TAHP
The Texas Association of Health Plans

Representing health insurers, health maintenance organizations, and other related health care entities operating in Texas.

Texas Medicaid Managed Care

Protecting Texas Taxpayers from Fraud, Waste, and Abuse (FWA)

Texas is a national leader in the use of the managed care model to increase access to care, manage costs, and improve health care quality in its Medicaid program. The managed care private market approach drives innovation through flexibility and competition, reduces health care costs, and holds managed care organizations (MCOs)—the health plans that contract with the State to manage Medicaid—accountable for providing access to quality care.

Texas Medicaid health plans, or MCOs, assume the full financial risk for reducing and preventing incidents of fraud, waste and abuse (FWA) for every individual they serve. MCO premiums are only set one time a year and cannot be adjusted to account for unanticipated FWA-related costs. If increased spending occurs as a result of fraud, waste and abuse, MCOs are at full risk for covering that cost. Because of this accountability, MCOs are successfully focusing their efforts on preventing FWA, reducing inappropriate payments, and finding real-time results and methods to transition away from the pay-and-chase environment common under the former fee-for-service model (FFS).

MCOs Successfully Reduce Fraud, Waste, and Abuse

- **Medicaid MCOs are at full risk of the cost for reducing and preventing incidents of fraud, waste, and abuse**
- **All MCOs have a compliance plan to guard against fraud, waste, and abuse**
- **Because of this accountability & a focus on prevention, TX Medicaid health plans estimate savings of $7.1B for FY10-FY18 compared to traditional FFS model**
- **Texas MCOs estimate 28.4% savings for Dental Managed Care program since FY13**

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

Definitions of Fraud Waste and Abuse

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

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

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

MCOs Ensure Appropriate Utilization to Prevent Fraud and Abuse

MCOs are responsible for ensuring appropriate utilization of Medicaid services. This means that MCOs are required to make sure that clients receive the medically necessary services they need. Medically necessary means most doctors would agree that it is the right or best treatment for a specific disease or problem and not more costly than an equally effective alternative treatment. This is often referred to as "utilization management." Prior authorizations and medical necessity requirements are examples of utilization management. Prior authorization is a process by which a provider submits a request for approval of a service prior to performing the service. Prior authorization is typically required for high-cost services such as inpatient hospitalization and for services that are most often misused or have been abused. Typically, an MCO will require the requesting provider to submit medical documentation indicating the medical necessity of the service. Another utilization management tool is utilization review. Utilization review is done after services have been provided to monitor and evaluate whether the services were necessary, appropriate, and effective.

MCO Strategies to Prevent FWA

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

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

Develop clear written standards and procedures for providers

Prior Authorization Requirements

Value-based Purchasing Initiatives

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

Fraud Hotlines

Each MCO is also required to establish and maintain a special investigative unit (SIU) that works in cooperation with the Health and Human Services Commission's (HHSC) Office of Inspector General (OIG). The SIU identifies and investigates cases of suspected fraud, waste, and abuse and also refers cases to the OIG. MCOs are required to submit an annual plan to the HHSC-OIG describing how the MCO will prevent and reduce fraud, waste, and abuse. MCOs also provide an open case list on a monthly basis to the OIG, as well as the Texas Attorney General's Medicaid Fraud Control Unit.

> *Texas has been very innovative in our policies to ensure Medicaid services are provided in a cost-effective manner through managed care.*
>
> Governor Greg Abbott, September 29, 2015, letter to the federal Centers for Medicare and Medicaid Services

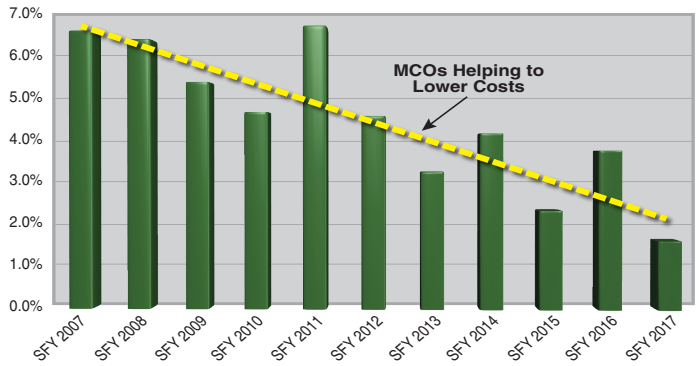
MCO Spotlight: How One Texas Health Plan Achieved Real Results in Reducing Fraud, Waste, and Abuse

After the State expanded managed care into South Texas, one MCO quickly identified that they were spending a disproportionate share of dollars on incontinence supplies for Medicaid members in the Hidalgo service area. Almost 70% of all incontinence supplies ordered in the State were going to the Hidalgo area. Total spending on incontinence supplies for STAR members in Hidalgo was found to be 456% more than all other regions of the state, and individuals in the Hidalgo area were receiving on average 16% more units compared to Medicaid members in other parts of the state. There was no authorization process in place and as a result, services were being used inappropriately. For example, the MCO identified that incontinence supplies were being ordered for children under the age of 3 for nocturnal enuresis (bed-wetting). The MCO initiated a prior authorization requirement for medically necessary incontinence supplies and almost immediately saw a 77% reduction in spending per-member, per-month, saving taxpayers $18 million a year.

MCOs Contain Cost: Preventing Fraud, Waste & Abuse

Through care management, focus on prevention and cost avoidance, Medicaid MCOs contain costs for Texas taxpayers. As it stands, medical costs are the largest component of spending in premiums (about 88-92% of premiums). MCO efforts to reduce FWA focus heavily on reducing the payment of improper claims, which results directly in contained medical costs. Through these efforts, over a 10-year time period, MCOs have steadily and successfully contained and reduced the growth of costs and the rate trend in the Texas Medicaid program.

MCOs Steadily Contain Costs in Texas Medicaid: STAR MCO Rate Trend



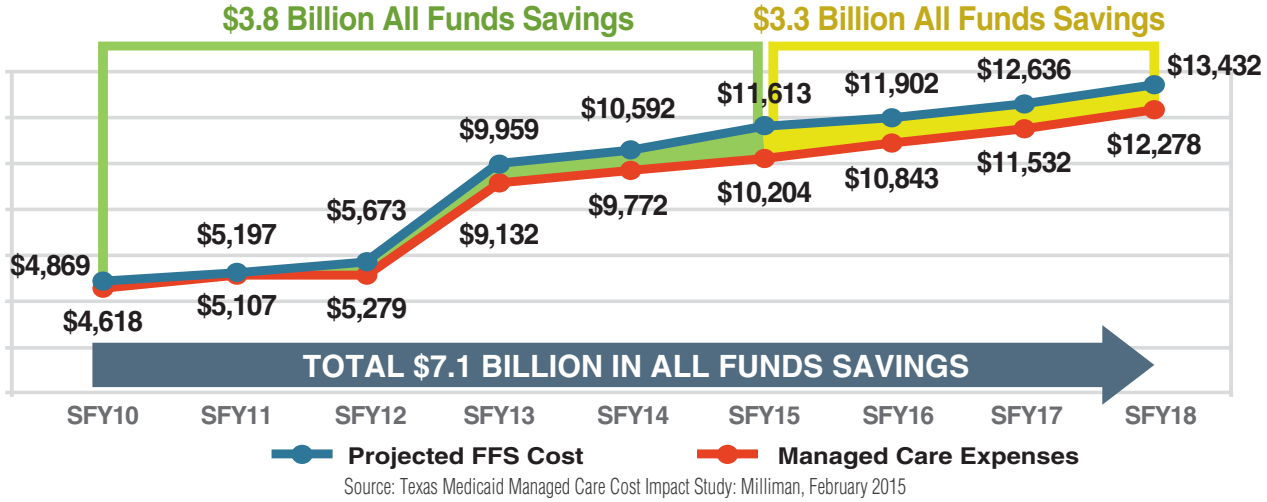
Note: Chart reflects the average cost trend assumed by HHSC in the STAR rates–medical costs as a function of unit cost and utilization.

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

Medicaid Managed Care Cost Savings

MCO efforts to reduce fraud, waste, and abuse, and efforts to prevent unnecessary services through better care coordinating and ensuring appropriate care is available have resulted in substantial cost savings for Texas taxpayers. Between SFY 2010 and SFY 2015, actuaries estimate that managed care reduced Medicaid costs by 7.9%, or nearly $3.8 billion, when compared to the traditional fee-for-service (FFS) model. This trend is expected to yield an additional $3.3 billion in savings through SFY 2018. Medicaid Dental managed care has experienced the highest percentage of total program savings: 28.4% since SFY 2013.

Managed Care vs. FFS Costs
(Dollars in Millions)



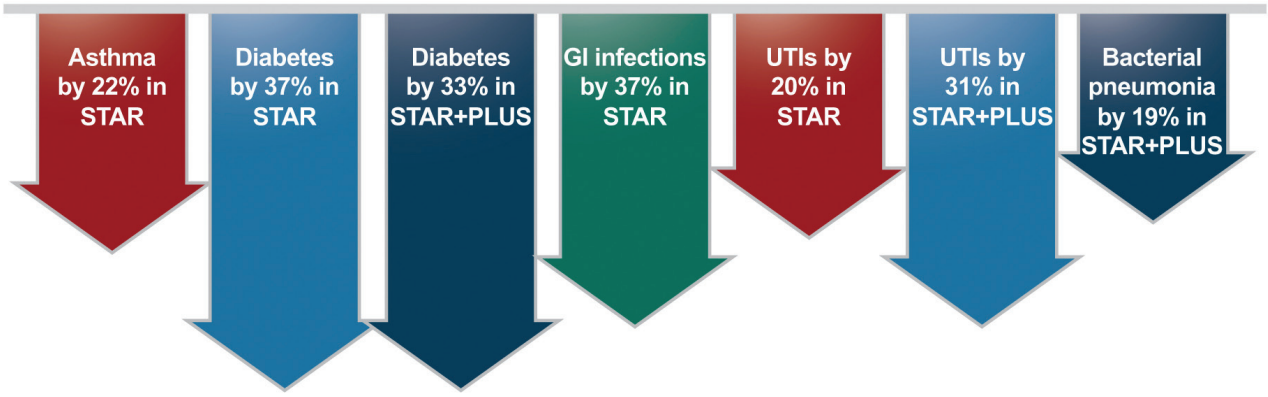
Source: Texas Medicaid Managed Care Cost Impact Study: Milliman, February 2015

Improved Outcomes and Quality of Care Prevents Unnecessary Services & Costs in Medicaid

Another way that Medicaid managed care reduces waste in the system is focusing on improving health care outcomes. Unlike FFS, the managed care model is designed to emphasize preventive care, early interventions, and appropriate care management to improve outcomes and lower health care costs by ensuring Medicaid consumers receive appropriate care at the right time and right place. HHSC contractually requires Medicaid health plans to improve quality of care and improve outcomes for Medicaid consumers. The focus on quality and outcomes through managed care has successfully resulted in double-digit reductions in hospital admissions for a number of conditions including asthma, diabetes, pneumonia, urinary tract infections (UTIs), and gastrointestinal (GI) infections for children and pregnant women served in the STAR program, and Texans who are elderly or have disabilities who are served through the STAR+PLUS program (2009-2011). As a result, Medicaid health plans have dramatically improved the lives, outcomes, and quality of care for Texans enrolled in Medicaid.

MCOs Improved Quality of Care

Between 2009 and 2011,
MCOs reduced hospital admissions for:



About TAHP

The Texas Association of Health Plans (TAHP) is the statewide trade association representing private health insurers, health maintenance organizations, and other related health care entities operating in Texas. As the voice for health plans in Texas, TAHP strives to increase public awareness about our members' services, health care delivery benefits and contributions to communities throughout the state.

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