



OIG Review of MCO Cost Avoidance and OIG Efforts in Medicaid Managed Care

**As Required by the
2020-21 General Appropriations
Act, House Bill 1, 86th Legislature,
Regular Session, 2019**

(Article II, HHSC, Rider 114)

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**Inspector
General**

**Texas Health
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Rider 114 Report: Executive Summary

Office of Inspector General

Pursuant to House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services (HHS), Rider 114), the Office of Inspector General (OIG) reviewed:

1. cost avoidance and waste prevention activities employed by managed care organizations (MCOs) and
2. the OIG's efforts to combat fraud, waste and abuse (FWA) in Medicaid managed care, including resources utilized and FWA incidences identified.

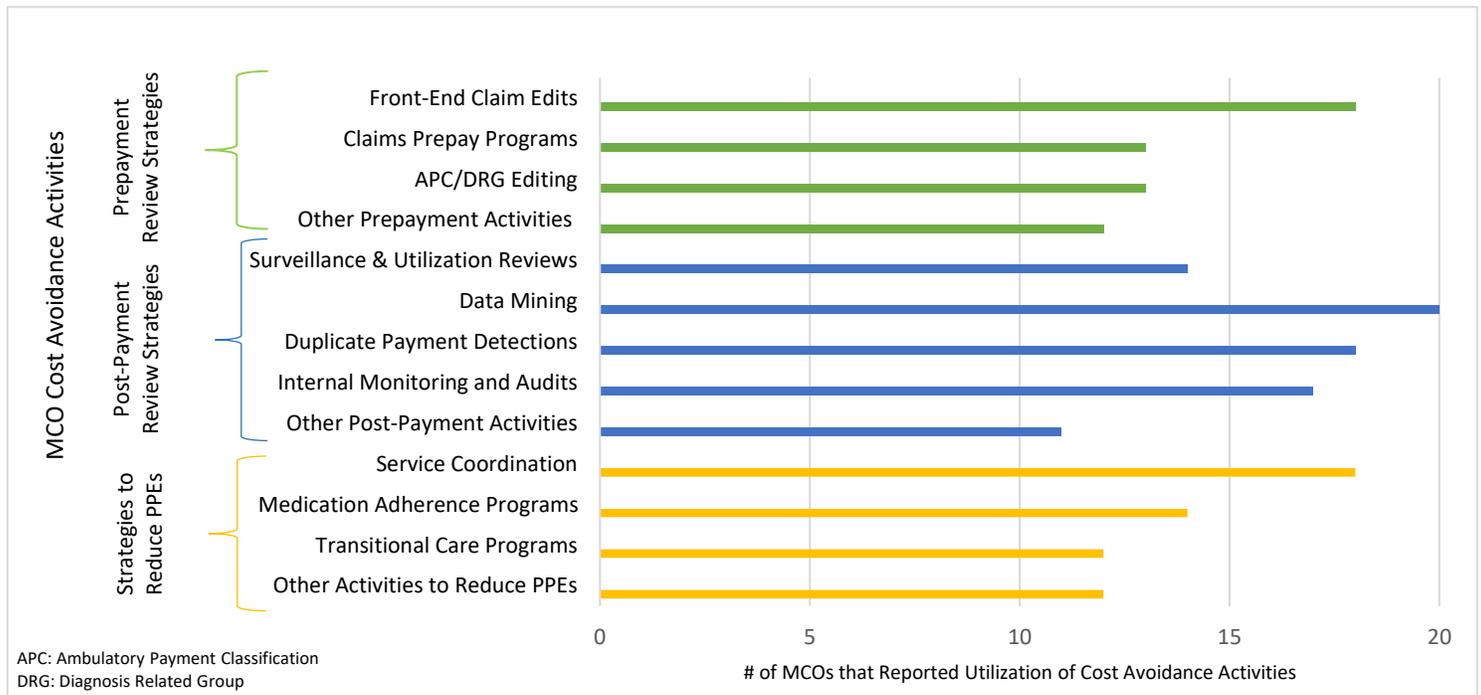
Below is a summary of the findings and recommendations based on these reviews.

1. MCO COST AVOIDANCE AND WASTE PREVENTION ACTIVITIES

The OIG reviewed cost avoidance and waste prevention activities employed by MCOs and Dental Maintenance Organizations (DMOs) participating in Texas Medicaid and the Children's Health Insurance Program (CHIP). The OIG surveyed and collaborated with all 20 MCOs and DMOs on their use and perceived effectiveness of the activities.

In this review, the OIG found that MCOs implement a variety of cost avoidance activities to promote program integrity in the provision of Medicaid and CHIP services. Figure 1 shows some of the activities, which are organized into three broad categories, including prepayment review strategies, post-payment review strategies and strategies related to reducing potentially preventable events (PPEs).

Figure 1: 2019 MCO-Reported Cost Avoidance Activities



The OIG identified various challenges in calculating the dollar value of MCO cost avoidance activities:

- Variation in MCO size and capacity, impacting the type and breadth of activities employed by MCOs.
- Intricacies and volume of data requirements. MCOs use a multitude of claims management systems and business processes related to program integrity, leading to different definitions of variables and data points.
- Increasing focus on innovative payment strategies. As HHS and MCOs transition to paying for value vs. volume, determining how to approach cost avoidance and waste prevention in alternative payment models presents new complexities and continues to be examined.

The OIG collaborated with HHS Medicaid CHIP Services (MCS) and MCOs to develop a framework to potentially calculate the value of certain MCO cost avoidance activities. The framework focuses on identifying program integrity related activities that can be measured and on activities for which the calculated value is not already captured by other reporting from MCOs to HHS. To calculate the value of explicit program integrity activities, the OIG proposes applying the following definition, criteria and guidelines to activities:

- Definition: An intervention that reduces or eliminates an improper payment before the payment is made.
- Criteria: An intervention that is tangible, quantifiable, related to FWA and not currently captured by HHS.
- Guidelines: Available data analyzed pre- and post-intervention for up to 12-months (a timeframe which aligns with MCO reporting of fraud and abuse recoveries).

Activities that may meet the definition, criteria and guidelines include prepayment review strategies and post-payment review strategies that result in changes that lead to cost avoidance in the future (not recoveries of already paid funds). It is important to note that any further review of the effectiveness of these activities would require standardization of the definition of cost avoidance across MCOs and development of consistent reporting processes to collect the requisite data from MCOs, which may include amendments to MCO contract requirements related to these activities.

2. OIG EFFORTS IN MEDICAID MANAGED CARE

The OIG also reviewed its resources and findings of incidences of FWA in Medicaid managed care. The OIG found that it dedicates half of its resources directly or indirectly to Medicaid managed care.

The OIG projects it will spend \$64.7 million (64 percent) of its State Fiscal Year (SFY) 2020-2021 operational budget (\$100.9 million) on Medicaid program integrity activities. The remaining 36 percent of the budget will be spent on OIG efforts in other non-Medicaid HHS programs, as well as the Texas Department of State Health Services (DSHS) and the Texas Department of Family and Protective Services (DFPS) oversight activities. Of its Medicaid spending, 83 percent is dedicated to activities in Medicaid managed care. Figure 2 shows the OIG’s projected operational budget for the biennium of Medicaid and Medicaid managed care efforts in comparison to total spending.

Figure 2: OIG Projected Operational Budget, SFY 2020 – SFY 2021 Biennium

	SFY 2020	SFY 2021	Biennium
OIG Budget	\$50,497,100	\$50,412,758	\$100,909,858
OIG Medicaid Budget	\$32,482,375	\$32,251,419	\$64,733,794
OIG Medicaid Managed Care Budget	\$26,880,541	\$26,820,692	\$53,701,233

Of its 639.5 full-time equivalent employees (FTEs), the OIG projects 410 (64 percent) will conduct work related to Medicaid. Of these FTEs, 325.5 (79 percent) will conduct work related to managed care. The OIG estimates the remaining 229.5 FTEs will conduct work outside Medicaid.

For this review, the number of incidences is based on completed activities, such as closed cases, reviews, or claims adjustments resulting from OIG work. These incidences do not include activities with no action or findings. Although the OIG is reporting a total number of incidences, it is important to note that there is no standard unit to measure and compare these incidences. For example, an audit may take longer to complete, and may review many claims and report several findings, but is only counted as one incidence. On the other hand, a claims or medical records review that takes comparatively minimal time is also counted as one incidence.

OIG program areas reported identifying 274,163 total incidences of FWA in Medicaid managed care in SFY 2019. The vast majority (265,751) of these incidences were related to individual claims adjustments for recoveries of waste from a liable third party resulting from work conducted by the OIG.

1. Introduction

The Texas Health and Human Services (HHS) Office of the Inspector General (OIG) submits this Review of Managed Care Organization Cost Avoidance and Waste Prevention Activities and OIG Efforts in Medicaid managed care Report in compliance with House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, HHS, Rider 114). Rider 114 requires the OIG to:

1. Continue its review of cost avoidance and waste prevention activities employed by managed care organizations (MCOs) in collaboration with MCOs, addressing:
 - a. The strategies MCOs are implementing to prevent waste; and
 - b. The effectiveness of cost avoidance strategies employed by the MCOs to prevent waste and the adequacy of current cost avoidance functions.
2. Conduct a review of the OIG's efforts to combat fraud, waste and abuse (FWA) in Medicaid managed care, addressing:
 - a. The allocation of resources (expenditures and full-time equivalent employees [FTE]) for State Fiscal Year (SFY) 2020 and SFY 2021;
 - b. Other information relevant to assess the percentage of resources in Medicaid managed care; and
 - c. The total incidence of FWA identified by the OIG in Medicaid managed care programs by entity.

This report outlines the OIG's findings and recommendations from its review of MCO cost avoidance and waste prevention activities conducted in collaboration with MCOs and HHS Medicaid & CHIP Services (MCS), as well as the OIG efforts to identify FWA in and out of Medicaid managed care.ⁱ

For this report, 'MCOs' is inclusive of Dental Maintenance Organizations (DMO). The review of MCO cost avoidance and waste prevention activities is based on:

- A comprehensive literature review.
- A 26-question survey of 20 Texas MCOs.

- Discussion and further qualitative analysis with MCOs and MCS through the MCO Cost Avoidance Workgroup.

This analysis builds on and details findings and recommendations from the OIG's continued review conducted since the OIG's *Review of Managed Care Organizations' Cost Avoidance and Waste Prevention Activities*.ⁱⁱ This 2018 report identified the variety of cost avoidance and waste prevention activities used by MCOs and difficulty of calculating cost avoidance in managed care. This report highlights specific types of activities on which to focus efforts to capture the value of MCO cost avoidance.

The analysis of OIG efforts in Medicaid managed care looks at resources and identified incidences of FWA in Medicaid managed care. The analysis of OIG resources is based on projected staffing and expenditures by program area for SFYs 2020 and 2021. The analysis of incidences of FWA identified by the OIG in Medicaid managed care is presented in the context of completed OIG activities.

The OIG endeavors to engage in data-driven and strategic program integrity work to achieve better outcomes and cost savings in the delivery of all health and human services.

2. MCO Cost Avoidance and Waste Prevention Activities

Background

HHS contracts with MCOs¹ to provide services to members enrolled in Texas Medicaid managed care and the Children's Health Insurance Program (CHIP). HHS pays MCOs a per member per month (PMPM) rate to deliver covered health services to their members. This is in contrast with the traditional Medicaid fee-for-service (FFS) model where the state manages Medicaid benefits and serves as the claims administrator to directly pay providers for covered services.ⁱⁱⁱ

In managed care, program integrity is a shared responsibility between the federal government, the state and the MCOs. Program integrity activities are aimed at preventing, detecting and deterring FWA. A robust program integrity program ensures taxpayer dollars are spent appropriately on accessible, quality and necessary care.^{iv} In Texas, the OIG collaborates with MCOs to prevent, detect and investigate FWA in Medicaid and CHIP managed care.^v

MCOs implement program integrity activities related to cost savings, including:

- Recovery efforts
- Cost avoidance and waste prevention activities
- Quality measures related to value-based payment (VBP) programs and alternative payment models (APMs).

HHS and the OIG currently measure the impact of some of these program integrity activities through various metrics, such as MCO reporting of fraud and abuse recoveries^{vi} and third-party liability (TPL) cost avoidance,^{vii} the medical Pay-for-Quality (P4Q) Program,^{viii} MCO contractual requirements for value-based contracting with providers,^{ix} and the hospital quality-based payment program.^x Reporting for each of these metrics is required in the MCO contracts and requires resources at HHS and/or the OIG to track and evaluate MCO performance.

¹ For the purposes of this report, the term 'MCOs' is inclusive of Dental Maintenance Organizations (DMOs) unless otherwise noted.

In Texas Medicaid and CHIP managed care, HHS is fundamentally shifting from paying for volume to paying for value of services.^{xi} HHS administers various programs and measures to improve health care quality and outcomes while containing costs. In the managed care model, MCOs have the ability to achieve efficiencies and promote improved health outcomes through the implementation of select contract requirements that may contain costs, such as Service Coordination. MCOs also conduct utilization management activities such as implementing prior authorization requirements for certain services. Utilization management focuses on providing appropriate care and medically necessary services. While this may ultimately reduce waste and cost within the system, this function is not explicitly focused on cost avoidance.

National Landscape for Measuring Program Integrity in Managed Care

Federal and state regulations require MCOs to engage in certain efforts to combat FWA in managed care.^{xii} MCOs must submit an annual compliance plan to the state, which details specific policies and procedures about how they will adhere to program integrity requirements.^{xiii}

The Centers for Medicare and Medicaid Services (CMS) conducts state Medicaid program integrity reviews. These reviews identify program vulnerabilities, determine if states' policies and practices comply with federal regulations, identify states' best practices, and monitor the states' corrective action plans.^{xiv} In several program integrity reviews conducted between January 2016 and January 2018, CMS recommended that states collect supporting documentation from Medicaid MCOs about their cost avoidance and prevention activities.^{xv} According to the Medicaid and CHIP Payment and Access Commission (MACPAC), while the value of many program integrity activities is acknowledged, there are few processes for determining the efficacy and cost savings resultant from the utilization of these activities.^{xvi}

In 2017, CMS reported that program integrity activities implemented in the Medicare FFS program resulted in approximately \$15.5 billion in cost savings. Approximately 86 percent of those savings resulted from cost savings that prevented improper payments while approximately 14 percent of the savings resulted from recovery of improper payments. While CMS uses standard calculation methodologies for capturing savings from Medicare Integrity Programs in FFS,^{xvii} CMS has not published guidance for states on defining or measuring MCO program integrity cost avoidance in Medicaid or CHIP managed care.

Given the flexibility that states have in approaching program integrity cost avoidance for Medicaid and CHIP managed care, the OIG reviewed other states to inform potential approaches for Texas to consider. The OIG found notable practices in two states:

- The Louisiana Department of Health (LDH) captures cost avoidance resulting from clinical prepayment review and claim edits. LDH defines cost avoidance as the total denied claims resulting from these activities.^{xviii} MCOs report prepayment review cost avoidance to the LDH in the Fraud, Waste and Abuse Activity Quarterly Report.^{xix}
- The New Mexico Human Services Department also captures MCO cost avoidance from prepayment review programs and certain front-end claim edits. MCOs report the dollar amount of the avoided payments to providers if not for their prepayment interventions.^{xx}

LDH identified similar challenges in capturing the value of MCO cost avoidance activities, as MCOs use different business rules related to the activities and differing methodologies for reporting the resultant cost avoidance.^{xxi} This review further details the existing challenges in quantifying the impact of MCO cost avoidance activities and proposes a potential approach to standardize how cost avoidance activities are defined in Texas.

MCO Program Integrity Efforts

In Texas, MCOs currently report to the OIG on select program integrity efforts related to referrals, FWA recoveries, Third Party Recoveries (TPR) and TPL cost avoidance to ensure Medicaid is the payer of last resort.^{xxii} The OIG works mainly with MCO Special Investigative Units (SIU) on MCO program integrity efforts. MCOs are required to establish an SIU to investigate allegations of FWA for all services outlined in the managed care contracts and described in the Texas Administrative Code (TAC).^{xxiii}

SIUs are responsible for investigating potential FWA and referring suspected FWA to the OIG.^{xxiv} MCO referrals and recovery efforts are part of several components for program integrity. MCOs have noted that they apply many strategies to prevent FWA. In SFY 2019, MCOs referred 346 cases of potential provider fraud or abuse to the OIG, a 90 percent increase from SFY 2018.^{xxv} MCOs are also required to report recoveries of improper payments related to fraud or abuse to the OIG.^{xxvi} In SFY

2019, 20 MCOs collectively recovered approximately \$4.9 million in improper payments related to fraud or abuse.^{xxvii}

MCOs also report TPR to the OIG, which may be a function of SIUs or other MCO business areas. MCOs collect TPR when Medicaid or CHIP paid for services when other responsible parties should have been billed. This helps to ensure that all other responsible parties have paid their share for services provided to Medicaid clients. In SFY 2019, MCOs reported recovering over \$87.4 million in TPR.^{xxviii}

In 2016, The Texas Association of Health Plans (TAHP) highlighted transitioning away from the traditional pay-and-chase recovery methods^{xxix} employed in FFS towards preventative cost avoidance activities.^{xxx}

More specifically, MCOs employ strategies to avoid costs by preventing improper payment of claims.^{xxxi} MCOs report TPL cost avoidance to the OIG. TPL cost avoidance is based on denied claims and other insurance credits related to Medicaid being the payer of last resort.^{xxxii} In SFY 2019, MCOs reported \$847.8 million in TPL cost avoidance, including \$439.5 million in denied claims and \$408.3 million in other insurance credits.^{xxxiii}

At this time, MCOs are not required by federal regulations, Texas law or state contracts to report on other types of cost avoidance resulting from additional strategies.^{xxxiv} In this review, the OIG examined other types of cost avoidance measures to be discussed in the following sections.

MCO Reported Cost Avoidance Activities

Rather than prescribe a cost avoidance definition and methodology for states to follow, CMS allows states the option to consider cost avoidance as a component of their contracted MCOs program integrity efforts. While some program integrity activities are required by federal and state regulations and MCO contracts, the flexibility regarding the consideration of cost avoidance enables states to establish parameters that best meet the unique needs of their state's residents.^{xxxv} This has led to considerable variation among the states' requirements and oversight of MCOs program integrity activities.^{xxxvi} MCOs utilize a variety of cost avoidance activities of which some, such as potentially preventable events (PPEs), are not applicable to DMOs due to differing contract requirements and service provisions.

To identify the cost avoidance activities employed by MCOs, the OIG requested the Texas Medicaid contracted MCOs to complete the *Medicaid and CHIP MCOs Program*

Integrity Cost Avoidance and Waste Prevention Activities Survey^{xxxvii} similar to the one conducted in 2017.^{xxxviii} All 20 MCOs and DMOs participated in the survey and collaborated in the MCO Cost Avoidance Workgroup.² The definitions of cost avoidance and waste prevention activities remained constant between the 2017 and 2019 surveys to allow for comparative analysis.

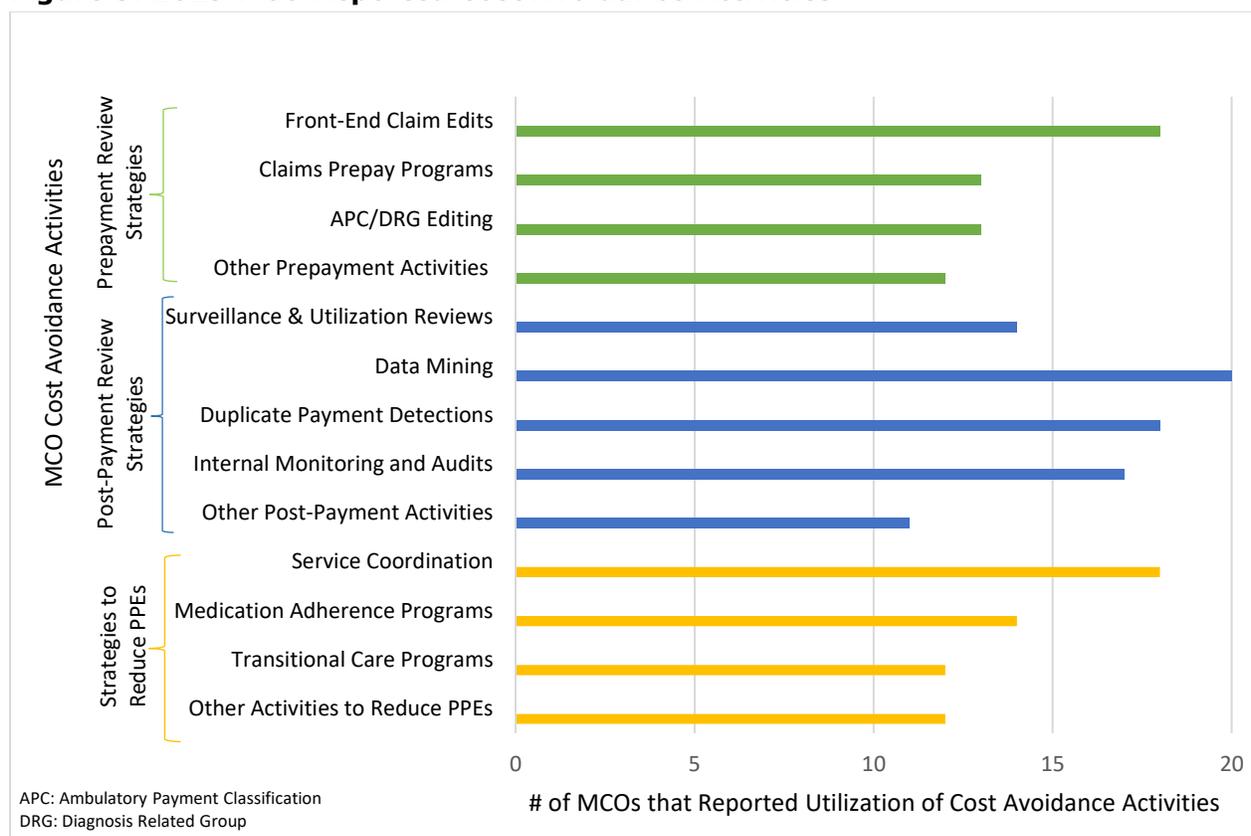
- **Cost Avoidance Activity:** An intervention that prevents, reduces or eliminates a cost that would have otherwise occurred if not for the use of the intervention; an activity that identifies and prevents improper payments before the payment is made; not pay-and-chase overpayment recoupments.
- **Waste Prevention Activity:** An activity taken to stop practices that a reasonably prudent person would deem careless or that would allow inefficient use of resources, items or services.³

For this review the OIG considers cost avoidance to be inclusive of waste prevention, as any prevented waste may result in cost savings. Figure 3 shows some of the activities reported by MCOs, which are organized into three broad categories including prepayment review strategies, post-payment review strategies and strategies related to reducing potentially preventable events (PPEs).

² See **Appendix A** for details regarding the methodology used for the OIG’s review of MCO cost avoidance and waste prevention activities.

³ See **Appendix B**, *Medicaid and CHIP MCOs Program Integrity Cost Avoidance and Waste Prevention Activities Survey* (2019).

Figure 3: 2019 MCO Reported Cost Avoidance Activities



All the MCOs reported using at least one prepayment and post-payment review strategy. Figure 4 illustrates the difference between which activities MCOs named as most effective in 2017 versus those they found to be effective in 2019. The greatest difference in the self-reported effectiveness of these activities between the two surveys was reducing PPEs. In 2017, 55 percent of the MCOs named these as effective activities compared to 89 percent in 2019. The most effective strategies reported by MCOs in 2017 and 2019 were prepayment review strategies and post-payment review strategies respectively.

Figure 4: 2017-2019 Comparison of MCO Cost Avoidance Activities⁴

Cost Avoidance Activity	Percent and Number of MCOs Identifying as Most Effective		Percent Difference
	2017	2019	
Prepayment Review Strategies	82% (18/22)	85% (17/20)	3%
Post-payment Review Strategies	77% (17/22)	95% (19/20)	18%
Strategies to Reduce Potentially Preventable Events (PPEs)	55% (11/20)	89% (16/18)	34%

The following sections provide further detail regarding activities reported by MCOs in each of these categories, including MCO success stories.

Prepayment Review Strategies

Prepayment review strategies focus on preventing improper payments to providers. In 2019, 85 percent of the MCOs named prepayment review strategies as one of the most effective methods to reduce costs. Prepayment review strategies may include:

- **Front-end claim edits**, which identify and deny claims that contain billing errors before the claims are accepted into the claims system.^{xxxix}
- **Claims prepayment review programs** or programs that review claims after they have been accepted into the claims system, but before payments have been processed.
- **Ambulatory Payment Classification (APC)^{xi} or Diagnosis Related Group (DRG)^{xli} edits** that are specific types of edits to prevent paying for outpatient hospital claims with improper APC codes or hospital clinic/emergency department claims with invalid DRG codes.

Success Stories Related to Prepayment Reviews Reported by MCOs

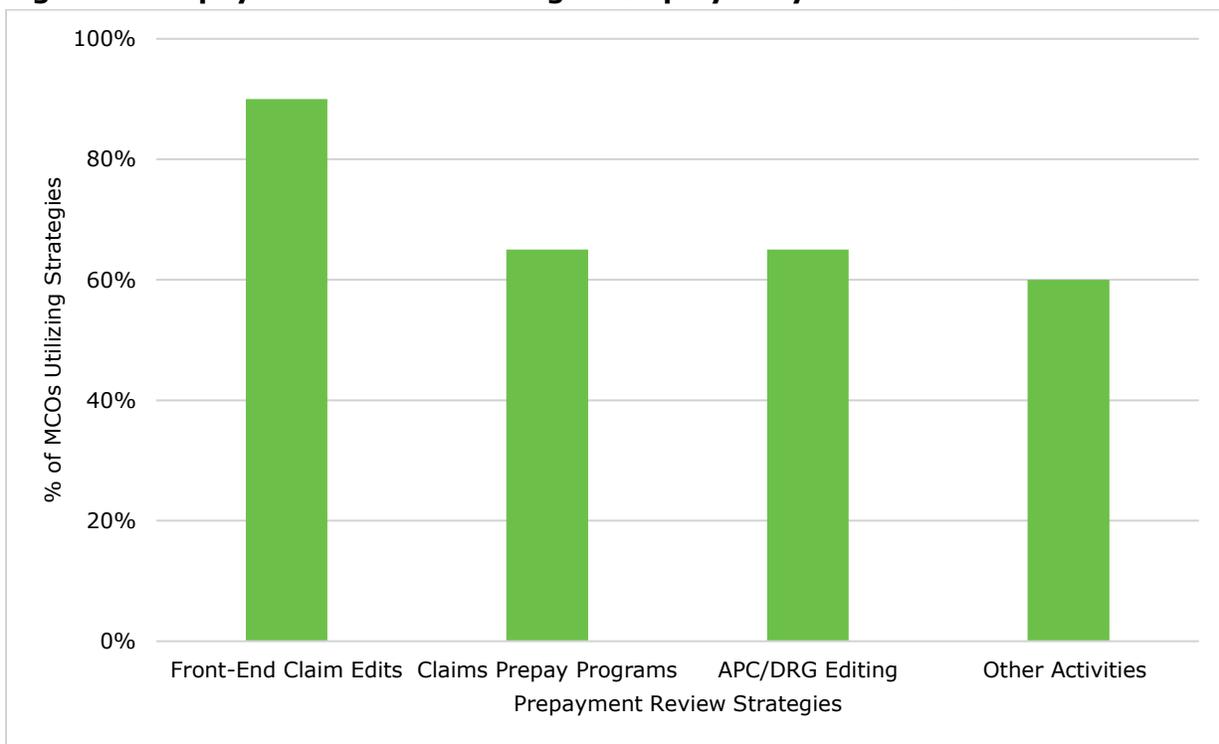
Several MCOs shared success stories related to the use of prepayment review activities. The following two examples provided by MCOs highlight these activities:

⁴ In the comparative analysis between 2017 and 2019 the OIG considered the change in the number of MCOs operating in Texas. At the time of the 2017 survey, there were 22 MCOs operating in Texas and at the time of the 2019 survey there were 20.

- An MCO’s prepayment review system flagged a family practice provider for excessively billing high-level evaluation and management services. The MCO placed 20 of the provider’s services on prepayment review, which resulted in cost savings.
- An SIU identified abnormal and high utilization for various tests including urine creatinine testing which led to the implementation of a prepayment protocol that resulted in cost savings.

Figure 5 shows the prepayment activities employed by the MCOs in 2019. Other prepayment activities reported by the MCOs included proactive data mining, use of third party fraud prevention services and member, provider, and employee FWA education.

Figure 5: Prepayment Review Strategies Employed by MCOs in 2019



A notable practice named by the MCOs is the use of multiple front-end claim edits software programs. By using more than one program, MCOs found that they could increase prepayment error identification and better ensure the prevention of improper payments.

Post-Payment Review Strategies

In addition to prepayment review activities, MCOs also employ post-payment review activities. In 2019, 95 percent of the MCOs named prepayment review strategies as one of the most effective methods to reduce costs. Generally, these program integrity activities prevent waste and are referred to as pay-and-chase strategies, as they occur post payment. For example, duplicate payment detection is a data-driven strategy to determine if duplicative claims have been paid. When detected, MCOs can recover or even prevent duplicative claims payments from providers. Post-payment review strategies may also include efforts to analyze data and implement interventions for prospective cost savings. Post-payment strategies to promote cost avoidance may include:

- **Data mining** is a broad and inclusive term that includes collecting data, and then analyzing and identifying trends and patterns in the data.^{xlii}
- **Predictive modeling** is the process of using detection theory to create, test and validate a model to predict the probability of a possible outcome, which can be used to identify potentially improper billings.^{xliii}
- **Surveillance and Utilization Reviews (SUR)** are used to evaluate whether provided services are appropriate when compared to treatment guidelines.
- **Internal monitoring and audits** identify improper payments that have been made to providers and are eligible for recovery.^{xliv}

Success Stories Related to Post-Payment Reviews Reported by MCOs

Several MCOs shared success stories related to the use of post-payment review activities. The following two examples provided by MCOs highlight these activities:

- During a post-payment review, an MCO found an area of improvement for the documentation of invoice priced Durable Medical Equipment (DME_ claims. The MCO reinforced DME invoice documentation guidelines, and shared examples of what was and was not permissible as a training tool.
- An MCO identified paid claims for services provided within a global surgery period by the same provider. The MCO collected overpayments and implemented new edits to prevent further overpayments.

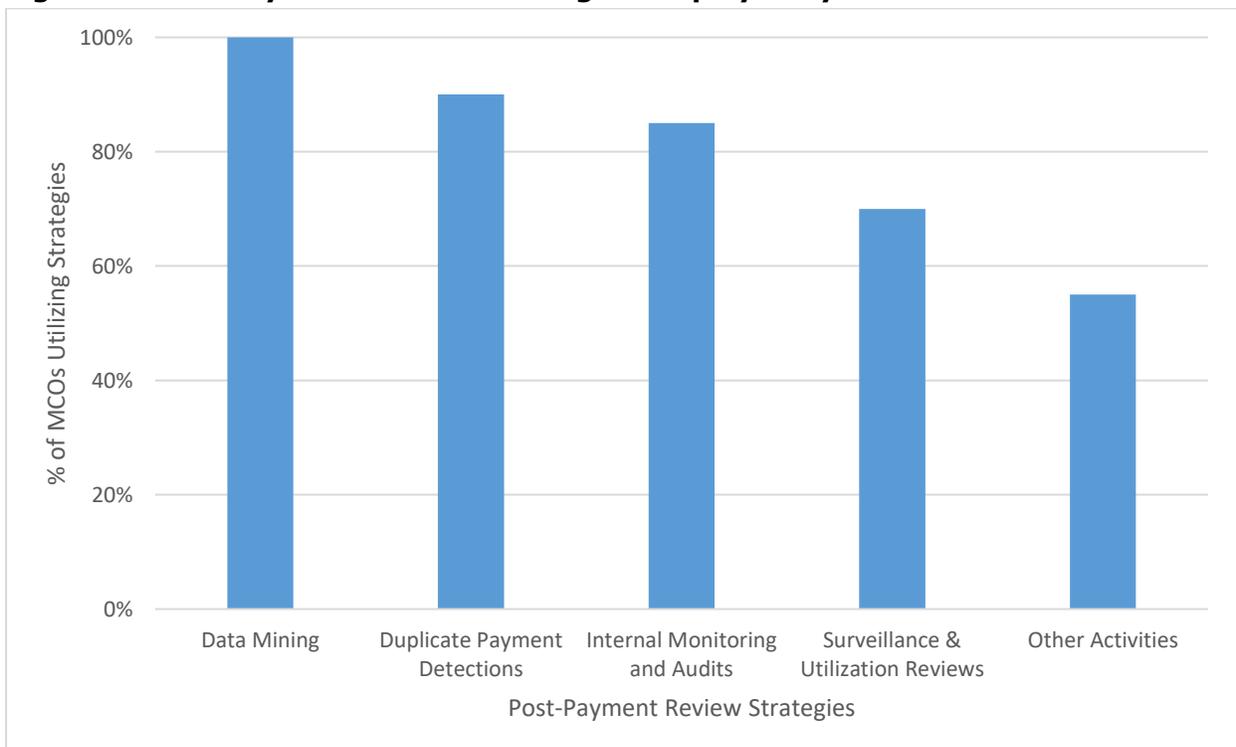
MCOs reported often using a combination of different activities to maximize cost savings. One notable practice reported by MCOs is the use of data mining to

identify the potential misuse of procedure codes. In this instance, the MCO placed the provider on prepayment review and sent educational information on how to appropriately adjust their billing practices. This type of intervention utilizing multiple cost avoidance strategies has the potential to:

- Identify and prevent improper payments.
- Prevent further inappropriate treatment and billing practices by providers reducing the potential for waste.
- Identify potential overpayments eligible for recoupment.

One MCO also noted that when SIU investigators partner with Provider Relations staff to engage in provider education there is a positive impact on provider practices with a reduction in inefficient use of resources, items and services. Figure 6 shows the post-payment activities employed by MCOs in 2019. Other post-payment activities reported by MCOs include the use of fraud tip lines, use of post-payment code editing programs and TPL cost avoidance. As previously mentioned, the OIG monitors TPL cost avoidance to ensure Medicaid and CHIP are the payers of last resort.

Figure 6: Post-Payment Review Strategies Employed by MCOs in 2019



Strategies to Reduce Potentially Preventable Events (PPEs)

HHS administers several quality initiatives to promote better care and health outcomes for Medicaid members. These measures include the P4Q program, alternative payment model requirements and hospital quality-based payment programs.^{xlv} MCOs reported on efforts to prevent waste by reducing PPEs, or health-care encounters that may have been avoided if a preventative intervention had been used.

HHS currently evaluates MCO efforts to reduce certain PPEs via the P4Q Program. In P4Q, MCOs can earn or lose a portion of their capitation payment based on performance on at-risk quality measures. MCOs are assessed on quality measure benchmarks and through performance against self, or a comparison of the measurement year to the previous year's performance. If an MCO's performance is poor, HHS recoups up to 3 percent of the MCO's capitation payment. MCOs can earn extra through a bonus pool.^{xlvi, xlvi}

Under the Hospital Quality-based Potentially Preventable Readmissions and Complications program, HHS collects data on PPEs to improve quality and efficiency. MCOs and hospitals are financially accountable for potentially preventable complications and potentially preventable readmissions flagged by HHS. Based on performance for these measures, adjustments are made to FFS hospital inpatient claims. Similar adjustments are made in each MCO's experience data, which affects capitation rates.^{xlviii}

MCO efforts to reduce PPEs may include:

- **Service Coordination** involves evaluation of clients' needs and coordinating services to promote quality, cost-effective outcomes.^{xlix}
- **Medication adherence programs** to help ensure that patients are taking their medications and that their prescriptions are refilled on time.
- **Transitional care programs** aimed to reduce specific types of PPEs by ensuring newly discharged hospital enrollees are not readmitted through coordination and continuity of health care for high-risk patient transitions.[!]

Success Stories Related to PPEs Reported by MCOs

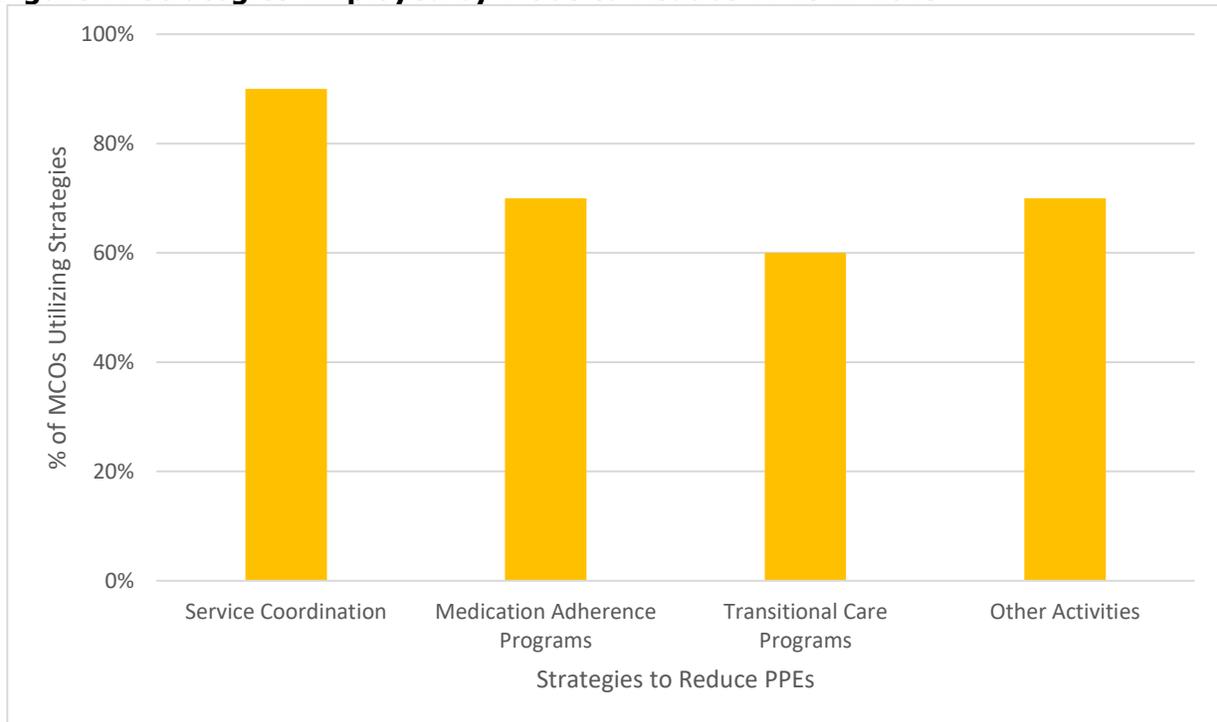
Several MCOs reported success stories related to reducing PPEs. These MCOs reported working in collaboration with service providers to identify gaps in care to improve client utilization of preventative care services and increase client

medication and care plan adherence. The following two examples provided by MCOs highlight these activities:

- An MCO had a member who had 10 emergency room visits and multiple hospitalizations over a one-year period. An MCO service coordinator identified the root cause of these hospitalizations to be complications from lack of access to preventative care and disease management support, as well as inability to locate a primary care provider. The service coordinator provided health education materials to and assisted the member in finding a provider and scheduling a wellness exam. As a result, the member reported maintaining provider visits and engaging in improved health behaviors.
- An MCO had a member who had several uncontrolled health issues including diabetes, diabetic neuropathy, congestive heart failure and high cholesterol. These issues led to nine emergency room visits in 12 months, four hospital admissions and pharmacy claims indicating poor medication adherence. After enrolling in the MCO's disease management program, the client's medication adherence improved from 11 percent to 68 percent over a 12-month period and the client has only had one hospital admission and emergency room visit in the last two years.

Figure 7 identifies strategies employed by MCOs to reduce PPEs in 2019. Other efforts reported employed by Texas MCOs to reduce PPEs include medical health homes, substance abuse intervention programs, and disease management for members with chronic diseases.

Figure 7: Strategies Employed by MCOs to Reduce PPEs in 2019⁵



Quantifying MCO Cost Avoidance

Challenges and Limitations

Based on MCO responses to the OIG's 2019 *Medicaid and CHIP MCOs Program Integrity Cost Avoidance and Waste Prevention Activities Survey*, information obtained through stakeholder meetings with the MCO Cost Avoidance Workgroup and research on other states' practices, the OIG identified the following challenges in quantifying the impact of MCO cost avoidance activities:

- **Variation in MCO size and capacity**, impacting the type and breadth of cost avoidance activities employed by MCOs. The services provided by MCOs depend on a variety of factors including but not limited to Medicaid product, service delivery area and number of clients served.

⁵ The term case management was utilized in the 2017 and 2019 iterations of *Medicaid and CHIP MCOs Program Integrity Cost Avoidance and Waste Prevention Activities Survey*.

- **Intricacies and volume of data requirements.** MCOs utilize a multitude of claims management systems and business processes related to program integrity, leading to different definitions of variables and data points.
- **Increasing focus on innovative payment strategies.** As HHS and MCOs transition to paying for value vs. volume,^{li} determining how to approach cost avoidance and waste prevention in alternative payment models presents new complexities and continues to be examined.

These challenges make it both difficult to develop a standard methodology for calculating the cost avoidance resulting from all activities utilized by MCOs and also to implement the reporting of a standard cost avoidance measure for MCOs.

Application

Those MCOs that do measure the impact of cost avoidance activities employ a variety of techniques to evaluate effectiveness.^{lii} The most commonly reported measure is calculating the dollar value of activities, using methodologies such as:

- The value of claims denied through front-end claim edits or prepayment review.^{liii}
- The net change in provider billing practices after an intervention.

Several MCOs detailed accounts of provider education efforts to reduce or prevent aberrant billing patterns. After implementing an intervention, one MCO noted calculating savings for claims not submitted due to the intervention. The difference between the amount paid per patient pre- and post-intervention is the estimated prevented loss or cost savings attributed to the intervention. The MCO calculates the cost savings for a period of up to 12 months based on available data.

More than one MCO evaluates the effectiveness of activities by examining the provider error rates after implementing post-payment reviews. A reduction in provider error rates after conducting the review would indicate that the measure had been successful.

Given the current challenges, opportunity exists to bolster MCO cost avoidance reporting requirements and create a reasonable level of standardization in how we define and evaluate cost avoidance activities. Use of consistent cost avoidance activity definitions may help facilitate comparable reporting across MCOs. Any further review of the effectiveness of these activities would require standardization of the definition of cost avoidance across MCOs and development of consistent

reporting processes to collect the requisite data from MCOs, which may include amendments to MCO contract requirements related to these activities.

OIG Approach to Measure MCO Program Integrity Cost Avoidance

To standardize how cost avoidance activities are defined in Texas, the OIG collaborated with MCOs and MCS to develop a recommended framework to focus efforts on select activities. This approach categorizes MCO cost avoidance activities into those related to 'implicit' vs. 'explicit' savings.

- **Implicit savings** are those resulting from activities that provide value to the managed care program but can be difficult to quantify. The value of these activities stems from increased coordination, focus on preventative services and ensuring medically necessary services are rendered.
- **Explicit savings** are those resulting from definitive activities, such as interventions for which a dollar value can be assigned.

While certain savings are implicit to the managed care model and provide value to the state and the administration of health-care services, the OIG's approach to measure MCO cost avoidance focuses on explicit cost savings related to program integrity.

Additionally, the OIG's approach does not include explicit savings already captured through MCOs reporting to HHS. Therefore, the OIG's approach excludes activities related to TPL and recoveries, as well as other reporting to HHS, to avoid duplicative counting of savings. The framework instead targets the unknown cost savings resulting from explicit program integrity cost avoidance activities.

Explicit program integrity cost savings are not the only type of MCO cost avoidance. The OIG's approach focuses on explicit cost savings that are quantifiable, data-driven and based on tangible interventions related to FWA. Figure 8 outlines how the MCO cost avoidance activities could potentially be categorized in the framework of explicit vs. implicit cost savings.

Figure 8: Examples of MCO Cost Avoidance, Implicit vs. Explicit Cost Savings Activities⁶

Total MCO Cost Avoidance		
<p>Explicit Program Integrity Cost Savings Activities</p> <ul style="list-style-type: none"> •Prepayment review strategies •Front-end claim edits •Claims prepay programs •Ambulatory payment classification (APC) or diagnosis related Ggroup (DRG) edits •Post-payment review strategies •Surveillance and utilization reviews (SUR) 	<p>Explicit Cost Savings Activities Currently Reported</p> <ul style="list-style-type: none"> •Third Party Liability (TPL) cost avoidance 	<p>Implicit Cost Savings Activities</p> <ul style="list-style-type: none"> •Strategies to reduce potentially preventable events (PPEs) •Service coordination •Transitional care programs •Medication adherence programs •Utilization management

⁶ Please note that this figure includes examples but is not meant to be a comprehensive representation of all the cost avoidance and waste prevention activities utilized by MCOs.

OIG Explicit Program Integrity Cost Avoidance Definition, Criteria and Guidelines

To guide MCO efforts in capturing the impact of various cost avoidance activities, the OIG worked in collaboration with the MCOs and MCS to better define how we talk about cost avoidance. Although the results of the 2017 and 2019 *Medicaid and CHIP MCOs Program Integrity Cost Avoidance and Waste Prevention Activities Surveys* are broad and inclusive of both explicit and implicit cost savings, the OIG proposes focusing on explicit program integrity cost avoidance. To narrow the focus, the OIG developed a definition, criteria and guidelines to help determine which activities to include. The following definition, criteria and guidelines capture explicit cost avoidance resulting from MCO utilization of program integrity related cost avoidance activities:

Definition: An intervention that reduces or eliminates an improper payment before the payment is made.

In developing this definition, the OIG considered previously used definitions, research and MCO identified activities to narrow the definition to explicit program integrity cost avoidance.

Criteria:

1. **Tangible:** Clear and definite.
2. **Quantifiable:** Relating to, measuring or measured by the quantity of something rather than its quality.
3. **Related to FWA,** as defined by Texas Administrative Code (TAC).^{7, liv}
4. **Not otherwise captured by HHS reporting.**

⁷Fraud: Any intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person. The term does not include unintentional technical, clerical, or administrative errors.

Waste: Practices that a reasonably prudent person would deem careless or that would allow inefficient use of resources, items, or services.

Abuse: A practice by a provider that is inconsistent with sound fiscal, business, or medical practices and that results in an unnecessary cost to the Medicaid program; the reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care; or a practice by a recipient that results in an unnecessary cost to the Medicaid program.

To refine which activities to consider in a further review of effectiveness, the OIG developed these criteria for activities. The criterion of 'tangible' is meant to ensure that activities are clear and definite, indicative of a definitive intervention or action. The criterion of 'quantifiable' is meant to ensure the feasibility of measuring and assigning a dollar value to activities that involve a direct cause and effect. The criterion of 'related to FWA' limits the activities to those related to program integrity. The criterion of 'not otherwise captured by HHS reporting' is meant to avoid duplicative reporting with various HHS metrics, such as MCO reporting of fraud and abuse recoveries^{lv} and TPL cost avoidance,^{lvi} the P4Q Program,^{lvii} MCO contractual requirements for value-based contracting with providers,^{lviii} the Hospital Quality Based Payment Program,^{lix} and the Pharmacy Lock-in Program.^{lx} These criteria focus the analysis on select activities for which the calculation of the dollar value of activities is both feasible and related to program integrity.

Guidelines: Using the above definition and criteria to determine potential inclusion in reporting, MCOs calculate the cost avoidance of identified activities for a prospective period for which data is available and analyzed pre- and post-intervention for up to a 12-month period.

In developing these guidelines, the OIG considered the calculation methodologies reported by MCOs and identified in other states. The requirement of data availability reinforces the criterion of quantifiable, as MCOs need available data to assign a dollar value to an activity. The OIG found it necessary to include a 12-month limitation for calculating cost avoidance given the frequency of changes that occur within the Medicaid program and to account for the sentinel effect. In this case, a sentinel effect occurs when billing behaviors are altered because of an action to reduce FWA.^{lxi} The OIG identified one state calculating cost avoidance up to 36 months and another state reporting cost avoidance based on a 3-month period, so the OIG considers the time parameter of 12 months reasonable. Additionally, three MCOs reported calculating cost avoidance based on a 12-month period. This reporting period would align with other HHS reporting requirements on alternative payment models and MCO fraud and abuse recoveries.

The OIG considered varying approaches of calculating the dollar value of cost avoidance based on what was billed by the provider versus what is allowed through both the Medicaid allowable amount and the MCO contracted rate with the provider. More than one MCO expressed limitations related to the feasibility of determining the dollar value of denied claims using solely the Medicaid allowable amount. The OIG recommends considering the use of the MCO's contracted rate to reflect the

anticipated payment to a particular provider. Alternatively, the Medicaid allowable amount could be used which would align with the requirement of MCOs to report the allowable amount of TPL cost avoidance SFY 2020 forward.^{lxii}

Applying the OIG Program Integrity Cost Avoidance Definition, Criteria and Guidelines to MCO Cost Avoidance Activities

To identify the currently unknown cost avoidance resulting from program integrity MCO cost avoidance activities, HHS could apply the OIG definition, criteria and guidelines to MCO activities. The application of this approach focuses efforts to capture the dollar value of activities on select activities for which this calculation is both feasible and related to program integrity. Figure 9 shows a general framework for applying these benchmarks to types of cost avoidance activities.

Figure 9: Framework to Evaluate the Effectiveness of MCO Cost Avoidance Activities

Cost Avoidance Activity	Meets Definition	Tangible	Quantifiable	Related to FWA	Not Currently Reported to HHS	Data Available for Pre-/Post-Analysis	Explicit Program Integrity Related Activity
Prepayment Review Strategies	Yes	Yes	Yes	Yes	Potentially ⁸	Yes	Yes
Post-Payment Review Strategies	Potentially	Yes	Yes	Yes	Potentially	Yes	Potentially
Reducing Potentially Preventable Events (PPEs)	No	Potentially	Potentially	Yes	No	Yes	No

Prepayment review strategies could potentially meet all the guidelines outlined above to qualify as an explicit program integrity related activity.

As previously discussed, post-payment review strategies generally focus on recoveries and therefore do not meet the OIG’s definition of program integrity cost avoidance. For example, internal monitoring and audits would generally not meet the definition requirement, as the activities do not involve reducing or eliminating an improper payment before the payment is made. Other post-payment review

⁸ The term ‘potentially’ is used when there are some activities in the category that could be considered under the proposed approach, but there are others within that same category that would be excluded.

strategies could potentially meet the definition requirement if the activities focused on implementing interventions for prospective cost savings and not pay-and-chase measures. If the post-payment review strategy met the remaining guidelines, then the activity could potentially qualify as an explicit program integrity related activity.

Efforts focusing on improving quality through reducing PPEs would not meet the definition requirement as other HHS metrics currently capture the impact of these activities.^{lxiii}

Findings and Recommendations

Together the state and MCOs engage in a variety of program integrity activities to combat FWA and ensure the delivery of quality, necessary care in Medicaid and CHIP managed care. These efforts can be measured by several metrics including recoveries, FWA referrals and health quality outcomes. In this review, the OIG found that in addition to these types of measures, MCOs implement a variety of cost avoidance activities to promote program integrity.

The OIG developed a potential approach to capture the value of certain MCO cost avoidance and waste prevention activities in Medicaid and CHIP managed care. The approach focuses on identifying program integrity related activities that 1) can be measured and 2) would not duplicate the value captured by other reporting from MCOs to HHS.

In its *Review of Managed Care Organizations' Cost Avoidance and Waste Prevention Activities* published in 2018, the OIG noted over 20 cost avoidance and waste prevention activities to consider when measuring the effectiveness of MCO cost avoidance efforts.^{lxiv}

This approach further refines cost avoidance activities by categorizing them into implicit cost savings, explicit cost savings currently captured by HHS reporting and explicit program integrity cost savings. To capture the value of explicit program integrity activities, the OIG proposes applying the following definition, criteria and guidelines to activities:

- **Definition:** An intervention that reduces or eliminates an improper payment before the payment is made.
- **Criteria:** An intervention that is tangible, quantifiable, related to FWA and not currently captured by HHS efforts; and

- **Guidelines:** Available data analyzed pre- and post-intervention for up to 12 months (a timeframe which aligns with MCO reporting of fraud and abuse recoveries).

This framework focuses efforts on program integrity related activities for which capturing the value is feasible and would not duplicate other value already being captured by HHS reporting. Based on this approach, OIG recommends focusing on prepayment review strategies and post-payment review strategies that result in changes that lead to cost avoidance in the future (not recoveries of already paid funds). The application of this framework will provide HHS a structure within which to capture the dollar value of currently unknown explicit cost savings resulting from MCO utilization of program integrity related activities.

As previously stated, any further review of the effectiveness of these activities would require standardization of the definition of cost avoidance across MCOs and development of consistent reporting processes to collect the requisite data from MCOs, which may include amendments to MCO contract requirements related to these activities. Any potential reporting metrics may also consider other factors such as provider abrasion and network adequacy in balance with cost savings to ensure patient access to quality care.

3. OIG Efforts in Medicaid Managed Care

Background

The OIG is charged with preventing, detecting and deterring fraud, waste and abuse in the delivery of all health and human services in the state. The budget for the health and human services system is approximately \$42 billion per year and over 53,000 employees.^{lxv} Of that total, approximately \$24 billion is dedicated to Medicaid managed care.^{lxvi}

The OIG expends significant effort in Medicaid but has additional responsibilities for non-Medicaid programs as well. Figures 10 through 13 outline the OIG programs that support the identification of FWA across all HHS programs, breaking out the programs that work solely in Medicaid, work in Medicaid and other HHS programs, and those work only in non-Medicaid HHS programs.

Programs outlined in Figure 10 work solely in Medicaid, both FFS and managed care. While the majority of the work is in managed care, some activities such as the Recovery Audit Contractor (RAC) are a required FFS activity. The OIG may also receive referrals or identify FWA in FFS that it will pursue.

Figure 10: OIG Programs – Medicaid Only

OIG Programs – Medicaid Only				
Tool	OIG Program Area	Focus	Programs	Potential Outcome(s)
Investigations	Medicaid Program Integrity (MPI)	<ul style="list-style-type: none"> Providers 	Medicaid	<ul style="list-style-type: none"> Recovery of overpayments Sanctions Referral to Medicaid Fraud Control Unit (MFCU) at Attorney General
Reviews	Medical Services	<ul style="list-style-type: none"> Providers Clients (substance abuse only) 	Medicaid	<ul style="list-style-type: none"> Recovery of overpayments Provider education Client lock-in⁹
Third Party Recoveries and Cost Avoidance	Third Party Recoveries	<ul style="list-style-type: none"> Providers 	Medicaid	<ul style="list-style-type: none"> Recoveries Cost Avoidance
Recovery Audit Contractor (RAC) Oversight	Medicaid Program Integrity (MPI)	<ul style="list-style-type: none"> Providers 	Medicaid	<ul style="list-style-type: none"> Recovery of overpayments

Figure 11 lists OIG programs that work across HHS programs. For example, Benefits Program Integrity (BPI) conducts investigations in several HHS programs, primarily focusing on the Supplemental Nutrition Assistance Program (SNAP), but also making recoveries in Medicaid, Temporary Assistance for Needy Families (TANF) program, CHIP, and the Women, Infants, and Children (WIC) program. The OIG Audit and Inspections & Investigations divisions complete audits and inspections in Medicaid managed care, but also work in other non-Medicaid programs. The OIG Provider Enrollment Integrity Screenings unit enrolls providers in Medicaid FFS and managed care, as well as other HHS programs.

⁹ When a Medicaid client is a “lock-in”, they are restricted to a designated pharmacy or health care provider by HHS.

Figure 11: OIG Programs – Medicaid & Non-Medicaid

OIG Programs – Medicaid & Non-Medicaid				
Tool	OIG Program Area	Focus	Programs	Potential Outcome(s)
Audits	Audit	<ul style="list-style-type: none"> Providers MCOs HHS agencies HHS contracts 	All HHS Programs	<ul style="list-style-type: none"> Recovery of overpayments Audit findings and recommendations
Investigations	Benefits Program Integrity (BPI)	<ul style="list-style-type: none"> Clients 	SNAP Medicaid TANF WIC CHIP	<ul style="list-style-type: none"> Recovery of overpayments Disqualification from program participation Referral for local prosecution
Inspections	Inspections & Investigations	<ul style="list-style-type: none"> Providers MCOs HHS agencies HHS contracts 	All HHS Programs	<ul style="list-style-type: none"> Inspection report findings and recommendations Recovery of overpayments
Data Analytics	Data & Technology (DAT)	<ul style="list-style-type: none"> Providers MCOs Clients 	All HHS Programs	<ul style="list-style-type: none"> Data analysis that supports and drives OIG work
Enrollment	Provider Enrollment Integrity Screenings	<ul style="list-style-type: none"> Providers 	Medicaid CHIP Other HHS Programs	<ul style="list-style-type: none"> Screening for high risk providers seeking to enroll in certain HHS programs
Internal Affairs (IA)	Chief Counsel	<ul style="list-style-type: none"> HHS Staff 	All HHS Programs	<ul style="list-style-type: none"> Findings related to HHS employee and contractor investigations

The OIG also has divisions with responsibilities outside of the Medicaid program, listed in Figure 12. For example, the State Centers Investigations Team (SCIT) conducts criminal investigations of allegations of abuse, neglect, and exploitation at state supported living centers and state hospitals.

Figure 12: OIG Programs – HHS Programs (Non-Medicaid)

Non-Medicaid Only				
Tool	OIG Program Area	Focus	Programs	Outcome(s)
Investigations	State Centers Investigations Team (SCIT)	<ul style="list-style-type: none"> State Supported Living Centers (SSLCs) State Hospitals 	Financial Assistance Program	<ul style="list-style-type: none"> Findings related to allegations of abuse, neglect and exploitation Referrals to local law enforcement
Investigations	Electronic Benefit Transfer (EBT) Trafficking Unit	<ul style="list-style-type: none"> Retailers Clients 	SNAP	<ul style="list-style-type: none"> Recovery of overpayments Referrals to local law enforcement
Investigations	Cooperative Disability Investigations	<ul style="list-style-type: none"> Claimants Providers 	Disability Determination Services (DDS)	<ul style="list-style-type: none"> Timely and accurate disability determinations Referrals to OIG for recovery
Inspections	WIC Vendor Monitoring Program	<ul style="list-style-type: none"> Vendors 	Women, Infants, and Children (WIC)	<ul style="list-style-type: none"> Recovery of overpayments Vendor disqualification

Figure 13 outlines the divisions that provide support across the office for OIG programs.

Figure 13: Summary of OIG Supporting Program Areas

Supporting Program Areas	
OIG Program Area	Activities to Support and Promote OIG divisions
Policy, Development & Innovation	<ul style="list-style-type: none"> Policy research, analysis, writing and training Project management
General Law and Litigation	<ul style="list-style-type: none"> Legal support Provider appeals for investigations and audits
External Relations	<ul style="list-style-type: none"> External stakeholder communication Outreach with legislators, consumers, MCOs and the media Leading OIG-wide initiatives and special projects
Operations	<ul style="list-style-type: none"> Budget, purchasing and contract management Fraud hotline Training services

For reference, detailed descriptions of the OIG’s programs and supporting divisions are included in **Appendix C**.

OIG Resources in Medicaid Managed Care

In this review, the OIG evaluated its resources (projected staffing and spending) in Medicaid managed care.

OIG Allocation of FTEs for Medicaid Managed Care in SFY 2020 - SFY 2021 Biennium

In January 2020, the OIG had 639.5 full-time equivalent employees (FTEs). The OIG estimates that it dedicates 410 (64.1 percent) to Medicaid and 325.5 (50.9 percent) directly or indirectly to identifying FWA in Medicaid managed care. Within its overall work in Medicaid, the OIG estimates that 79.4 percent of its effort is in managed care. The OIG’s estimate is based on a percentage of work performed by individual FTEs reported by each OIG program area, not dedicated FTEs assigned specifically to managed care.¹⁰ Figure 14 shows the actual allocation for SFY 2020 and planned allocation for SFY 2021 of OIG FTEs by program area.

¹⁰ See **Appendix A** for details regarding the methodology used to determine the number of FTEs working directly or indirectly in Medicaid managed care by OIG program area.

Figure 14: OIG FTE Allocation by OIG Program Area in SFY 2020 – SFY 2021 Biennium

	Medicaid Managed Care FTEs	Total FTEs	% of FTEs in Medicaid Managed Care
OIG Programs – Medicaid Only			
Medicaid Program Integrity	69.4	77.0	90.1%
Medical Services	73.2	98.0	74.7%
Third Party Recoveries	6.5	12.0	54.2%
Recovery Audit Contractor	0.0	2.0	0.0%
OIG Programs – Medicaid & Non-Medicaid			
Audit	40.9	75.0	54.5%
Benefits Program Integrity	16.8	117.0	14.4%
Inspections ¹¹	15.9	23	69.1%
Data and Technology	24.0	26.0	92.3%
Provider Enrollment Integrity Screenings	14.4	16.0	90.0%
OIG Programs – Non-Medicaid Only			
Investigations	0.0	52.0	0.0%
Internal Affairs	0.0	35.0	0.0%
WIC Vendor Monitoring Program	0.0	8.0	0.0%
OIG Supporting Program Areas			
Chief Counsel ¹²	27.8	32.5	85.5%
Operations	18.2	40.0	45.5%
Policy, Development & Innovation ¹³	11.9	14.0	85.0%
Chief of Staff ¹⁴	6.0	11.0	54.5%
Executive Management	0.5	1.0	50.0%
Total	325.5	639.5	50.9%

¹¹ Inspections for this analysis does not include the WIC Vendor Monitoring Program.

¹² Chief Counsel for this analysis includes General Law and Litigation and excludes Internal Affairs.

¹³ Policy, Development & Innovation for this analysis includes the Chief Strategy Officer and support employee.

¹⁴ Chief of Staff for this analysis includes External Relations (Government Relations, Communications and Strategic Initiatives).

As indicated by Figure 14, OIG programs spend half of their resources combatting FWA in Medicaid managed care.

For those programs that work across the HHS system, there are still significant resources spent on Medicaid managed care. The Data and Technology (DAT) division spends 92.3 percent of its resources on managed care, with Audit (54.5 percent) and Inspections (69.1 percent) also completing work in this area. As discussed above, the BPI division is focused on SNAP recoveries.

Investigations (inclusive of the EBT Trafficking Unit, Cooperative Disability Investigations (CDI), and SCIT) and Internal Affairs reported no employees contributing directly or indirectly to Medicaid managed care efforts. This aligns with their work outside of managed care and Medicaid.

Among the OIG's supporting program areas, the OIG allocates 65.4 percent of its staff to Medicaid managed care. Chief Counsel and Policy, Development & Innovation both use at least 85 percent of their FTEs in managed care, while the remainder of the support divisions spend around half of their time in support of managed care.

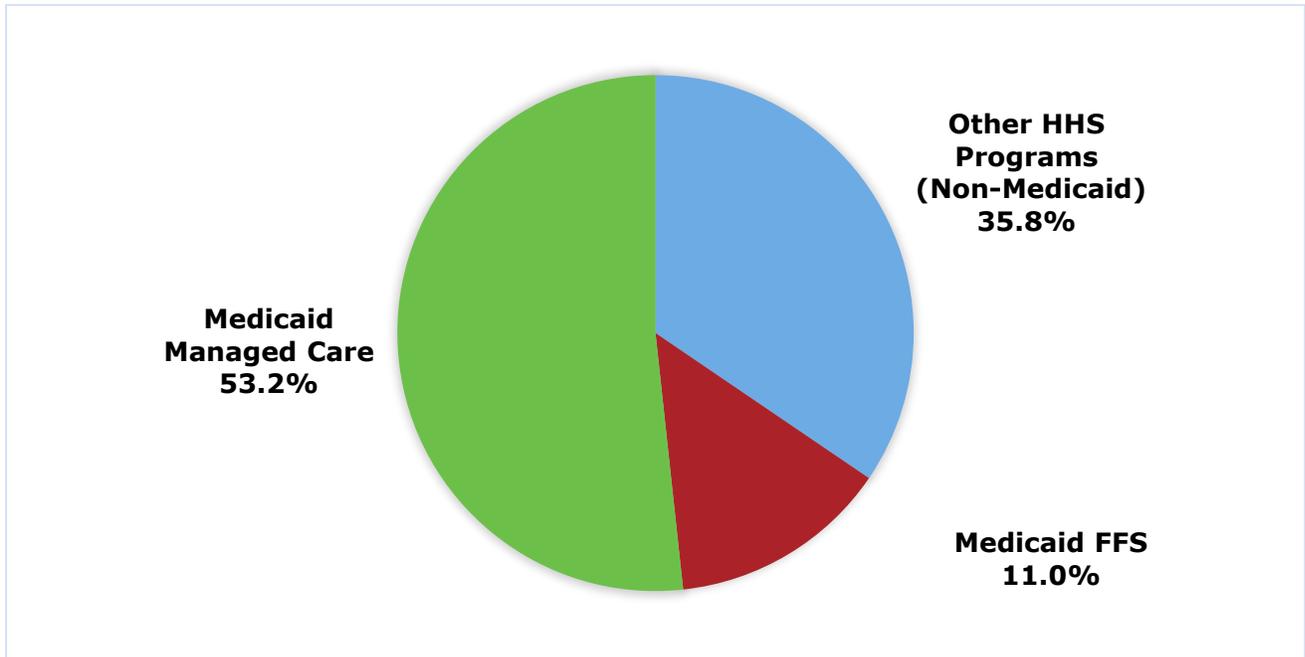
OIG Expenditures in Medicaid Managed Care in the SFY 2020 - SFY 2021 Biennium

In SFY 2020 and SFY 2021, the OIG's projected operational biennial budget^{lxvii} totals over \$100.9 million (\$50.5 million in SFY 2020, \$50.4 million in SFY 2021). Of this, the OIG projects dedicating roughly 64.2 percent (more than \$64.7 million in the biennium) to combating FWA in Medicaid.¹⁵

Within its efforts in Medicaid, the OIG estimates 83.0 percent of its operational budget will be spent on managed care. Figure 15 shows the OIG budget allocation by percentage in Medicaid managed care, Medicaid FFS, and other HHS non-Medicaid programs for the SFY 2020 – SFY 2021 biennium.

¹⁵ See **Appendix A** for details regarding the methodology used to determine the OIG's projected operational budget related to Medicaid managed care.

Figure 15: OIG Budget Allocation for SFY 2020 - SFY 2021 Biennium by Percentage in Medicaid, Medicaid Managed Care and HHS Programs (Non-Medicaid)



As discussed above, the OIG has some FFS activities that are required, and may also pursue referrals or other FWA identified in FFS Medicaid. Although most persons with Medicaid receive covered services through managed care, some populations continue to receive services through the FFS delivery model.^{lxviii} The OIG may also investigate providers that serve both FFS and managed care clients.

The OIG also dedicates 35.8 percent of its SFY 2020 – SFY 2021 biennial budget to other HHS non-Medicaid programs. These efforts include activities such as audits, inspections, BPI investigations and provider enrollment integrity screenings conducted outside of Medicaid in addition to work conducted by OIG areas that work solely in non-Medicaid HHS programs, including Internal Affairs, the EBT Trafficking Unit, the WIC Vendor Monitoring program and SCIT.

Figures 16 and 17 show the OIG’s planned budget allocation for the SFY 2020 – SFY 2021 biennium, delineating resources related to Medicaid and Medicaid managed care. Within Medicaid, the OIG has allocated 83.0 percent of its budget for the SFY 2020 – SFY 2021 biennium directly or indirectly to Medicaid managed care.

Figure 16: Summary of OIG Projected Budget in Medicaid Managed Care, SFY 2020 – SFY 2021 Biennium

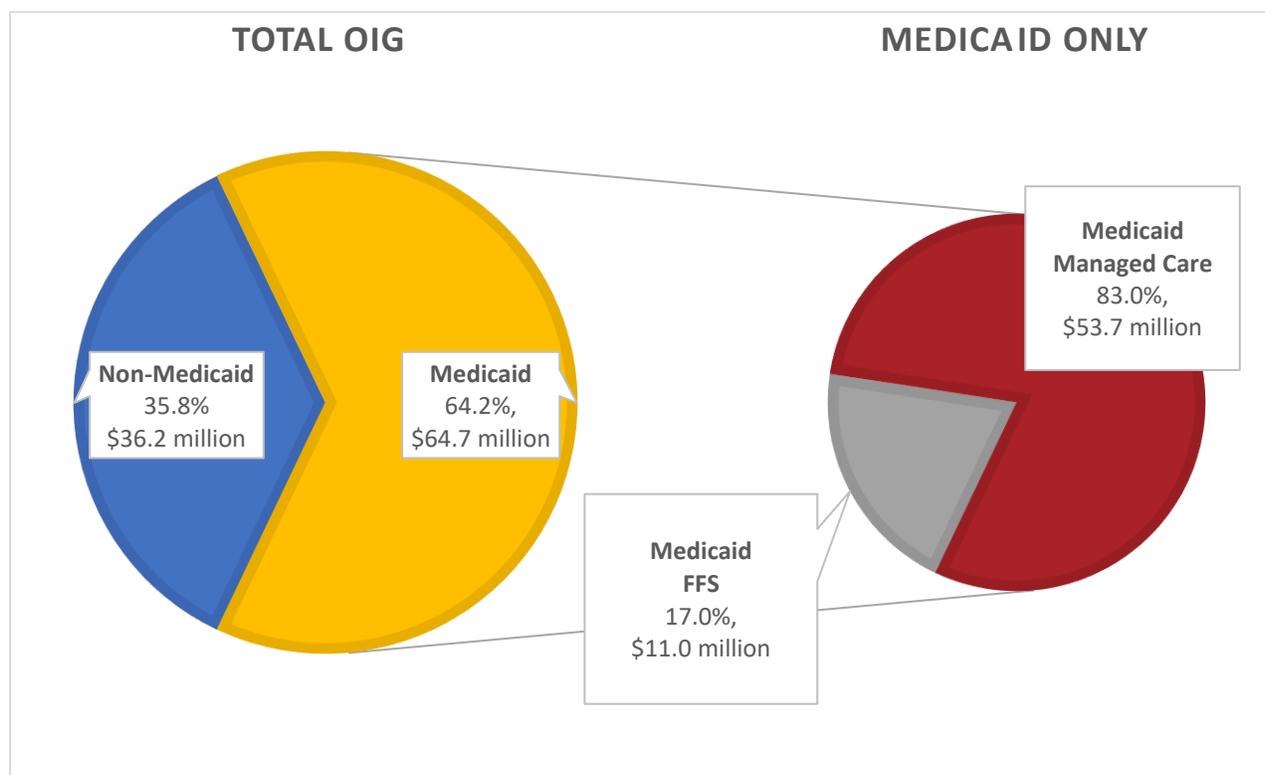


Figure 17: OIG Projected Operational Budget, SFY 2020 – SFY 2021 Biennium

	SFY 2020	SFY 2021	Biennium
OIG Budget	\$50,497,100	\$50,412,758	\$100,909,858
OIG Medicaid Budget	\$32,482,375	\$32,251,419	\$64,733,794
OIG Medicaid Managed Care Budget	\$26,880,541	\$26,820,692	\$53,701,233
% Medicaid of OIG Budget	64.3%	64.0%	64.2%
% Managed Care of OIG Budget	53.2%	53.2%	53.2%
% Managed Care of OIG Medicaid Budget	82.8%	83.2%	83.0%

As actual expenditures for SFY 2020 were not final at the time of this report’s preparation, the OIG operational budget is used as a proxy for SFY 2020 actual expenditures. Actual year-to-date expenditures for SFY 2020 as of December 2019 totaled \$14,457,903.74. Of these expenditures, the OIG estimates 56 percent (\$8,097,799.84) to be related to Medicaid managed care.

In summary, the OIG found that it dedicates half of its resources directly or indirectly to Medicaid managed care.

FWA Incidences Identified by the OIG in Medicaid Managed Care

FWA Recoveries and Cost Avoidance in SFY 2019

To evaluate the impact of its work, the OIG tracks certain measures related to the financial outcomes of its efforts to combat FWA. An investigation, audit, inspection or review performed, managed or coordinated by the OIG can result in:

Dollars recovered: Dollars recovered are overpayments collected based on the results of an investigation, audit, inspection or review.

Dollars identified for recovery: Dollars identified include overpayments identified for recovery during an OIG investigation, audit, inspection or review for: an alleged violation of a statute, law, regulation, rule, policy, or other authority governing the expenditure of funds or the provision of services; a finding that a cost is not supported by adequate documentation; or a finding that funds were not used for their intended purpose or were unnecessary, unreasonably spent or wasteful.^{lxix}

Cost avoidance: Cost avoidance results in resources used more efficiently; an increase in available resources from reductions in inefficient expenditures; or avoidance of unnecessary expenditure of funds for operational, medical, contract or grant costs.

In SFY 2019, the OIG recovered \$421.2 million in improper payments, of which the OIG estimates more than \$391.7 million was in Medicaid, including both FFS and managed care. The OIG also identified a potential \$170.8 million for future recoveries and achieved \$164.1 million in cost avoidance.

FWA Incidences Identified by the OIG in Medicaid Managed Care in SFY 2019

For this review, the number of incidences is based on completed activities, such as closed cases, reviews, or claims adjustments resulting from OIG work. These incidences do not include activities with no action or findings. It is important to note that although the OIG is reporting a number of incidences, there is no standard unit to measure these incidences. For example, an Audit may take months to complete, and as part of the process may review many claims and report several findings but

is only counted as one incidence. On the other hand, a claims or medical records review that takes comparatively minimal time is also counted as one incidence.

OIG program areas reported identifying 274,163 total incidences of FWA in Medicaid managed care in SFY 2019. The vast majority (265,751) of these incidences was related to individual claims adjustments for recoveries of waste from a liable third party resulting from work conducted by the OIG.

FWA Incidences Identified by Third Party Recoveries in SFY 2019

TPR works to ensure that Medicaid is the payer of last resort by recovering and avoiding third party liability payments and operates the Medicaid Estate Recovery Program. TPR brings in significant Medicaid recoveries, more than \$295.7 million in SFY 2019. In managed care, TPR work resulted in 270,702 FWA incidences associated with third party recoveries, including 265,751 incidences related to individual claims adjustments for recoveries of waste (133,319 MCO encounter claims, 132,432 pharmacy encounter claims) and 4,951 subrogation (tort) cases. The responsible entity for the 133,319 MCO encounter recoveries was from other health insurance carriers, the 132,432 pharmacy encounter recoveries was from Pharmacy Benefit Managers (PBMs), and the 4,951 tort cases was from other liable third party settlements. Figure 18 shows the incidences of FWA identified by TPR in Medicaid managed care by entity in SFY 2019.

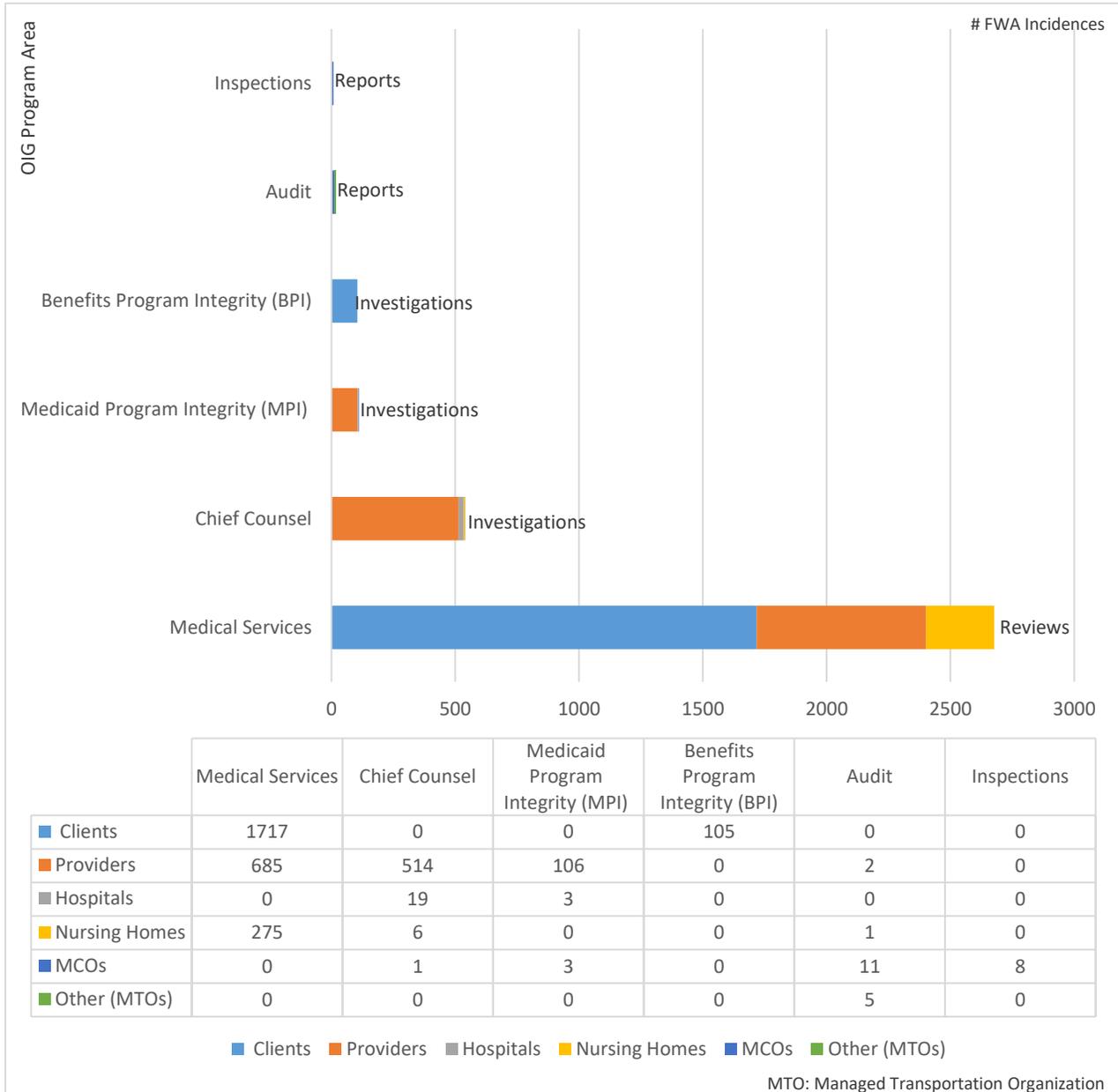
Figure 18: FWA Incidences Identified by Third Party Recoveries in Medicaid Managed Care in SFY 2019

	Insurance Carriers	Pharmacy Benefit Managers (PBMs)	Other Liable Third Parties	Total
Third Party Recoveries	133,319	132,432	4,951	270,702

Other OIG Program Areas Identified FWA Incidences in SFY 2019

As demonstrated in Figure 19, several other OIG program areas reporting identified incidences of FWA in Medicaid managed care in SFY 2019. Other OIG program areas reporting identified incidences of FWA included Medical Services (2,677), Chief Counsel (540), MPI (112), BPI (105), Audit (19) and Inspections (8). The FWA incidences for each program area by responsible entity (clients, providers, hospital, nursing homes, etc.) are as follows with the supporting methodology. For reference, the applicable unit is included for each program area (reports, investigations, reviews) with the identified FWA incidence. The program areas are in descending order by the number of FWA incidences identified in SFY 2019.

Figure 19: Summary of FWA Incidences Identified not Related to Third Party Recoveries in Medicaid Managed Care in SFY 2019 by OIG Program Area and Entity



Medical Services

Medical Services conducts claims and medical record reviews in Medicaid FFS and managed care. In SFY 2019, Medical Services conducted 18,098 hospital claims reviews, 529 nursing facility reviews and 1,229 Acute Care Surveillance (ACS) reviews. Medical Services also enrolled 1,717 clients in the Lock-In program.

Of these reviews, 2,677 were in Medicaid managed care and identified incidences of FWA. The responsible entity for 64.1 percent (1,717) of these incidences was a Medicaid client, 25.6 percent (685) a Medicaid provider, and 10.3 percent (275) a nursing home.

The 1,717 incidences involving Medicaid clients is the average number of clients in the Pharmacy Lock-In Program. The 685 incidences involving a Medicaid provider are the number of providers reviewed by ACS and the 275 incidences involving a nursing home are the number of facilities reviewed by Nursing Facility Utilization Review (NFUR) with findings. It is important to note that the reviews of providers and nursing homes involve multiple claims and/or forms, but only one incidence is counted per entity. While Medical Services conducted hospital reviews in Medicaid managed care in SFY 2019, final determinations for these reviews will be completed and reported in SFY 2020. Figure 20 shows the incidences of FWA identified by Medical Services in Medicaid managed care by entity in SFY 2019.

Figure 20: FWA Incidences Identified by Medical Services in Medicaid Managed Care in SFY 2019

	Clients	Providers	Hospitals	Nursing Homes	MCOs	Other	Total
Medical Services	1,717	685	-	275	-	-	2,677

Chief Counsel

Chief Counsel provides legal counsel to the Inspector General and the OIG divisions for work in and out of Medicaid FFS and managed care. In SFY 2019, Chief Counsel closed 570 cases. Of these cases, 540 related to Medicaid managed care. The responsible party for 95.2 percent (514) of these incidences was a provider, 3.5 percent (19) a hospital, and 1.1 percent (6) a nursing home. One incidence involved an MCO. Figure 21 shows the incidences of FWA identified by Chief Counsel in Medicaid managed care by entity in SFY 2019.

Figure 21: FWA Incidences Identified by Chief Counsel in Medicaid Managed Care in SFY 2019

Program	Clients	Providers	Hospitals	Nursing Homes	MCOs	Other	Total
Chief Counsel	-	514	19	6	1	-	540

Medicaid Program Integrity (MPI)

MPI investigates and reviews allegations of FWA committed by Medicaid providers in FFS and managed care. In SFY 2019, MPI conducted 2,039 preliminary Medicaid provider investigations and 260 full-scale Medicaid provider investigations. MPI referred 382 cases of potential fraud to the MFCU for further investigation. MPI closed 112 cases related to Medicaid managed care in SFY 2019 with incidences of FWA. Of these incidences, 94.6 percent (106) was in the provider population and the other 5.4 percent (6) split evenly between MCOs and hospitals. These incidences do not include cases referred to MFCU. Figure 22 shows the incidences of FWA identified by MPI in Medicaid managed care by entity in SFY 2019.

Figure 22: FWA Incidences Identified by MPI in Medicaid Managed Care in SFY 2019

	Clients	Providers	Hospitals	Nursing Homes	MCOs	Other	Total
Medicaid Program Integrity (MPI)	-	106	3	-	3	-	112

Benefits Program Integrity (BPI)

BPI investigates allegations of overpayments involving persons receiving Medicaid, either through FFS or managed care. However, most of BPI’s work focuses on non-Medicaid HHS programs, primarily SNAP, but also TANF, CHIP and WIC. In SFY 2019, BPI conducted 15,008 investigations. Of these cases, BPI pursued overpayments of Medicaid managed care in 105 cases, all in the Medicaid client population. Figure 23 shows the incidences of FWA identified by BPI in Medicaid managed care by entity in SFY 2019.

Figure 23: FWA Incidences Identified by BPI in Medicaid Managed Care in SFY 2019

	Clients	Providers	Hospitals	Nursing Homes	MCOs	Other	Total
Benefits Program Integrity (BPI)	105	-	-	-	-	-	105

Audit

Audit conducts risk-based performance, provider and information technology audits related to (a) the accuracy of medical provider payments, (b) the performance of HHS agency contractors, and (c) programs, functions, processes, and systems within the HHS system. In SFY 2019, Audit issued 38 audit reports.^{lxx} Nineteen of these audits were related to Medicaid managed care and identified an incidence of FWA. MCOs were the responsible party for 57.9 percent (11) of these identified incidences. Five incidences involved a managed transportation organization (MTO), two a provider, and one a nursing home. Figure 24 shows FWA incidences identified by Audit in Medicaid managed care by entity in SFY 2019.

Figure 24: FWA Incidences Identified by Audit in Medicaid Managed Care in SFY 2019

	Clients	Providers	Hospitals	Nursing Homes	MCOs	Other lxxi	Total
Audit	-	2	-	1	11	5	19

Inspections

Inspections conducts inspections of HHS programs, systems and functions focused on FWA, and systemic issues to improve the HHS System. In SFY 2019, Inspections performed nine inspections related to Medicaid managed care and identified incidences in eight of the nine inspections. One hundred percent of the identified incidences involved MCOs. Figure 25 shows the incidences of FWA identified by Inspections in Medicaid managed care by entity in SFY 2019.

Figure 25: FWA Incidences Identified by Inspections in Medicaid Managed Care in SFY 2019

	Clients	Providers	Hospitals	Nursing Homes	MCOs	Other	Total
Inspections	-	-	-	-	8	-	8

In total, the OIG identified 274,163 incidences of FWA. Again, it is important to note that a standard unit does not measure these incidences. With this approach each activity, such as an Audit or Inspection where many claims were reviewed, might have several findings but only one incidence would be reported. TPR identified a much larger number of FWA incidences in Medicaid managed care in SFY 2019 due to counting individual claim adjustments, while no other program measures incidences by claim in this report.

4. Conclusion

The OIG, HHS and MCOs each play a unique role in combating FWA in the provision of health and human services in Texas. With continued collaboration and strengthened SIUs, these partnering entities can work to achieve better outcomes for Texans by promoting the cost-effective delivery of quality services together.

In its review of MCO cost avoidance and waste prevention activities, the OIG found that MCOs implement a variety of cost avoidance and waste prevention activities to promote program integrity in the provision of Medicaid and CHIP services and some challenges as a result of differences in how MCOs currently capture cost-avoidance activities.

The OIG developed a framework to further refine how to potentially capture the value of MCO cost avoidance and waste prevention activities in Medicaid and CHIP managed care. The OIG recommends any further review focus on activities that prevent an improper payment; are tangible, quantifiable and related to FWA; are not currently reported to HHS; and for which data is available and analyzed pre- and post-intervention for up to 12 months.

Any further review of the effectiveness of these activities would require the standardization of the definition of cost avoidance across MCOs and development of consistent reporting processes to collect the requisite data from MCOs, which may include amendments to MCO contract requirements related to these activities. The state also engages in a variety of program integrity activities to combat FWA and ensure the delivery of quality, necessary care in Medicaid and CHIP managed care.

The OIG continues to engage in data-driven and strategic work to enhance its work in and out of Medicaid managed care. For the SFY 2020 – SFY 2021 biennium, the OIG has allocated 53.2 percent of its operational budget and 50.9 percent of its FTEs to combating FWA in Medicaid managed care. Within Medicaid, the OIG allocates 83.0 percent of its budget and 79.4 percent of its FTEs to work related to managed care. This resulted in 274,163 total incidences of FWA in Medicaid managed care identified by the OIG in SFY 2019. The vast majority (265,751) of these incidences were related to individual claims adjustments for recoveries of waste from a liable third party resulting from work conducted by the OIG.

List of Acronyms

Acronym	Full Name
ACS	Acute Care Surveillance
APG	Ambulatory Payment Classification
APM	Alternative Payment Model
BPI	Benefits Program Integrity
CDI	Cooperative Disability Investigations
CHIP	Children's Health Insurance Program
DAT	Data and Technology
CMS	Centers for Medicare and Medicaid Services
DDS	Disability Determination Services
DFPS	Texas Department of Family and Protective Services
DME	Durable Medical Equipment
DMO	Dental Maintenance Organization
DRG	Diagnosis Related Group
DSHS	Texas Department of State Health Services
EBT	Electronic Benefits Transfer

FDO	Fraud Detection Operation
FFS	Fee-For-Service
FTE	Full-Time Equivalent
FWA	Fraud, Waste and Abuse
HHS	Texas Health and Human Services
HHSC	Texas Health and Human Services Commission
HUR	Hospital Utilization Review
IA	Internal Affairs
IAC	Interagency Contract
LBB	Legislative Budget Board
LDH	Louisiana Department of Health
MACPAC	Medicaid and CHIP Payment and Access Commission
MCO	Managed Care Organization
MCS	HHS Medicaid & CHIP Services
MFCU	Medicaid Fraud Control Unit
MPI	Medicaid Program Integrity
MTO	Managed Transportation Organization
NCCI	National Correct Coding Initiative

NFUR	Nursing Facility Utilization Review
NPI	National Provider Identifier
OIG	HHS Office of the Inspector General (Texas)
P4Q	Pay-for-Quality
PDI	Policy, Development & Innovation
PDC	Performance Data Compiler
PEIS	Provider Enrollment Integrity Screenings
PERM	Payment Error Rate Measurement
PMPM	Per Member Per Month
PBM	Pharmacy Benefit Manager
PPE	Potentially Preventable Event
RAC	Recovery Audit Contractor
SCIT	State Centers Investigations Team
SFY	State Fiscal Year
SIU	Special Investigative Unit
SNAP	Supplemental Nutrition Assistance Program
SUR	Surveillance and Utilization Review
SSLC	State Supported Living Center

TAC	Texas Administrative Code
TAHP	Texas Association of Health Plans
TANF	Temporary Assistance for Needy Families
TMHP	Texas Medicaid & Healthcare Partnership
TMPPM	Texas Medicaid Provider Procedures Manual
TPL	Third Party Liabilities
TPR	Third Party Recovery
UMCC	Uniform Managed Care Contract
UMCM	Uniform Managed Care Manual
UOIG	Utah Office of the Inspector General
UPIC	Unified Program Integrity Contractors
US HHS	United States Department of Health and Human Services
UTHealth	University of Texas Health Science Center School of Public Health
VBP	Value Based Payment
WIC	Women, Infants and Children

Appendix A. Report Methodology

To address the requirements of House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, HHS, Rider 114), the OIG:

1) Conducted a Review of MCO Cost Avoidance and Waste Prevention Activities:

- Surveyed all 20 MCOs and DMOs participating in Texas Medicaid and CHIP in June 2019 about their cost avoidance and waste prevention activities and had a 100 percent response rate.
- Distributed an updated version of the 2017 OIG Cost Avoidance and Waste Prevention 29-question survey to provide MCOs and DMOs the opportunity to document their efforts and strategies, as well as to share success stories or any additional relevant information pertaining to Rider 114. This report details the aggregate findings from survey responses and provides a comparison of MCO and DMO survey responses from 2019 to 2017. The survey questions can be found in **Appendix B**.
- Executed an Inter-Agency Contract (IAC) with UTHealth to establish standard criteria and guidelines to define and options for methodologies to calculate cost avoidance by MCOs. Researched and reviewed national practices about cost avoidance, waste prevention strategies and documented practices used by various states.
- Established the 'MCO Cost Avoidance Workgroup' with stakeholders from the OIG, MCS, MCOs and DMOs. Facilitated four webinars and two meetings with MCS stakeholders to present findings and solicit state and MCO feedback for consideration and to obtain further insight into Texas MCO cost avoidance and waste prevention activities.
- The information provided in the report from MCOs and DMOs is self-reported data and was not independently validated or audited by the OIG.

2) Conducted a Review of OIG Efforts in Medicaid Managed Care:

- To determine the number of FTEs in Medicaid managed care, OIG program areas reported percentage of time worked directly or indirectly related to Medicaid managed care for each employee. The total number of OIG FTEs utilized for this analysis (639.5) matches the January 2020 Active Position Employee Report (APER) and includes OIG appropriated FTEs and FTEs dedicated to Disability Determination Services (DDS) and WIC investigations. This number excludes four audit positions moved to the Health and Human Services Commission (HHSC).

- At the time of this report's preparation, OIG actual expenditures for SFY 2020 or planned expenditures for SFY 2021 are not yet available. The OIG used the operational budget for SFY 2020 and SFY 2021 as of December 2019 as a proxy. To determine the budget for Medicaid managed care in SFY 2020 and SFY 2021, the percent of FTE time reported by each OIG program area was applied to that program area's budget for SFY 2020 and SFY 2021. SFY 2020 actual expenditures and expenditures in Medicaid managed care as of December 2019 are also included using this methodology.
- To determine the incidences of FWA identified by the OIG in Medicaid managed care in SFY 2019, each OIG program area reported the number of closed activities (investigations, audits, reviews, inspections, claims, etc.) in Medicaid managed care in SFY 2019 with findings of FWA. It is important to note that with this approach although one activity might have several findings of FWA, only one 'incidence' would be reported per activity. For instance, one audit with several findings of FWA would only be represented as one incidence. Subsequently, there is no standard unit for comparison of FWA incidences between OIG program area and entity.
- To provide information relevant to assess the percentage of resources used to perform activities related to Medicaid managed care relative to other OIG activities, this report addressed the full breadth of OIG work inside and outside of Medicaid managed care – highlighting those activities which are specific to Medicaid managed care and those activities that are unrelated to Medicaid or Medicaid managed care. See **Appendix C** for more detailed descriptions of OIG program areas and their efforts.

Appendix B. Medicaid and CHIP MCOs Program Integrity Cost Avoidance and Waste Prevention Activities Survey

Purpose

This survey is an opportunity for your organization to collaborate with the OIG and to document the program integrity cost avoidance and waste prevention activities your organization uses. It also provides the chance to share success stories and suggestions about how the OIG could better support your MCO's program integrity cost avoidance efforts.

Definitions

Cost Avoidance Activity: An intervention that prevents, reduces or eliminates a cost that would have otherwise occurred if not for the use of the intervention; an activity that identifies and prevents improper payments before the payment is made; not "pay and chase" overpayment recoupments.

Waste Prevention Activity: An activity taken to stop practices that a reasonably prudent person would deem careless or that would allow inefficient use of resources, items or services.

Survey Questions

General Cost Avoidance and Waste Prevention Activities:

1. What is the name of your MCO?
2. Please identify two individuals the OIG may contact if follow up is required.

Contact Name:

Contact Name:

Phone Number:

Phone Number:

Email:

Email:

3. Please identify the activities that have been most effective in reducing costs through cost avoidance and waste prevention:

Prepayment Reviews

Post-payment Reviews

Potentially Preventable Event Reductions of (hospital readmission, etc.)

Conduct Internal Monitoring and Internal Audits

Other Activities (please specify):

4. Please explain why your MCO has found these activities to be the most effective in avoiding cost and/or preventing waste.
5. How does your MCO evaluate the effectiveness of its cost avoidance activities (e.g. performance measures, such as the total number of incorrectly billed claims avoided)?
6. What specific activities of cost avoidance/waste prevention could be expanded or strengthened?

Prepayment Review Activities:

7. Please identify which of the following lines of business your responses in this section apply to:

STAR

STAR Health

Star +PLUS

Medicare-Medicaid Dual Demonstration

Star Kids

CHIP

Dental

8. Please select all methods and activities used to identify possible overpayments related to fraud, waste and abuse. For activities not listed, please identify in "Other Activities."

Front-End Claim Edits

Claims Prepay Programs

APC/DRG Editing

Other Activities (Please Specify):

9. Provide an example of a success story of a prepayment review activity:

Post-payment Review Activities:

10. Please identify which of the following lines of business your responses in this section apply to:

STAR

STAR Health

Star +PLUS

Medicare-Medicaid Dual Demonstration

Star Kids CHIP

Dental

11. Please select all methods and activities used to identify possible overpayments related to fraud, waste and abuse. For activities not listed, please identify in "Other Activities."

Surveillance & Utilization Reviews

Data Mining

Duplicate Payment Detections

Other Activities (Please Specify):

12. What are actions and activities taken to ensure that overpayments from fraud, waste and abuse are recouped?

13. Provide an example of a success story of a post-payment review activity:

Activities to Decrease Potentially Preventable Events:

14. Please identify which of the following lines of business your responses in this section apply to:

STAR STAR Health

Star +PLUS Medicare-Medicaid Dual Demonstration

Star Kids CHIP

Dental

15. What diagnosis groups are the focus of your efforts to reduce Potentially Preventable Events (e.g. Potentially Preventable Hospital Admissions, Potentially Preventable Readmissions, etc.)?

Asthma

Chronic Obstructive Pulmonary Disease

Diabetes

Heart Failure

Other Diagnosis Groups/Populations (Please Specify):

16. What activities are used to reduce Potentially Preventable Events beyond the disease management provisions required by the [Texas Administrative Code](#)

[\(1 Tex. Admin. Code §353.421\)](#) and the HHSC Uniform Managed Care Manual ([Chapter 9](#))?

Case Management

Medication Adherence Programs

Transitional Care Programs

Other Activities (Please Specify):

17. Provide an example of a success story about reducing Potentially Preventable Events:

Internal Monitoring and Audits:

18. Does your MCO use internal monitoring and internal audits to evaluate and improve cost avoidance activities? Yes No

19. Provide an example of a success story from a recommendation implemented as the result of an internal audit:

Further Questions:

20. Please identify prepayment and post-payment activities used to prevent waste, as defined by the Texas Administrative Code, "Practices that a reasonably prudent person would deem careless or that would allow inefficient use of resources, items, or services."

21. Please identify performance measures that your MCO uses to evaluate cost avoidance and waste prevention activities (i.e. the dollar value of costs avoided through prepayment reviews), including how each performance measure is defined and calculated.

22. How could the OIG better support your program integrity cost avoidance and waste prevention activities?

23. Beyond participating in the OIG's Special Investigative Unit quarterly meetings, how does your MCO collaborate with other Medicaid and CHIP MCOs when a provider is suspected of overpayments related to fraud, waste and abuse?

24. Are there planned cost avoidance or waste prevention activities (new or expansion of an existing activity) not otherwise identified in this survey your organization will use in state fiscal years 2019 - 2021?

25. Are there other information/comments related to program integrity cost avoidance and waste prevention efforts and activities you would like to share?

26. If your organization provides Medicaid and CHIP services, does your MCO's cost avoidance and waste prevention activities differ between programs? If so, please describe which and how these activities differ.

Appendix C. OIG Program Area Overview

For reference, descriptions of the OIG's program areas are included below. The program areas are categorized into 'Medicaid only', 'Medicaid and non-Medicaid', 'non-Medicaid only' and 'supporting program areas'.

OIG Programs – Medicaid Only

Investigations

Medicaid Program Integrity (MPI) investigates and reviews allegations of FWA committed by Medicaid providers. Once MPI receives referrals, it is legislatively-required to complete each investigation within 180 days. MPI can self-initiate cases based on data analytics or trends seen by its investigators, but most referrals come through the OIG Fraud Hotline or the Inspector General's online FWA Electronic Referral System. This includes referrals from the 20 MCOs in the state.

MPI investigations may result in referral to OIG Chief Counsel, or when MPI detects criminal Medicaid fraud, a referral to the Attorney General's Medicaid Fraud Control Unit (MFCU). The OIG and MFCU work together on joint investigations by sharing resources and information that will lead to successful administrative or criminal prosecution.

Reviews

Medical Services, within MPI, conducts claims and medical record reviews in Medicaid FFS and managed care. In these billing reviews, the OIG reviews medical records to ensure the documentation accurately reflects:

- The level of service billed
- The service or supply was provided
- Medical necessity
- Correct coding guidelines
- Quantity billed matches quantity delivered
- Policies and procedures are followed
- No duplicate billing
- No billing for non-covered services.

Medical Services is made up of several units, including:

- Acute Care Surveillance (ACS): The ACS team identifies patterns of aberrant billing and performs Surveillance Utilization Reviews required by the federal Centers for Medicare and Medicaid Services. The ACS team also develops and runs targeted data queries to identify acute care billing outliers.
- Hospital Utilization Review (HUR): The HUR team conducts the retrospective utilization review of paid inpatient hospital admissions for services provided to Medicaid recipients.
- Nursing Facility Utilization Review (NFUR): The NFUR team conducts retrospective onsite utilization reviews of nursing facilities to evaluate whether facilities correctly assessed and documented residents' needs, Medicaid reimbursements were appropriate for the level of care provided, and care was medically necessary.
- Lock-In Program: Lock-In Program staff work with MCOs to monitor recipient use of prescription medications and acute care services and determine if clients should be limited to one pharmacy and/or provider.

Medical Services also provides clinical consultation to the Audit and Inspections and Investigations divisions on dental, medical, nursing and pharmacy services.

Reviews conducted by the Medical Services may result in provider education and/or the recovery of identified overpayments. In instances of identified overpayments, cases may be referred to OIG Budget for collection and tracking.

Third Party Recoveries (TPR)

TPR works to ensure that Medicaid is the payer of last resort by recovering and avoiding third party liability payments and operates the Medicaid Estate Recovery Program.

Federal law and regulations require states to ensure Medicaid recipients use all other resources available to them, to pay for all or part of their medical care before billing Medicaid. Resources might include health insurance and/or casualty coverage resulting from an accidental injury.

A third party is any individual, entity, or program that is, or might be, liable to pay for any medical assistance furnished to a participant under the approved state Medicaid plan. Third parties might include private health insurance, employer-

sponsored health insurance, medical support from absent parents, automobile insurance, court judgments or settlements from a liability insurer and state worker's compensation.

As a condition of eligibility, a person who has Medicaid assigns their rights (and the rights of any other eligible person on whose behalf he or she has legal authority under state law to assign such rights) to medical support and payment for medical care from any third party to Medicaid.

TPR maintains the Third Party Liabilities (TPL) program by using the following:

- **Identification** - Provide efficient and timely identification, maintenance, and follow-up on third party information and third party liability from all sources.
- **Cost Avoidance** – A primary payer is identified automatically through claims processing, claims are denied, and provider is instructed to bill the other insurance.
- **Cost Recovery (Pay & Chase)** – Seek reimbursement from third parties whenever Medicaid has paid claims for which there are third parties that are liable for payment of the claims.
- **Subrogation (Tort)** - Recovery of Medicaid expenditures related to a Medicaid recipient's injuries from any settlement with, or judgment against, a liable third party.

Recovery Audit Contractor (RAC)

MPI manages the RAC contract. The RAC addresses a federal requirement for states to identify and reduce overpayments in the Medicaid program. The RAC reviews Medicaid paid claims in FFS to determine if services were provided according to federal and state laws, rules and regulations. The RAC uses data mining algorithms to develop reviews to identify specific types of Medicaid claims where the potential exists for overpayments. The Health and Human Services Commission (HHSC) pays the RAC based on a percentage of the total dollars collected from the RAC-identified overpayments.

OIG Programs – Medicaid & Non-Medicaid

Audits

Audit conducts risk-based performance, provider, and information technology audits related to (a) the accuracy of medical provider payments, (b) the performance of HHS agency contractors, and (c) programs, functions, processes, and systems within the HHS system.

The OIG develops a Rolling Audit Plan, which is available on the OIG website. OIG Audit Division conducts a continuous risk assessment to select potential audit topics for inclusion in its Rolling Audit Plan. Potential audit topics consist of programs, services, providers and contractors with an elevated potential for FWA. Audit selects topics through a variety of methods.

Audits may result in final audit reports, which include findings and recommendations. Audits may identify overpayments and disallowed costs or other issues, and may offer recommendations to improve performance, mitigate risks, address control weaknesses and reduce privacy and IT security vulnerabilities. Auditors refer potential fraud to MPI or Internal Affairs. If an audit results in no findings or recommendations, the OIG issues a no-findings letter to the auditee.

Investigations

Benefits Program Integrity (BPI) investigates allegations of overpayments to clients in the Supplemental Nutrition Assistance Program (SNAP), Medicaid, Temporary Assistance for Needy Families (TANF) program, Children’s Health Insurance Program (CHIP) and the Women, Infants, and Children (WIC) program. BPI also analyzes trends and patterns of behavior and refers cases for Administrative Disqualification Hearings and prosecution to proper state or federal regulatory and law enforcement authorities.

Investigations conducted within BPI may result in the cessation of benefits to clients receiving services from HHS programs.

Inspections

Inspections conducts inspections of HHS programs, systems and functions focused on FWA, and systemic issues to improve the HHS System. Inspections are performed in compliance with the Quality Standards for Inspections and

Evaluations, promulgated by the Council of the Inspectors General on Integrity and Efficiency.

Inspections result in final reports that are published on the OIG's website.

Data Analytics

Data and Technology (DAT) implements tools and innovative data analytic techniques that streamline OIG operations and increase the identification of FWA in HHS programs. DAT uses data research and data analytics to identify, monitor and assess trends and patterns of behavior of providers, clients and retailers participating in HHS programs.

The DAT unit develops targeted algorithms to allow investigators within the MPI and BPI divisions to focus their work on areas with higher risk for Medicaid fraud. Using data as a starting point helps investigators be more efficient in their work and realize a higher success rate in fraud detection. DAT also works with MCOs on deconfliction to ensure that double recoupment from providers does not occur.

DAT also supports Fraud Detection Operations (FDO) in conjunction with MPI. An FDO is a data-driven investigation designed to review providers that appear as statistical outliers among their peers and assess whether this outlier status is due to program violations related to FWA.

Provider Enrollment Integrity Screenings (PEIS)

The **PEIS** unit within MPI conducts federal and state-required screening activities for providers seeking to enroll in Medicaid, CHIP and other state health care programs.

Internal Affairs (IA)

IA investigates employee misconduct in the provision of health and human services, including contract fraud within the HHS system.

OIG Programs – Non-Medicaid Only

Investigations

Investigations includes commissioned peace officers and non-commissioned personnel and is comprised of the following three units:

State Centers Investigations Team (SCIT)

The SCIT team is comprised of law enforcement commissioned investigators who conduct criminal investigations of allegations of abuse, neglect and exploitation at state supported living centers and state hospitals.

Cooperative Disability Investigations (CDI)

The CDI program combats fraud by investigating statements and activities that raise suspicion of disability fraud by claimants, medical providers, interpreters or other service providers. The investigative evidence helps Disability Determination Services (DDS) make timely and accurate disability determinations.

Electronic Benefits Transfer (EBT) Trafficking

The EBT Trafficking unit is comprised of law enforcement commissioned and non-commissioned investigators who conduct criminal investigations regarding EBT misuse. The unit investigates those who intentionally violate provisions related to the Supplemental Nutrition Assistance Program (SNAP).

Inspections

WIC Vendor Monitoring Program (WIC)

OIG Inspections oversees the state's WIC Vendor Monitoring unit. This unit conducts in-store reviews, compliance buys and invoice audits to monitor vendors participating in the WIC program.

OIG Supporting Program Areas

The OIG supporting program areas provide support of operations for primary tool activities. These supporting program areas include the Policy, Development & Innovation (PDI), General Law and Litigation, External Relations and Strategic Initiatives, and Operations program areas within the OIG. A description of the

activities conducted within each of these divisions to support the OIG's work in Medicaid managed care is detailed below.

Policy, Development & Innovation (PDI)

The **PDI** unit within the Policy & Data and Technology Division serves as the health care policy subject matter expert and liaison across the OIG. PDI makes recommendations for contract and policy changes, liquidated damages and corrective action plans that promote program integrity.

PDI performs the following activities in support of the primary tools the OIG uses to conduct its work:

- **Systems Innovation:** Identify and implement innovative practices to advance the OIG's mission.
- **OIG Mission Support:** Support OIG critical projects and other priorities through project management and collaboration.
- **Collaboration:** Coordinates within the OIG, HHSC, and external stakeholders including Texas MCOs.
- **Policy Research, Analysis, Writing, and Training:** Conducts research, policy analysis, writes concise policy documents and develops and conducts trainings to boost OIG knowledge and application of managed care and other topics.

General Law and Litigation

General Law provides legal support for audits, investigations, inspections and reviews. General Law also supports OIG operations, including researching termination/exclusion issues, reviewing federal share obligations, analyzing extrapolation processes, contracting and assisting with rule and statute changes affecting the agency.

Litigation handles the appeal of investigations and audits that determined providers received Medicaid funds to which they were not entitled.

External Relations and Strategic Initiatives

Government Relations serves as the primary point of contact for the executive and legislative branches of government and state policy makers. Government Relations also analyzes legislation to understand the impact to OIG operations.

Communications manages press relations, maintains the OIG website and social media platforms, publishes the agency's external facing reports and work products, and facilitates communication between the Inspector General and various stakeholders.

Strategic Initiatives leads OIG-wide initiatives and special projects.

Operations

Operations performs the following functions to support activities within the OIG:

Operations Support includes OIG purchasing, contract management and the OIG Fraud Hotline. The Fraud Hotline receives allegations of FWA and refers them for further investigation to MPI or BPI, or for other action as appropriate.

Finance and Budget oversees the OIG budget, tracks recoveries, reports Legislative Budget Board performance measures and works closely with HHSC Central Budget on the agency's Legislative Appropriations Request /Exceptional Items.

Strategic Operations and Professional Development promotes OIG training services and internal policy development.

Appendix D. Endnotes

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- ⁱ Eighty-sixth Texas Legislature. (2019). *General Appropriations Act, Article II, HHS Rider 114*. Pages II-79 and II-80. Retrieved from: https://www.lbb.state.tx.us/Documents/GAA/General_Appropriations_Act_2020_2021.pdf.
- ⁱⁱ OIG. (2018). *Review of Managed Care Organizations' Cost Avoidance and Waste Prevention Activities* as directed by Rider 151, Article II, 85th Texas Legislature. Retrieved from: <https://oig.hhsc.texas.gov/sites/oig/files/reports/IG%20Rider%20151%20report%20%E2%80%8CFINAL.pdf>.
- ⁱⁱⁱ HHS. (2018). *Texas Medicaid and CHIP Reference Guide*, 12th edition. Page 91. Retrieved from: <https://hhs.texas.gov/reports/2018/12/texas-medicaid-chip-reference-guide-pink-book>.
- ^{iv} MACPAC. (2017). *Program Integrity in Medicaid Managed Care*. Page 100. Retrieved from: <https://www.macpac.gov/publication/program-integrity-in-medicaid-managed-care/>.
- ^v TAC, Title 1, Sections 353.501 through 353.505 identify requirements for MCOs to prevent and detect possible acts of FWA. Office of the Secretary of State. Retrieved from [https://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=5&ti=1&pt=15&ch=353&sch=F&rl=Y](https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=1&pt=15&ch=353&sch=F&rl=Y).
- ^{vi} OIG. (2019). *Annual Report on Certain Fraud and Abuse Recoveries by Managed Care Organizations (MCOs) - SFY 2019*. Retrieved from: <https://oig.hhsc.texas.gov/sites/oig/files/Annual-MCO-Recoveries-Report-%20FY-2019.pdf>.
- ^{vii} OIG. (2019). *Quarterly Report: Quarter 4 Fiscal Year 2019*. Page 5. Retrieved from: <https://oig.hhsc.texas.gov/sites/oig/files/documents/OIG-Quarterly-Report-Q4-FY19-V2a.pdf>.
- ^{viii} HHS. *Pay-for-Quality (P4Q) Program*. Retrieved from: <https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/pay-quality-p4q-program>.
- ^{ix} HHS. *FY18 UMCC/UMCM: MCO Alternative Payment Models (APMs) with Providers*. Retrieved from: <https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/FY18-MCO-UMCC-UMCM-APM-providers-042117.pdf>.
- ^x HHS. *Potentially Preventable Events*. Retrieved from: <https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/potentially-preventable-events>.
- ^{xi} HHS. (2019). *Annual Report on Quality Measures and Value-Based Payments*. Page 10. Retrieved from: <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb-1629-quality-measures-value-based-payments-dec-2019.pdf>.
- ^{xii} HHS. *Managed Care Contracts and Manuals*. Retrieved from: <https://hhs.texas.gov/services/health/medicaid-chip/provider-information/managed-care-contracts-manuals>.
- ^{xiii} HHS. *Uniform Managed Care Manual Version 2.1: Deliverables to the Office of Inspector General*. Pages 2-3. Retrieved from: <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/5-5-1.pdf>.
- ^{xiv} CMS. *State Program Integrity Reviews*. Retrieved from: <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews>.
- ^{xv} OIG Staff reviewed all reports released from January 2016 until January 2018. The 10 program integrity reviews that contained recommendations for MCOs to provide evidence of cost avoidance activities were: NH, NJ, NY, OH, RI, SC, TX, VA, WI and WV. CMS. See: *State Program Integrity Review Reports List*. Retrieved from: <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews>.
- ^{xvi} MACPAC. (2017). *Program Integrity in Medicaid Managed Care*. Page 105. Retrieved from: <https://www.macpac.gov/publication/program-integrity-in-medicaid-managed-care/>.

-
- xvii CMS. Center for Program Integrity. Pages 9-10. *FY2017 Annual Report*. Retrieved from: <https://www.cms.gov/About-CMS/Components/CPI/Downloads/FY-2017-Medicare-and-Medicaid-Integrity-Programs-Report-to-Congress.pdf>.
- xviii LDH. (personal communication, Jun. 14, 2019).
- xix LDH. *Fraud, Waste and Abuse Activity Quarterly Report Template*. Retrieved from: http://ldh.la.gov/assets/docs/BayouHealth/MCO_Templates/PI145_FWA_Quarterly_Report_revised_3.12.18.xlsx.
- xx Human Services Department. *Centennial Care Reporting Instructions Program Integrity - Report #56*. State of New Mexico. Pages 7-9. Retrieved from: https://www.hsd.state.nm.us/uploads/FileLinks/c06b4701fbc84ea3938e646301d8c950/%2356_Program_Integrity_Instructions_v4_2014_12.pdf.
- xxi LDH. (personal communication, Jan. 14, 2020).
- xxii Third Party Liability (TPL) means the legal responsibility of another individual or entity to pay for all or part of the services provided to members under the Contract. See: [1 Tex. Admin. Code §354.2301](#) et seq., relating to Third Party Resources and HHS. *Uniform Managed Care Contract, Version 2.29, Attachment A – Medicaid and CHIP Managed Care Services RFP, Uniform Managed Care Contract Terms and Conditions*. Page 19. Retrieved from: <https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf>.
- xxiii HHS. *Uniform Managed Care Contract, Special Investigative Units, Section 8.1.19.1*. Retrieved from: <https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf>.
- xxiv TAC. *Title 1, Part 15, Chapter 353, Subchapter F, Rule §353.502 Managed Care Organization's Plans and Responsibilities in Preventing and Reducing Waste, Abuse, and Fraud*. Office of the Secretary of State. Retrieved from: [https://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=353&rl=502](https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=353&rl=502).
- xxv OIG. (2019). *Medicaid Fraud and Abuse Detection System (MFADS) Program Integrity Case Tracker - Business Objects Template: Case Tracker Report*.
- xxvi TAC. Title 1, Sections 353.501 through 353.505 identifies requirements for MCOs to prevent and detect possible acts of FWA. Office of the Secretary of State. Retrieved from: [https://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=5&ti=1&pt=15&ch=353&sch=F&rl=Y](https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=1&pt=15&ch=353&sch=F&rl=Y).
- xxvii MCO self-reported data. See: OIG. *Annual Report on Certain Fraud and Abuse Recoveries by Managed Care Organizations (MCOs) – SFY 2019*. Pages 3-5. Retrieved from: <https://oig.hhs.gov/sites/oig/files/Annual-MCO-Recoveries-Report-%20FY-2019.pdf>.
- xxviii OIG. (2019). *Report: Third Party Recoveries Liability (TPR/TPL) Summary SFY 2019*.
- xxix Pay-and-chase method occurs when States pay providers for submitted claims and then attempt to recover payments from liable third parties. See: OIG. (2013). *Medicaid Third-Party Liability Savings Increased, But Challenges Remain*. US HHS. Retrieved from: <https://oig.hhs.gov/oei/reports/oei-05-11-00130.pdf>.
- xxx The Texas Association of Health Plans. (2016). *Reducing Fraud, Waste, and Abuse in Medicaid Managed Care*. Retrieved from: https://www.senate.texas.gov/cmtes/84/c610/091316-TAHP_Jamie_Dudensing-c9.pdf.
- xxxi The Texas Association of Health Plans. (2016). *Reducing Fraud, Waste, and Abuse in Medicaid Managed Care*. Retrieved from: https://www.senate.texas.gov/cmtes/84/c610/091316-TAHP_Jamie_Dudensing-c9.pdf.

-
- xxxii In SFY 2019, some MCOs reported denied claims cost avoidance based on billed amounts and some MCOs reported it on Medicaid allowable amounts. In SFY 2020, all MCOs are to report on Medicaid allowable amounts.
- xxxiii OIG. (2019). *Report: Third Party Recoveries Liability (TPR/TPL) Summary SFY 2019*.
- xxxiv HHS. *Managed Care Contracts and Manuals*. Retrieved from:
<https://hhs.texas.gov/services/health/medicaid-chip/provider-information/managed-care-contracts-manuals>.
- xxxv CMS. Center for Program Integrity. *FY2017 Annual Report*. Retrieved from:
<https://www.cms.gov/About-CMS/Components/CPI/Downloads/FY-2017-Medicare-and-Medicaid-Integrity-Programs-Report-to-Congress.pdf>.
- xxxvi MACPAC. (2017). *Program Integrity in Medicaid Managed Care*. Page 100. Retrieved from:
<https://www.macpac.gov/publication/program-integrity-in-medicicaid-managed-care/>.
- xxxvii OIG. (2019). *Medicaid and CHIP MCOs Program Integrity Cost Avoidance and Waste Prevention Activities Survey*.
- xxxviii The 2017 survey was collected in preparation for the OIG's 2018 report, as directed by Rider 151, Article II, 85th Texas Legislature. See: OIG. (2018). *Review of Managed Care Organizations' Cost Avoidance and Waste Prevention Activities* as directed by Rider 151, Article II, 85th Texas Legislature. Retrieved from:
<https://oig.hhs.gov/sites/oig/files/reports/IG%20Rider%20151%20report%20%E2%80%8CFINAL.pdf>.
- xxxix HHS OIG. (2000). *Medicaid Claims Processing Safeguards*. Page 7. Retrieved from
<https://oig.hhs.gov/oei/reports/oei-05-99-00071.pdf>.
- xl CMS. Medicare Learning Network Fact Sheet. Hospital Outpatient Prospective Payment System. Page 4. Retrieved from: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsh.pdf>.
- xli CMS. MS-DRG Classifications and Software. Retrieved from:
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software>.
- xliv Brown, Martin. (2012). *Data Mining Techniques*. International Business Machines Corporation. Page 1. Retrieved from: <https://developer.ibm.com/technologies/analytics/articles/ba-data-mining-techniques/>.
- xlvi Predictive Analytics Today. *What is Predictive Modeling?* Retrieved from:
<https://www.predictiveanalyticstoday.com/predictive-modeling/>. - "Predictive modeling is the process of creating, testing, and validating a model to best predict the probability of an outcome."
- xlvii OIG. (2018). *Review of Managed Care Organizations' Cost Avoidance and Waste Prevention Activities*. Paged 5-6. Retrieved from:
<https://oig.hhs.gov/sites/oig/files/reports/IG%20Rider%20151%20report%20%E2%80%8CFINAL.pdf>.
- xlviii HHS. (2019). *Annual Report on Quality Measures and Value-Based Payments*. Pages 10 – 19. Retrieved from: <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb-1629-quality-measures-value-based-payments-dec-2019.pdf>.
- xlix HHS. *UMCC*. Page 6-6. Retrieved from:
<https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf>.
- l HHS. Texas Health and Human Services. "HHSC Uniform Managed Care Manual, Medical Pay-for-Quality (P4Q) Program, Chapter 6.2.14, Version 2.1.1." 15 September 2019. Page 6 of 64. Retrieved from
<https://hhs.texas.gov/services/health/medicaid-chip/provider-information/contracts-manuals/texas-medicaid-chip-uniform-managed-care-manual>.

-
- xlviii HHS. "Potentially Preventable Events." Retrieved from <https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/potentially-preventable-events>
- xlx The term case management was utilized in the 2017 and 2019 iterations of *Medicaid and CHIP MCOs Program Integrity Cost Avoidance and Waste Prevention Activities Survey*, but for this analysis responses are demonstrated as related to 'Service Coordination'. See: Case Management Society of America. (2007). Definition of Case Management. Retrieved from <https://www.cmsa.org/who-we-are/what-is-a-case-manager/>.
- l National Association of Clinical Nurse Specialists. "Definitions of Transitional Care." Retrieved from: <http://nacns.org/professional-resources/toolkits-and-reports/transitions-of-care/definitions-of-transitional-care/>.
- li HHS. (2019). *Annual Report on Quality Measures and Value-Based Payments*. Retrieved from: <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb-1629-quality-measures-value-based-payments-dec-2019.pdf>.
- lii This analysis' review of the effectiveness of cost avoidance (and waste prevention) strategies employed by MCOs and their adequacy is based on self-reported data provided by MCOs.
- liii MCOs reported using the billed amount for claims denials to determine the dollar value of costs avoided. The MCOs' justification for this application being that since the claims are denied and not adjudicated, it is challenging to come up with the actual dollar value of costs avoided.
- liv TAC. *Title 1, Part 15, Chapter 371 Subchapter B, Rule §371.1 Definitions*. Office of the Secretary of State. Retrieved from: [https://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=371&rl=1](https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=371&rl=1).
- lv OIG. *Annual Report on Certain Fraud and Abuse Recoveries by Managed Care Organizations (MCOs) - SFY 2019*. Retrieved from: <https://oig.hpsc.texas.gov/sites/oig/files/Annual-MCO-Recoveries-Report-%20FY-2019.pdf>.
- lvi OIG. *Quarterly Report: Quarter 4 Fiscal Year 2019*. Page 5. Retrieved from: <https://oig.hpsc.texas.gov/sites/oig/files/documents/OIG-Quarterly-Report-Q4-FY19-V2a.pdf>.
- lvii HHSC UMCM Medical Pay-for Quality (P4Q) Program, Version 2, January 1, 2020. Retrieved from: <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/6-2-14.pdf>.
- lviii HHS. *FY18 UMCC/UMCM: MCO Alternative Payment Models (APMs) with Providers*. Retrieved from: <https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/FY18-MCO-UMCC-UMCM-APM-providers-042117.pdf>.
- lix HHS. *Potentially Preventable Events*. Retrieved from: <https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/potentially-preventable-events>.
- lx The OIG Lock-In Program operates under guidelines and regulations contained in: TAC, Title 1, Part 15, Chapter 354, Subchapter K and CFR, Title 42, Part 431.54(e).
- lxi CMS. Center for Program Integrity. *FY2017 Annual Report*. Page 9. Retrieved from: <https://www.cms.gov/About-CMS/Components/CPI/Downloads/FY-2017-Medicare-and-Medicaid-Integrity-Programs-Report-to-Congress.pdf>.
- lxii OIG-TPR updated language in the UMCM deliverables for TPL cost avoidance reporting to clarify that cost avoidance, denied claims is based on the Medicaid allowable amount. This change was effective December 20, 2019. MCOs submit the TPL reports quarterly and were instructed to begin using the Medicaid allowable amount beginning with FY20, Quarter 1 reports, which were due on December 31, 2019. HHS. *Uniform Managed Care Manual* Section 5.3.4.1 – 5.3.4.4. Retrieved from: <https://hhs.texas.gov/services/health/medicaid-chip/provider-information/contracts-manuals/texas-medicaid-chip-uniform-managed-care-manual>.
- lxiii HHS. *Distinguishing PPE Programs Chart*. Retrieved from: <https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/distinguishing-ppe-programs-chart.pdf>.

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- lxiv OIG. *Review of Managed Care Organizations' Cost Avoidance and Waste Prevention Activities* as directed by Rider 151, Article II, 85th Texas Legislature. (March 1, 2018), Retrieved from: <https://oig.hhsc.texas.gov/sites/oig/files/reports/IG%20Rider%20151%20report%20%E2%80%8CFINAL.pdf>.
- lxv Eighty-sixth Texas Legislature. (2019). *General Appropriations Act, Article II, HHS Rider 114*. Page II-123. Total, Article II – Health and Human Services. Retrieved from: [https://www.lbb.state.tx.us/Documents/GAA/General Appropriations Act 2020 2021.pdf](https://www.lbb.state.tx.us/Documents/GAA/General_Appropriations_Act_2020_2021.pdf).
- lxvi Provided by HHSC Budget 12/19/2019. Source: FY2020 Total Budget - Operating Budget FY2020, FY2020 Medicaid Budget - Operating Budget FY2020, FY2021 Total Budget - 86th Leg GAA Art II HHSC Appropriated, FY2021 Medicaid Budget - Latest Client Services Model. FY2020 Medicaid managed care includes MCO, DMO, and MTO projected expenditures.
- lxvii The OIG operational budget differs from the appropriation budget by including program areas (from other appropriations such as WIC and DDS) that report to OIG and exclude those program areas that are within the OIG appropriations, but OIG does not have control of (such as Central Buyers and HHSC IT).
- lxviii HHS. *Uniform Managed Care Contract, Version 2.29, Attachment B-1, Section 8.2.2.8 Medicaid Non-Capitated Services*. Pages 8-172 and 8-173. Retrieved from: <https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf>.
- lxix All instances of identified overpayments and/or recoveries refer to potential, preliminary dollar amounts as part of ongoing inspections and investigations.
- lxx The OIG conducted 34 audits and oversaw four added Medicaid Integrity Contractor (MIC) audits in SFY 2019.
- lxxi These five audits related to audits of MTOs and HHS processes.