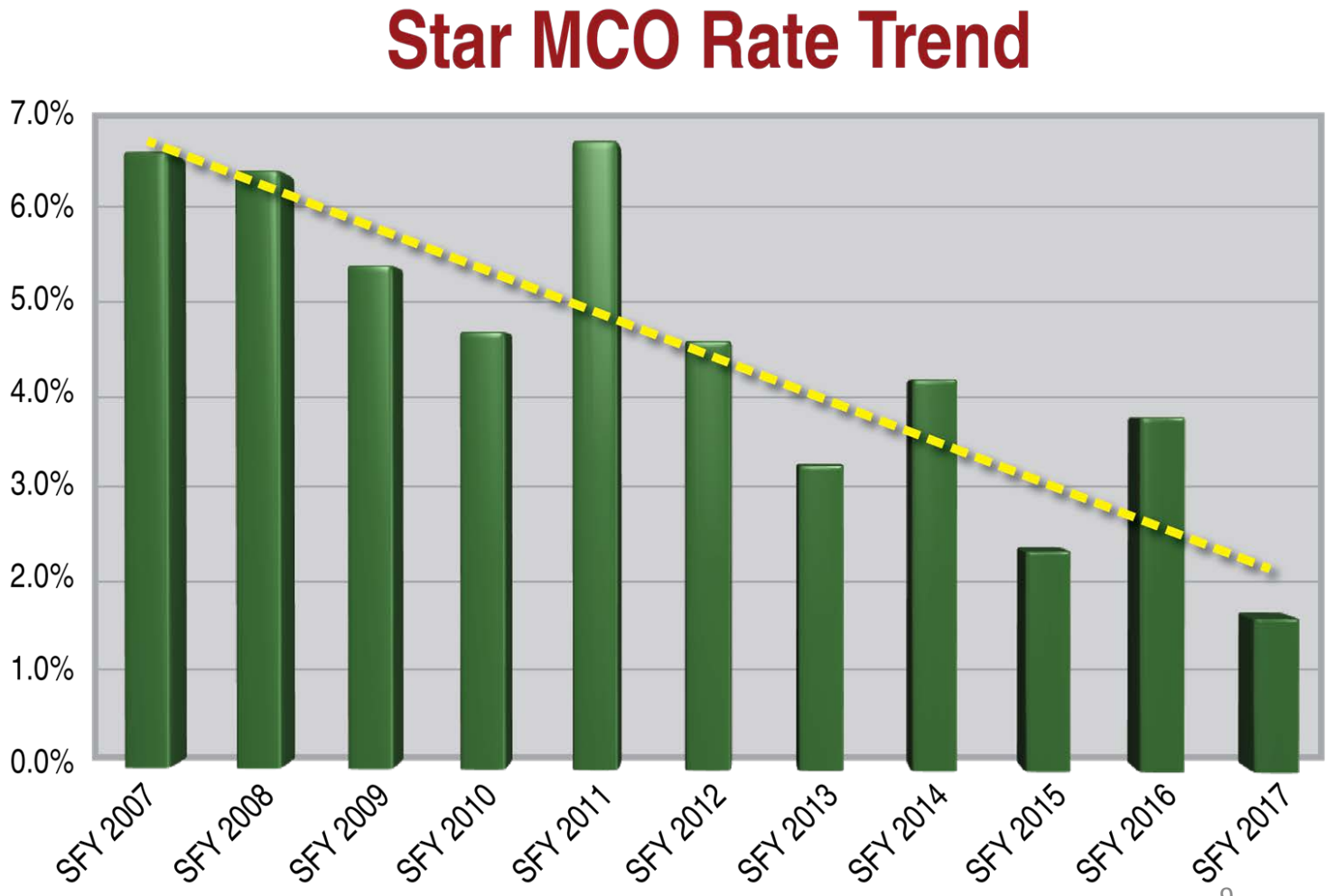
- MCOs are required per the managed care contract to establish and maintain a Special Investigation Unit (SIU).
- SIUs meet regularly with the IG to share techniques for identifying fraud, waste, and abuse and are required to:
  - Identify, investigate and report possible acts of FWA to the IG within 30 days
  - Report to the IG 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
  - IG has 10 days from receipt of SIU report to keep the investigation or allow the MCO/DMO to recover overpayments

Reporting of FWA Recoveries in Managed Care

- Fraud, waste and abuse recoveries are required to be submitted in MCO Financial Statistical Reports (FSRs)
- Recoveries are recorded in the FSRs as reductions/offsets to the MCOs' medical costs and included in the reported gross margin (and pre-tax net income)
- MCO FSRs are audited by HHSC's external audit firms
- These FSRs, which include FWA cost reductions/recoveries are utilized as the baseline to establish MCO premiums in the rate-setting process
- Premium rates paid to the MCOs incorporate and build in these reductions for cost reductions and recoveries
- MCOs' FSR pre-tax net income is also utilized for the experience rebate calculations

MCOs Contain Cost: Preventing Fraud, Waste & Abuse

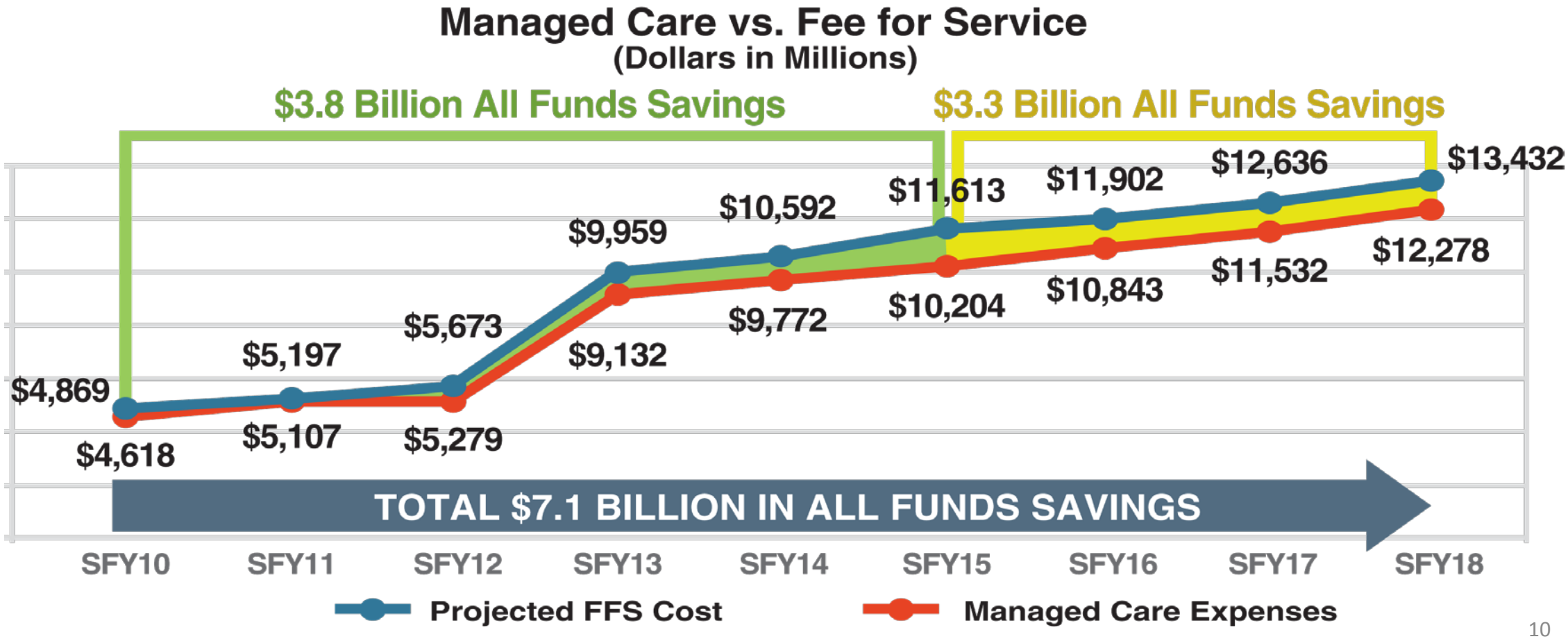
- MCO FWA efforts focus heavily on cost avoidance and reducing payment of improper claims
- Nonpayment of improper claims results in a reduction in medical costs
- Efforts to monitor and require appropriate utilization reduce waste and contain medical cost



Footnote: Chart reflects the average cost trend assumed by HHSC in the STAR Health rates – medical cost as a function of unit cost and utilization.

Sources: Rudd and Wisdom Rating Documents for the Texas Medicaid Program

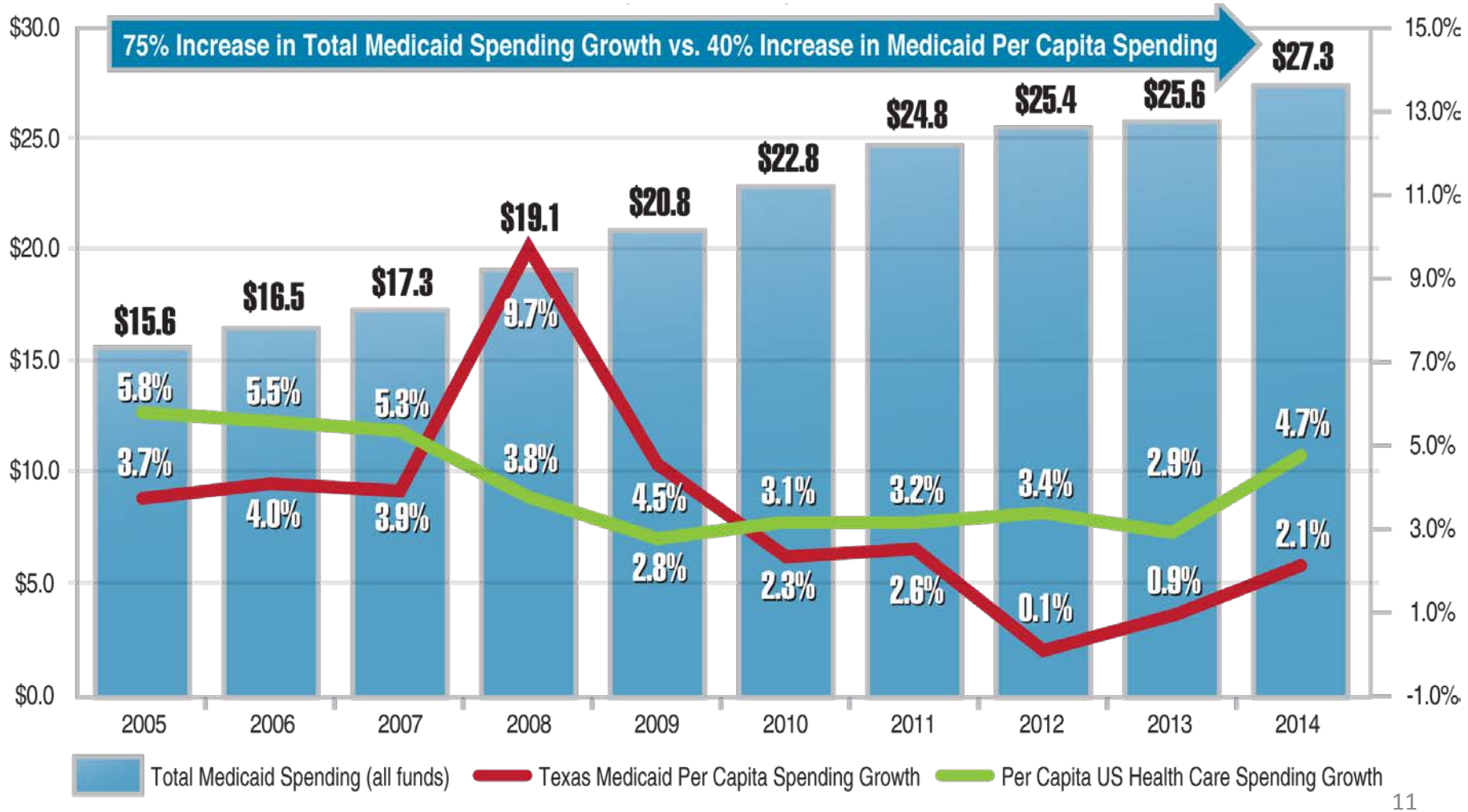
Texas Managed Care Savings: Managed Care Compared to Fee-for-Service



Source: Texas Medicaid Managed Care Cost Impact Study. Milliman. February 2015.

Texas Medicaid Spending vs. Per Capita Spending

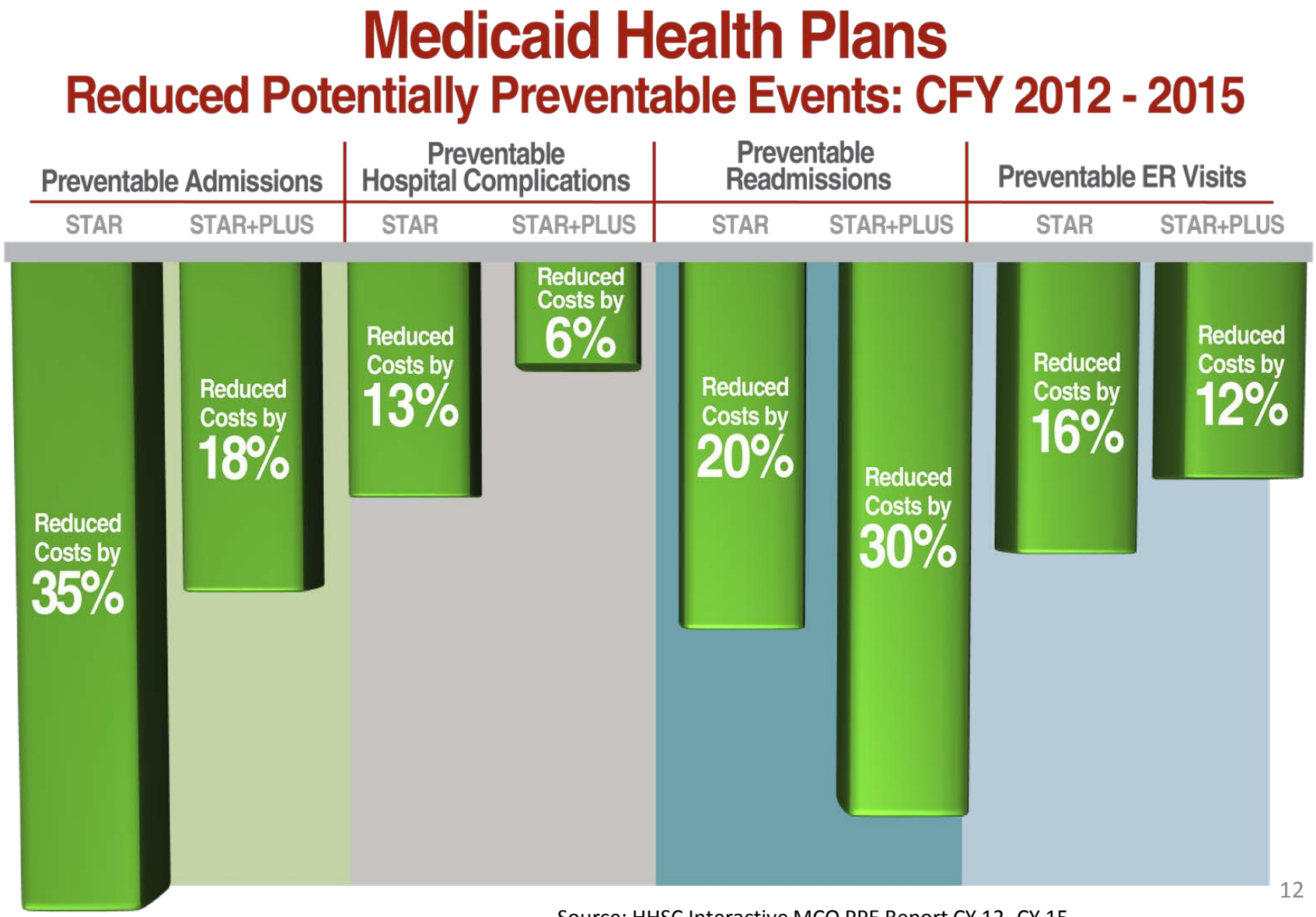
- As use of managed care has increased, Medicaid per capita spending growth has decreased
- Medicaid per capita spending is usually lower than U.S. per capita spending
- Exception: Frew rate increases in 2007-2008



Sources: Analysis of Health and Human Services Caseload and Cost and Kaiser Family Foundation Analysis of National Health Expenditure Data from the Centers for Medicare and Medicaid Services' Office of the Actuary.

Texas Medicaid Managed Care: Improved Outcomes and Quality of Care

- "Right care, right time, & right place"
- Focus on outcomes
- Focus on reducing Potentially Preventable Events (PPEs)



Source: HHSC Interactive MCO PPE Report CY 12- CY 15.

Opportunities for Further FWA Prevention

- **“Cost Avoidance” is a Key Component to Cost Containment**
- **Increased Focus on Prevention:** Cost avoidance or dollars that are not paid out for improper claims result in Medicaid savings to the state - Medicaid integrity initiatives should focus on these strategies instead of post-payment recovery efforts (“pay & chase”)
- **Developing Outcome Measures for Cost Avoidance:** Working with IG to develop measures of cost avoidance - Currently there is no measure of cost avoidance reported in the MCO’s monthly reporting to the IG; therefore, the report does not capture FWA prevention efforts
- **IG and MCOs are working together to develop solutions to more effectively share information – Ex:** IG shares info about providers placed 'on hold' after IG investigations are complete - however, they do not share other MCO FWA investigations (in progress) to enhance the 'cost avoidance' effort across all MCOs

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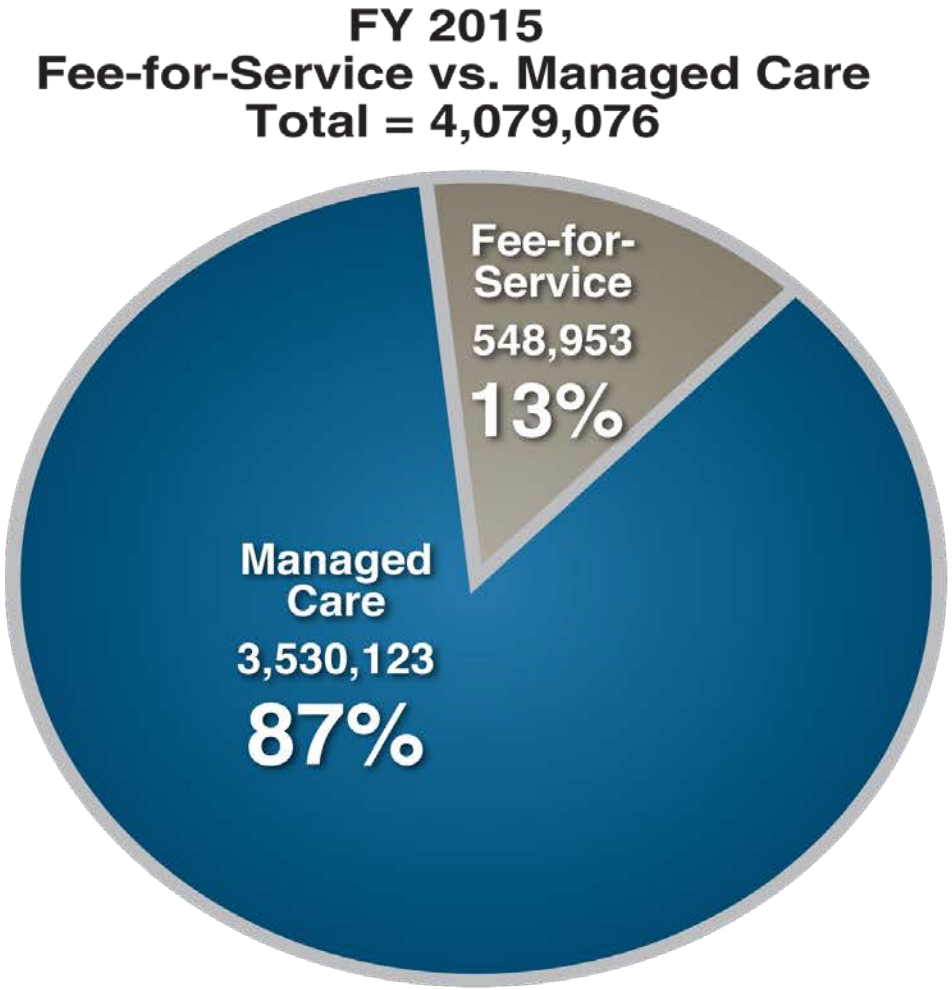
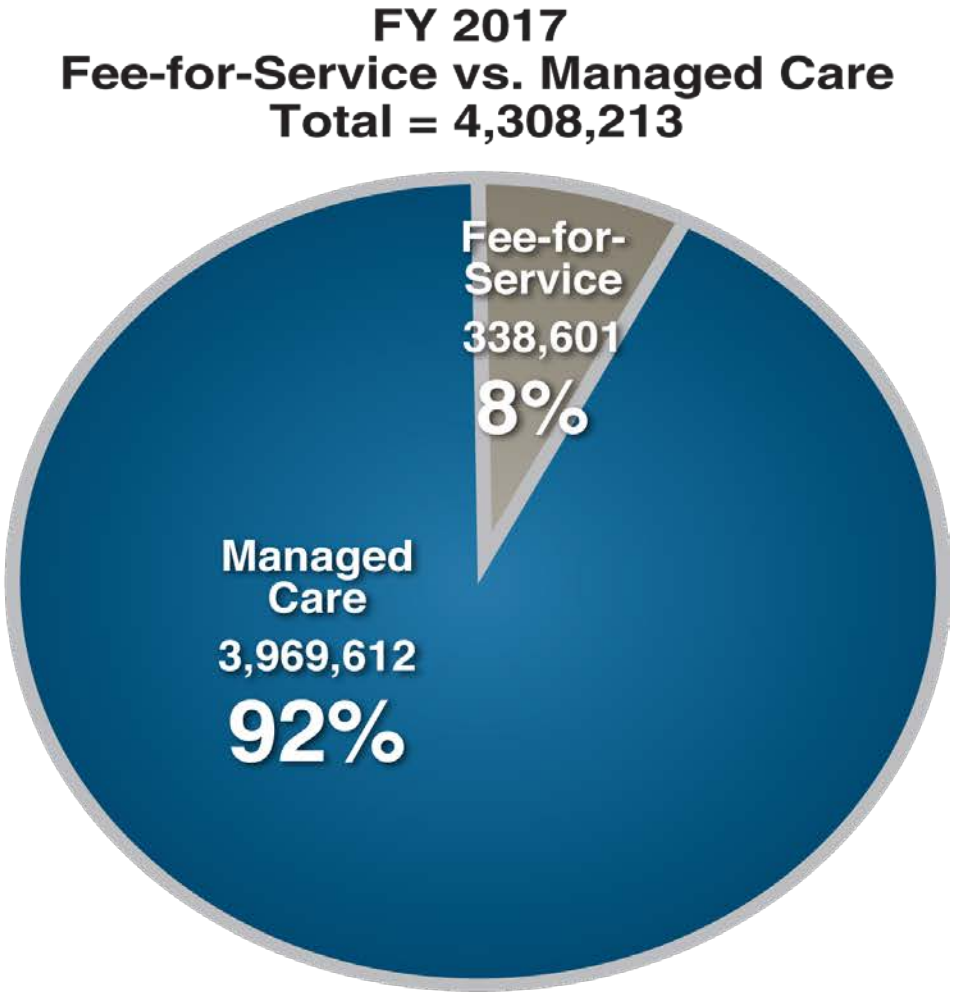
Appendix: Reducing Fraud, Waste, and Abuse in Medicaid Managed Care

Texas Medicaid MCO Enrollment

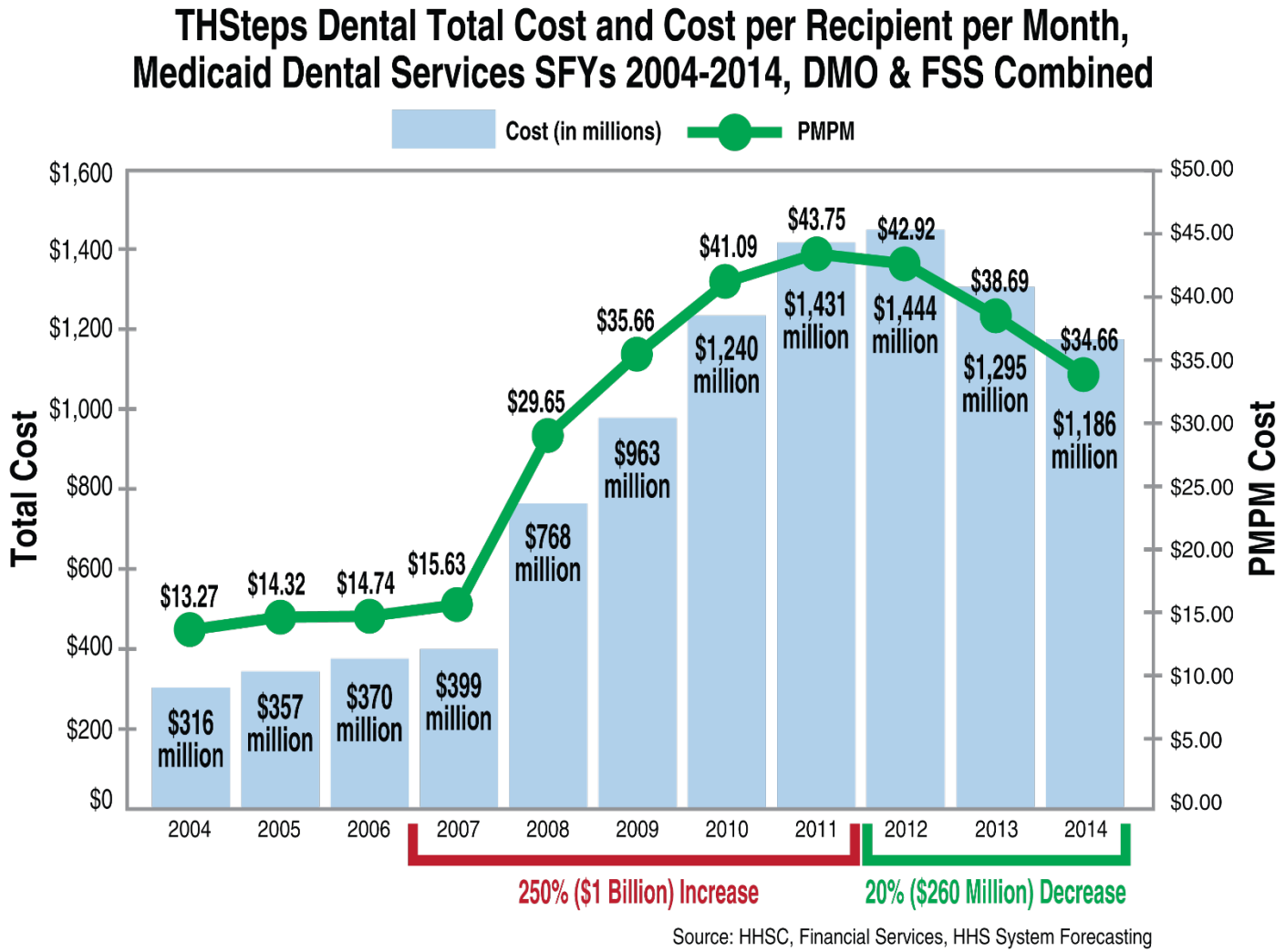




Source: Texas Health and Human Services System 2015 Fact Book.

Dental MCO Cost Savings

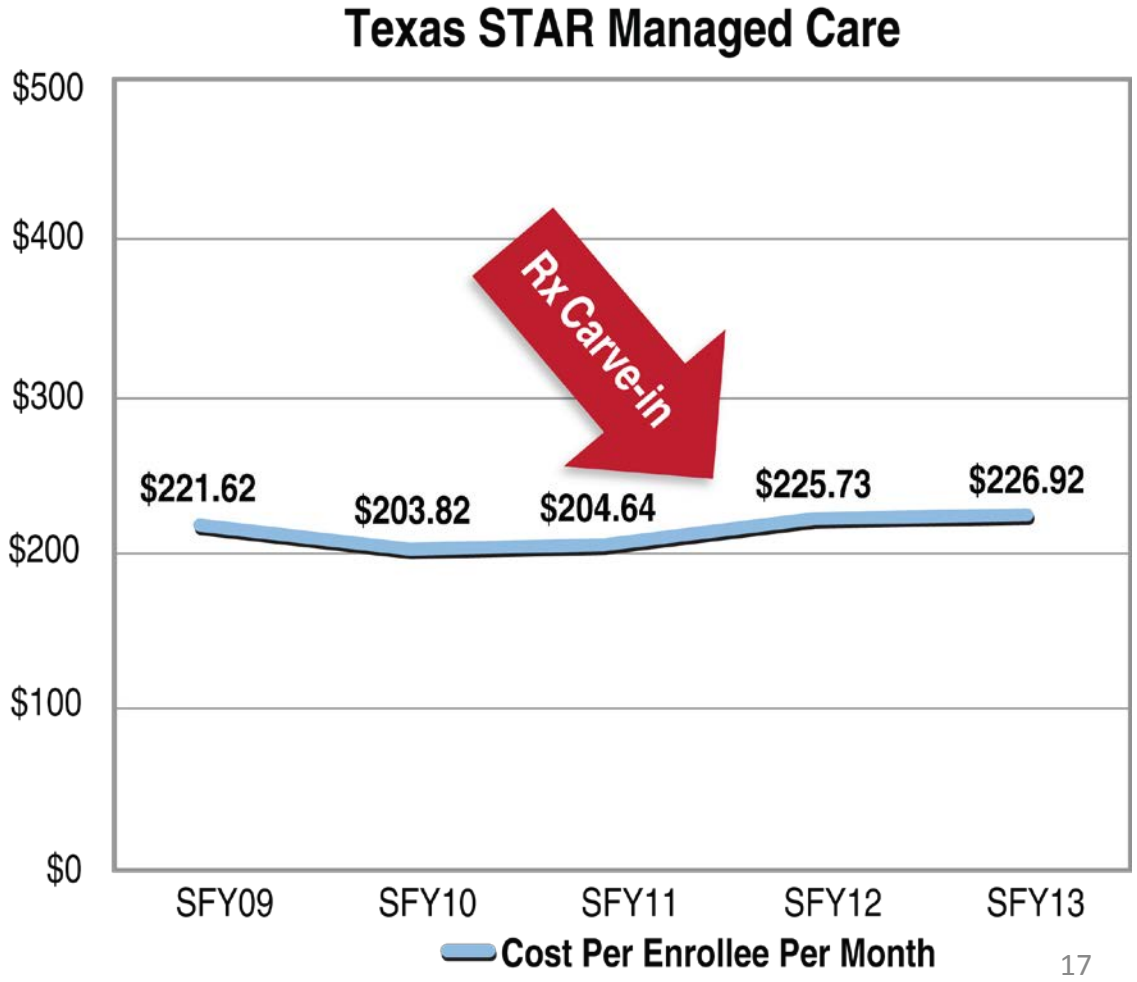
- Dental costs grew more than 250% between FY07-FY11: **$1 billion**
- Orthodontia costs rose from $102 million in FY08 to $185 million in FY10: **81% increase**
- DMO implementation - 20% decrease from FY12-FY14: **$260 million savings (81% decrease in orthodontia costs)**
- Total FY14 Spending: **$1.2 billion**



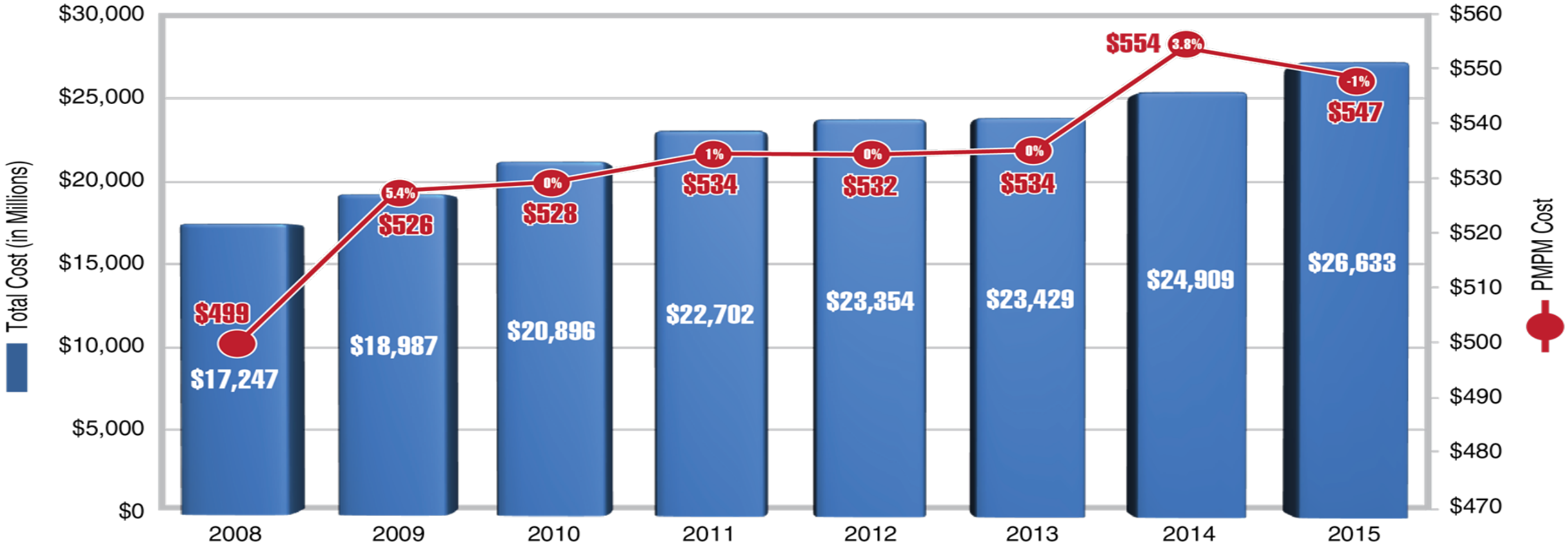
Source: HHSC, Financial Services, HHS System Forecasting

MCOs Contain Costs for Taxpayers

- Texas Medicaid's largest managed care program is STAR with 2.7 million consumers (66% of MCO Enrollment)
- STAR premiums only grew 2.2% from FY09 to FY13
- National health care costs grew 7x's as much, or 15%, over the same period



Texas Medicaid Acute and Long-Term Services Costs:
Total and Per Member Per Month Costs for *Full-Benefit Clients*



Total Growth: 2008 - 2015	
Caseload	41%
pmpm Cost	10%
Total Growth	54%

Medicaid Program Caseload - Recipient Months

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
RMs	2,878,126	3,005,620	3,298,099	3,543,057	3,655,930	3,658,629	3,746,124	4,056,693
Trend	2%	4%	10%	7%	3%	0%	2%	8%

Source: Presentation to the House Appropriations Subcommittee on Article II: Growth Trends and Quality Initiative, HHSC, April 6, 2016