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

As Required by the

2022-23 General Appropriations

Act, Senate Bill 1, 87th Legislature,

Regular Session, 2021

(Article II, HHSC, Rider 104)

Office of the Inspector General

February 25, 2022

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Pursuant to Senate Bill 1, 87th Legislature, 2021 (Article II, Health and Human Services (HHS), Rider 104), the Office of Inspector General 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. 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 MCOs continue to 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, organized into three broad categories: prepayment review strategies, post-payment review strategies and strategies to reduce potentially preventable events (PPEs).

Figure 1: 2021 MCO-Reported Cost Avoidance Activities. Note: The shaded section at the end of each bar represents DMO responses.
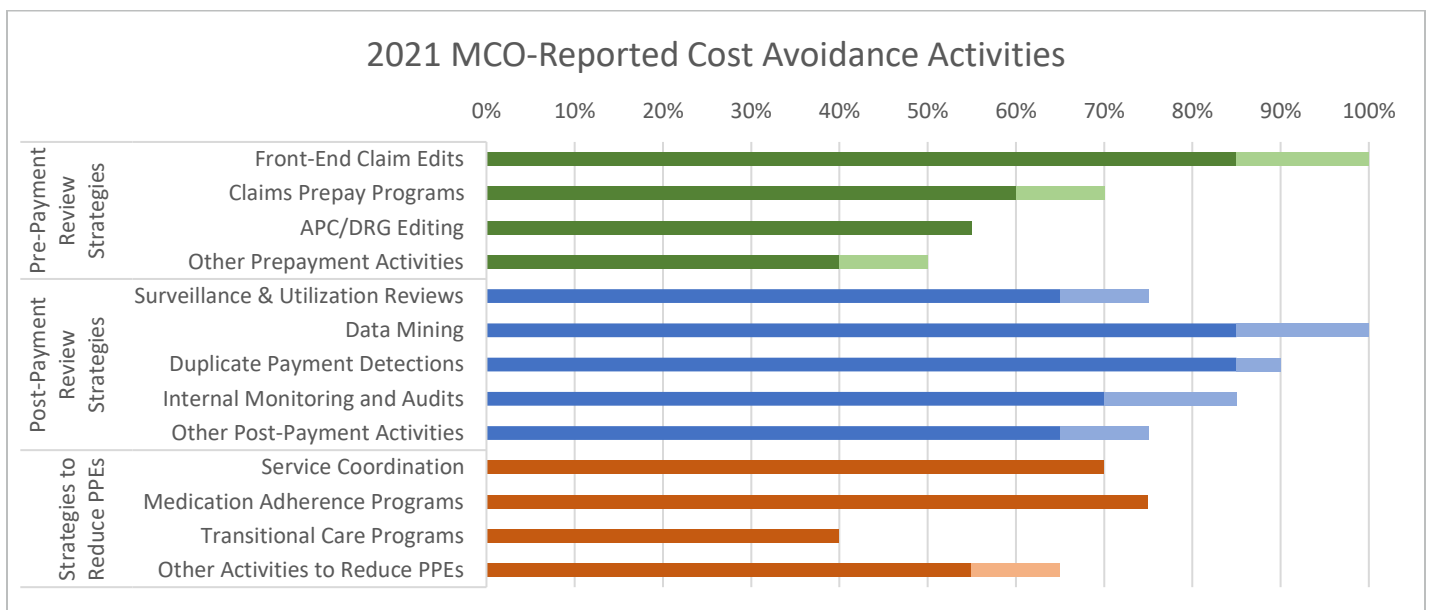
The OIG proposed standard definitions, cost avoidance accounting and reporting methodologies, which focused on capturing the number and dollar-value of claims denied through front-end claim edits. Based on MCO contributions, the OIG identified numerous challenges:

- Variation in MCO size and capacity which impacts the type and breadth of cost avoidance activities utilized and the capacity to report activities.

- The intricacies and volume of data requirements, as well as MCO utilization of multiple claims management systems, lead to different definitions of variables and data points across participants.

- HHS and MCOs are transitioning to value-based care models, which will continue to influence the OIG's approach to cost avoidance and waste prevention.

- Elements of front-end claims edit data are not uniform across MCOs; the same activities utilized by MCOs are uniquely implemented such that standardized reporting of the results is not feasible.

2. OIG Efforts in Medicaid Managed Care

In response to Rider 104, the OIG also reviewed its resource allocation and findings of incidences of FWA in Medicaid managed care. The OIG dedicates approximately 54 percent of its full-time employee (FTE) equivalent resources to combating FWA in Medicaid managed care.

The OIG anticipates spending 72.5 percent of its State Fiscal Years (SFY) 2022-2023 operational budget ($84.6 million) on Medicaid program integrity activities, which is a 12.9 percent increase from the previous biennium. The remaining 27.5 percent of the budget will be spent on OIG efforts in other non-Medicaid HHS programs, as well as Texas Department of State Health Services (DSHS) and Texas Department of Family and Protective Services (DFPS) oversight activities. Of the OIG's Medicaid spending, 72 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.

	FY 2022	FY 2023	Biennium
OIG Budget	$58,377,746	$58,377,746	$116,755,493
OIG Medicaid Budget	$42,305,522	$42,305,522	$84,611,043
OIG Medicaid Managed Care Budget	**$30,480,250**	**$30,480,250**	**$60,960,499[1]**

Of the OIG's 592.5 FTEs, the OIG projects approximately 320.6, or 54.1 percent, conduct work directly or indirectly related to Medicaid managed care. This is a 6.3 percent increase over FYs 2020 and 2021.

OIG program areas reported identifying 172,877 total incidences of FWA in Medicaid managed care in SFY 2021. As in 2019, the vast majority (169,982) was related to waste from a liable third party. For the OIG's review, the number of incidences does not include activities with no action or findings. It is important to note no standard unit to measure and compare incidences exists. For example, one audit may take longer to complete, involve many claims and report several findings but it would count as one incidence. A claim or medical records review, which takes substantially less time, also counts as a single incidence.

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[1] The biennium budget differs from the sum of the FY 2022 and FY 2023 budgets by $1 due to rounding.

1. Introduction

The Texas Health and Human Services (HHS) Office of 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 Senate Bill 1, 87th Legislature, Regular Session, 2021 (Article II, HHS, Rider 104). Rider 104 requires the OIG to:

1. Continue its review of cost avoidance and waste prevention activities employed by managed care organizations (MCO) 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 Fiscal Year (FY) 2022 and FY 2023;

    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.

The OIG engages in data-driven and strategic program integrity work to achieve better outcomes and cost savings in the delivery of all health and human services. 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. The report also details OIG efforts to identify FWA in and out of Medicaid managed care.[i]

For this report, 'MCO' is inclusive of Dental Maintenance Organizations (DMO). The findings and recommendations are based on a review and consideration of the following:

- A comprehensive literature review;
- Research of the approach of other states;
- MCO reported cost avoidance and waste prevention activities;
- MCO responses to a 24-question cost avoidance survey; and
- Discussion and further qualitative analysis with MCOs through the MCO Cost Avoidance Workgroup.

This report builds on the OIG's continued review and the analysis of findings and recommendations from previous work, as referenced in the OIG's *Review of Managed Care*

Organizations' Cost Avoidance and Waste Prevention Activities.[ii] A 2018 review and report identified the variety of cost avoidance and waste prevention activities used by MCOs and difficulty of quantifying cost avoidance in managed care. The 2020 report categorizes and identifies activities on which to focus efforts to capture the value of MCO cost avoidance. This 2022 report includes details of efforts to uniformly quantify some of these MCO cost avoidance and waste prevention activities.

The analysis of OIG efforts in Medicaid managed care considers dedicated resources and incidences of FWA in Medicaid managed care. The analysis of OIG resources is based on projected staffing and expenditures by OIG program area for FY 2022 and 2023. The analysis of incidences of FWA identified by the OIG in Medicaid managed care is presented in the context of completed OIG activities.

2. MCO Cost Avoidance and Waste Prevention Activities

Background

HHS contracts with MCOs to provide covered 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 manage the delivery of covered health services to their members. This differs from the traditional Medicaid fee-for-service (FFS) model where the state manages Medicaid benefits and directly pays providers for the delivery of services through the claims administrator.[iii]

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 managed care, program integrity is a shared responsibility between the federal government, the state and the MCOs. The OIG collaborates with MCOs to prevent, detect and investigate FWA in Medicaid and CHIP managed care.[v]

MCOs implement program integrity activities associated with cost savings, including:

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

MCOs may achieve efficiencies and improve health outcomes through the implementation of select contract requirements that may contain costs, such as service coordination. MCOs also conduct utilization management activities which focus on providing appropriate care and medically necessary services, such as prior authorization requirements. However, utilization management is not explicitly focused on cost avoidance.

HHS continues to shift from paying for volume to paying for value of services[vi] and administers various programs and measures within managed care to improve health care quality and outcomes while containing costs. HHS and the OIG measure the impact of some of these activities related to program integrity through various metrics, such as MCO reporting of fraud and abuse recoveries,[vii] third party liability (TPL) cost avoidance,[viii] the medical Pay-for-Quality (P4Q) Program,[ix] MCO contractual requirements for value-based contracting with providers,[x] and the hospital quality-based payment program.[xi] Using MCO-reported data, HHS and the OIG track and evaluate MCO performance related to the metrics highlighted in this section.

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 detailing specific policies and procedures related to program integrity requirement adherence.[xiii]

The Centers for Medicare and Medicaid Services (CMS) conduct 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,xv] In several program integrity reviews conducted between November 2018 and July 2020, CMS recommended states collect supporting documentation from Medicaid MCOs about their cost avoidance and prevention activities.[xvi] According to the Medicaid and CHIP Payment and Access Commission (MACPAC), while the value of many program integrity activities is acknowledged, few processes exist to determine the efficacy and cost savings resultant from the utilization of these activities.[xvii]

CMS uses standard calculation methodologies for capturing savings from Medicare Integrity Programs in FFS;[xviii] however, CMS has not published guidance for states for defining or measuring MCO program integrity cost avoidance in Medicaid or CHIP managed care.

In FY 2018, CMS reported the federal share of Medicaid and CHIP savings totaled approximately $1.286 billion. CMS estimated cost avoidance in the Medicaid and CHIP programs at approximately $507 million for FY 2018, which comprises 39.4 percent of the total federal share savings.[xix]

OIG reviewed the approaches of other states to inform potential approaches related to measuring cost avoidance for Texas to consider. As part of this review, OIG identified similar challenges exist in other states related to quantifying the impact and value of MCO cost avoidance activities and standardizing cost avoidance activity definitions. MCOs' different business rules and cost avoidance calculation methodologies create obstacles to uniform assessment of cost avoidance activities.

The OIG found notable practices in three 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.[xx] MCOs report prepayment review cost avoidance to the LDH in the Fraud, Waste and Abuse Activity Quarterly Report.[xxi]
- 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 payments to providers avoided attributed to their prepayment interventions.[xxii]
- The Arizona Health Care Cost Containment System (AHCCCS) captures claim edits data as a component in contractor's quarterly Program Integrity (PI) Reports. Contractors' payment systems may adjust or deny claims with incorrect or overbilled elements and codes.[xxiii]

MCO Program Integrity Efforts

In Texas, MCOs report to the OIG 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.[xxiv] MCOs are required to establish a Special Investigative Unit (SIU) to investigate allegations of FWA for all services outlined in the managed care contracts and described in the Texas Administrative Code (TAC).[xxv] The OIG works mainly with SIUs on MCO program integrity efforts.

SIUs investigate potential FWA and must refer suspected FWA to the OIG.[xxvi] MCOs note they apply many strategies to prevent FWA, and MCO referrals and recovery efforts are part of several components of program integrity. In FY 2021, MCOs referred 509 cases of potential provider fraud or abuse to the OIG, a 47 percent increase from FY 2019.[xxvii] MCOs are also required to report recoveries of improper payments related to fraud or abuse to the OIG, [xxviii] and 20 MCOs collectively recovered approximately $3.4 million in FY 2019.[xxix] In FY 2020, 20 MCOs collectively recovered approximately $2.5 million in improper payments[xxx] related to fraud or abuse and $6.8 million in FY 2021.[xxxi]

MCOs also collect TPR when Medicaid or CHIP paid for services but other responsible parties should have been billed. MCOs report TPR to the OIG, which helps ensure other responsible parties pay their share for services provided to Medicaid clients. In FY 2021, MCOs reported recovering over $65.5 million in TPR.[xxxii]

MCOs employ strategies to avoid costs by preventing improper payment of claims. 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. In FY 2021, MCOs reported $1.023 billion in TPL cost avoidance, including $605.9 million in denied claims and $417.6 million in other insurance credits.[xxxiii]

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]

MCO Reported Cost Avoidance Activities

Certain program integrity activities are required by federal and state regulations and MCO contracts. However, CMS allows states the option to consider cost avoidance as a component of their contracted MCOs' program integrity efforts rather than prescribe a cost avoidance definition and methodology for states to follow. While this flexibility enables states to establish parameters related to the consideration of cost avoidance that best meet their unique needs,[xxxv] it contributes to considerable variation among the states' requirements and oversight of MCO program integrity activities.[xxxvi]

The OIG requested the Texas Medicaid contracted MCOs complete the *MCO Cost Avoidance and Waste Prevention Activities Survey*[2] to identify the cost avoidance activities employed by MCOs. All 20 MCOs and DMOs participated in the survey and collaborated with OIG in the MCO Cost Avoidance Workgroup. Beginning in FY 2021, UHC Dental joined Medicaid managed care and Children's Medical Center opted to exit Medicaid managed care, bringing the active number of contractors to 3 DMOs and 17 MCOs.

MCOs utilize a variety of cost avoidance activities, of which some are not applicable to DMOs due to differing contract requirements and service provisions. The definitions of cost avoidance and waste prevention activities remained constant since the 2017 survey 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 would allow inefficient use of resources, items or services.[3] Waste is defined in Texas Administrative Code. [Title 1, Part 15, Chapter 371 Subchapter B, Rule §371.1 Definitions](#).

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, organized into three broad categories (prepayment review strategies, post-payment review strategies and strategies related to

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[2] See **Appendix A** for details regarding the methodology used for the OIG's review of MCO cost avoidance and waste prevention activities and **Appendix B** for the full list of questions.

[3] See **Appendix B,** *MCO Cost Avoidance and Waste Prevention Activities Survey* (2021).

reducing potentially preventable events (PPEs)). All MCOs reported using at least one prepayment and post-payment review strategy.

Figure 3: 2021 MCO-Reported Cost Avoidance Activities

2021 MCO-Reported Cost Avoidance Activities
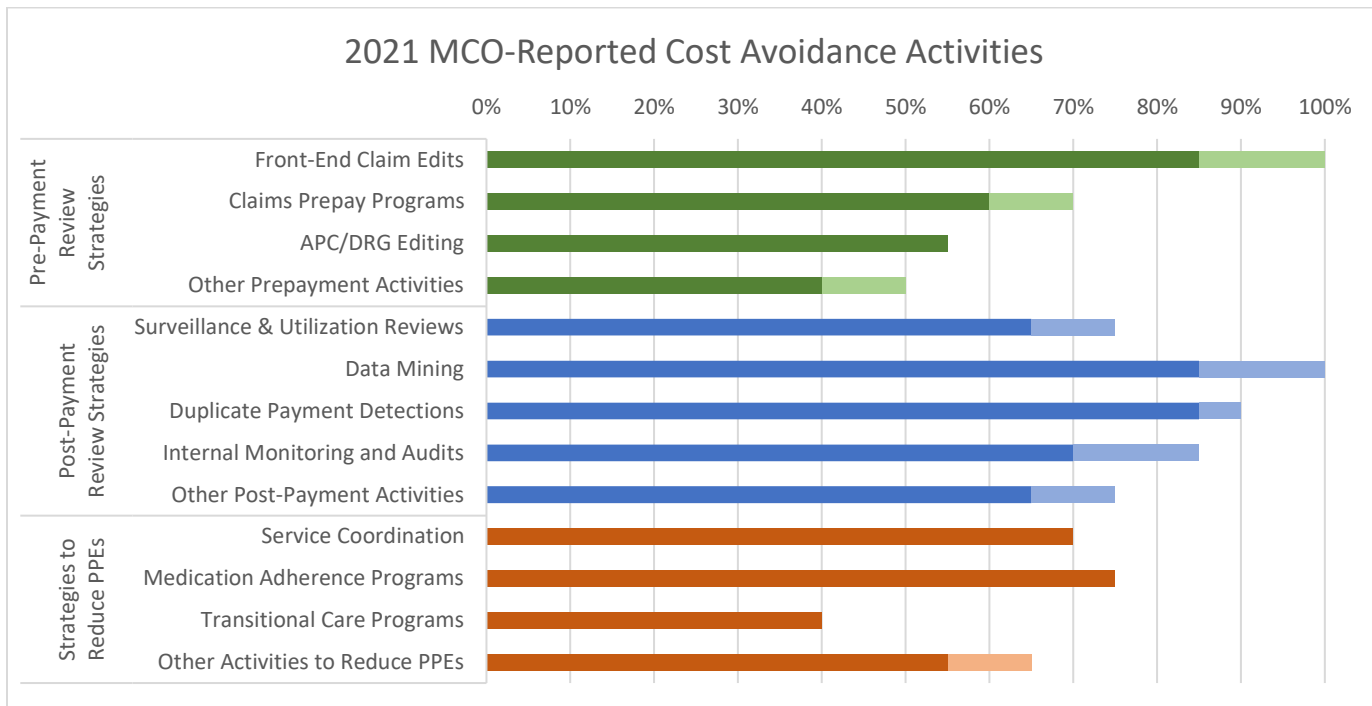
Note: DMO responses are indicated by the lighter color segments at the end of each bar. Because of the nature of the benefits DMOs are contracted to administer, certain strategies may not be indicated. For instance, ambulatory payment classification (APC) and diagnosis-related group (DRG) reimbursement methodologies are relevant to hospital reimbursement and do not apply to DMOs. Strategies to reduce the number of PPEs are generally unnecessary for DMOs to incorporate in cost avoidance. This contributes a portion of the depiction of decreased utilization of certain activities relative to other activities.

As part of the *MCO Cost Avoidance and Waste Prevention Activities Survey*, MCOs were asked to identify the most effective cost avoidance and waste prevention activities for their organization.

In 2021, 14 of the 20 MCOs indicated prepayment review strategies were among their most effective cost avoidance and waste prevention activities. Additionally, 17 of the 20 MCOs responded that post-payment review strategies were among their most effective cost avoidance and waste prevention activities. While only 11 MCOs selected strategies to reduce PPEs as one of their most effective cost avoidance and waste prevention activities, the question is not applicable to DMOs. As such, OIG has not included DMOs in the calculation of overall utilization for this category in any year of survey administration.

Figure 4: 2017-2021 Comparison of MCO Cost Avoidance Activities[4]

Cost Avoidance Activity	Percent and Number of MCOs Selecting Activity as Among Most Effective		
	2017	2019	2021
Prepayment Review Strategies	82% (18/22)	85% (17/20)	70% (14/20)
Post-payment Review Strategies	77% (17/22)	95% (19/20)	85% (17/20)
Strategies to Reduce Potentially Preventable Events (PPEs)	55% (11/20)	89% (16/18)	65% (11/17)

The following sections further describe 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 2021, 70 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.[xxxvii]
- **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)[xxxviii] or Diagnosis Related Group (DRG)[xxxix] edits,** which 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

MCOs shared the following prepayment review success stories on the 2021 survey:

- Prepayment review by an MCO identified a Houston area provider billing for identical services for multiple members. The provider's activities were referred to the MCO SIU for further investigation and referral to the OIG and the Office of Attorney General (OAG) once the investigation was completed.

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[4] In the comparative analyses between 2017, 2019 and 2021, 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. At the time of the 2019 and 2021 surveys there were 20. On this question, the responses were not mutually exclusive; participants could select any combination of the choices as their organization's most effective activities.

- An MCO has optimized a pre-check claim edit system which identified numerous claims for improperly billed services which included unbundling, National Correct Coding Initiative (NCCI)-prohibited claims, and more. The claim edit system has reduced use of the pay-and-chase model and increased claim accuracy.

Figure 5 shows the prepayment activities employed by the MCOs in 2021. Other prepayment activities reported by the MCOs included proactive data mining, use of third party fraud prevention services and artificial intelligence models.

Figure 5: Prepayment Review Strategies Employed by MCOs in 2021

2021 MCO-Reported Prepayment Review Activities
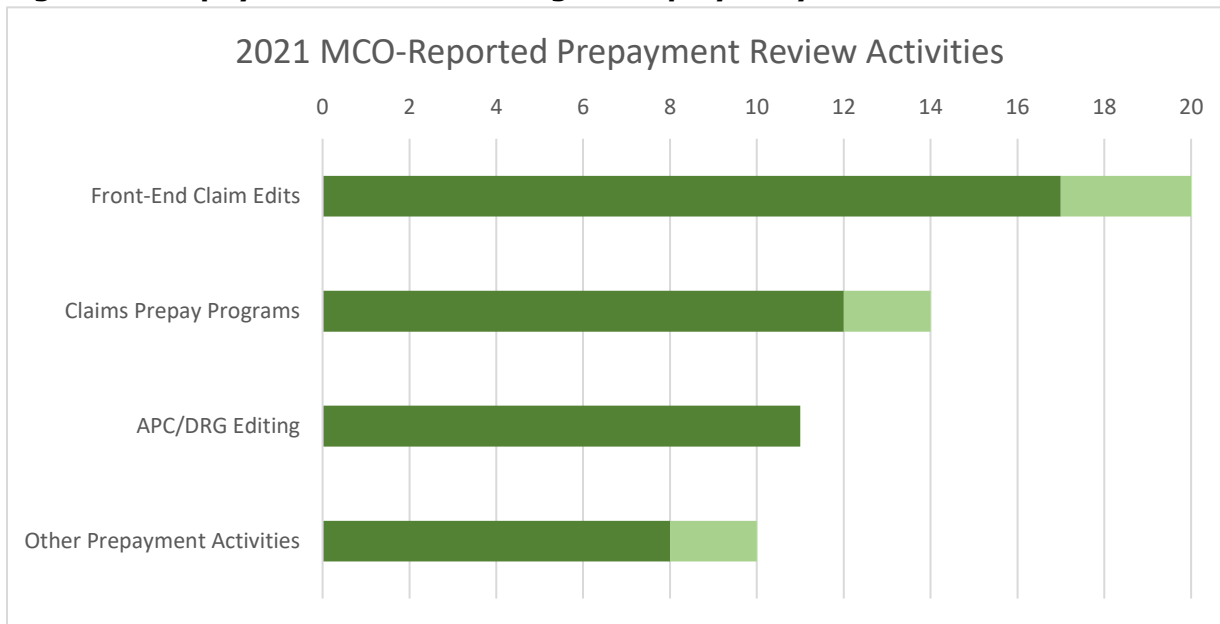
Note: DMO responses are indicated by the lighter color segments at the end of each bar. As stated previously, certain strategies may not be indicated by DMOs because of the nature of the benefits DMOs are contracted to administer. For instance, ambulatory payment classification (APC) and diagnosis-related group (DRG) reimbursement methodologies are relevant to hospital reimbursement and do not apply to DMOs.

Post-Payment Review Strategies

In addition to prepayment review activities, MCOs also employ post-payment review activities. In 2021, 85 percent of MCOs named post-payment review strategies as one of the most effective methods to reduce costs. Generally, these program integrity activities are referred to as pay-and-chase strategies as they occur post-payment. However, the strategies may contribute to cost avoidance if the post-payment review leads to a change which prevents future FWA. 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 the following activities:

- **Data mining** is a broad and inclusive term that includes collecting data, and then analyzing and identifying trends and patterns in the data.[xl]

- **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.[xli]
- **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.[xlii]

Of note, all DMOs participating in Texas Medicaid reporting utilizing post-payment review strategies in their program integrity activities. All DMOs also report use of data mining and internal monitoring and audits. Only two of the three DMOs use surveillance and utilization reviews, and other post-payment review activities. Additionally, one DMO reported use of a duplicate payment detection system.

Success Stories Related to Post-Payment Reviews Reported by MCOs

Based on the framework previously developed in collaboration with MCS and the MCOs, available for reference in the next section, some post-payment review activities meet the standards for a cost avoidance or waste prevention activity while other activities do not. Several MCOs shared the following success stories related to the use of post-payment review activities:

- An MCO received a complaint from a member which alleged a DME provider had billed incorrectly for services provided. The MCO reviewed claims data and medical records, confirmed the provider had overbilled and referred the case to the OIG.

- An MCO identified abnormal billing patterns through an audit. The MCO's SIU denied services due to invalid credentials, conflicting documentation, failure to document date of service and failure to meet service code definition.

- Another MCO reviewed claims for multiple medical facilities following peer comparisons and data mining. Following the SIU's request for medical records, the provider self-reported their error in billing services. The MCO continues to monitor the provider and they have billed appropriately since the investigation.

MCOs often reported 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. MCOs may use data mining to identify providers for prepayment review processes or to educate providers regarding appropriate billing practices. Through the use of multiple cost avoidance activities, these interventions have 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
- Positively impact provider practices with an efficient use of resources, items and services

Figure 6 shows the post-payment activities employed by MCOs in 2021. Other post-payment activities reported by MCOs include the use of data analytics, FWA software, internal referrals, use of post-payment code editing programs, news alerts and external collaboration. 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 2021
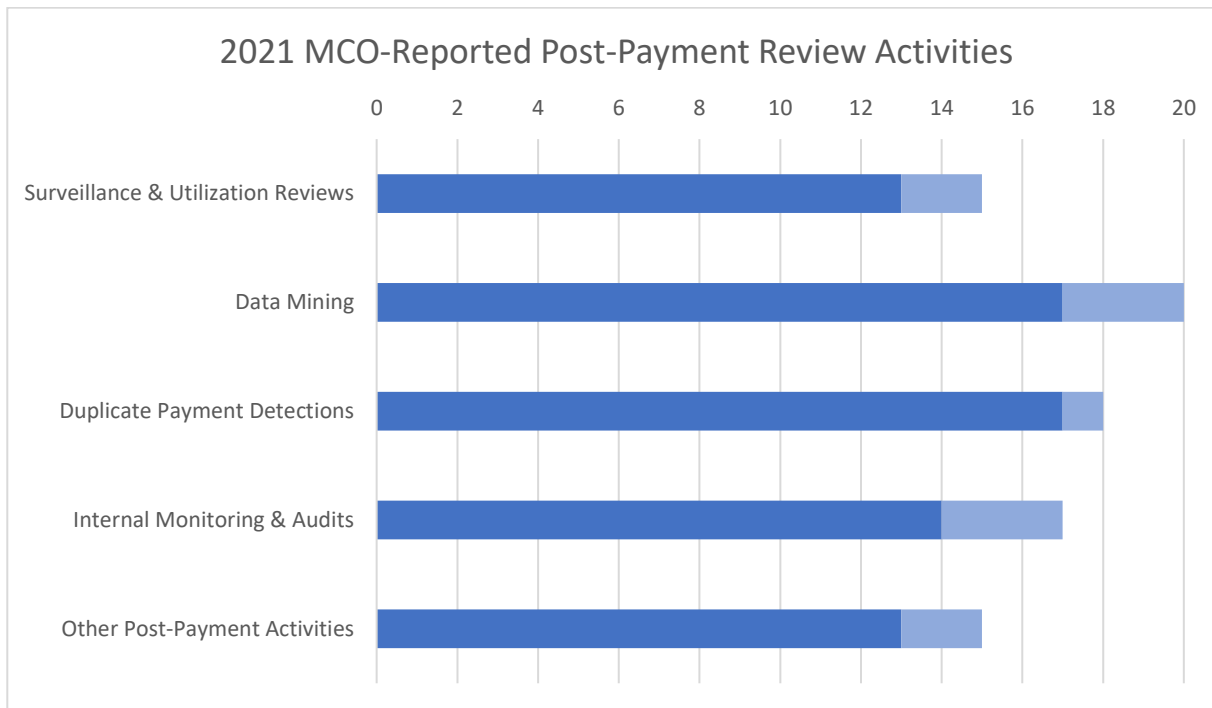
Note: DMO responses are indicated by the lighter color segments at the end of each bar.

Strategies to Reduce Potentially Preventable Events (PPEs)

HHS administers 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.[xliii] MCOs reported 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 payment through a bonus pool.[xliv, xlv] In the Dental P4Q program, HHS may recoup up to 1.5 percent of the DMO's capitation payment.[xlvi] The P4Q program was suspended for measurement years 2020 and 2021 but has resumed operation for measurement year 2022.[xlvii]

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,** which involves evaluation of clients' needs and coordinating services to promote quality, cost-effective outcomes.[xlix]
- **Medication adherence programs** to help ensure patients are taking their medications and 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.[l]

Success Stories Related to PPEs Reported by MCOs

MCOs reported success stories related to reducing PPEs, including collaboration with service providers to identify gaps in care and improve utilization of preventative care services and client medication and care plan adherence. The following two examples provided by MCOs highlight these activities:

- An MCO created a member profile tool which integrated data from multiple sources to ensure primary care providers are aware of emergency department visits, admissions and medications prescribed by other providers.

- An MCO identified a member with several emergency department visits. The MCO service coordinator completed discharge assessments and determined the visits were for non-emergency purposes. Using this information, the MCO provided education regarding the use of primary care services and urgent care facilities. Recent utilization indicates services are being delivered in more appropriate settings.

Figure 7 identifies strategies employed by MCOs to reduce PPEs in 2021. Other efforts reported by Texas MCOs to reduce PPEs include care coordination, readmission probability assessments, discharge planning, education, case management and disease management for members with chronic diseases.

Figure 7: Strategies Employed by MCOs to Reduce PPEs in 2021[5]
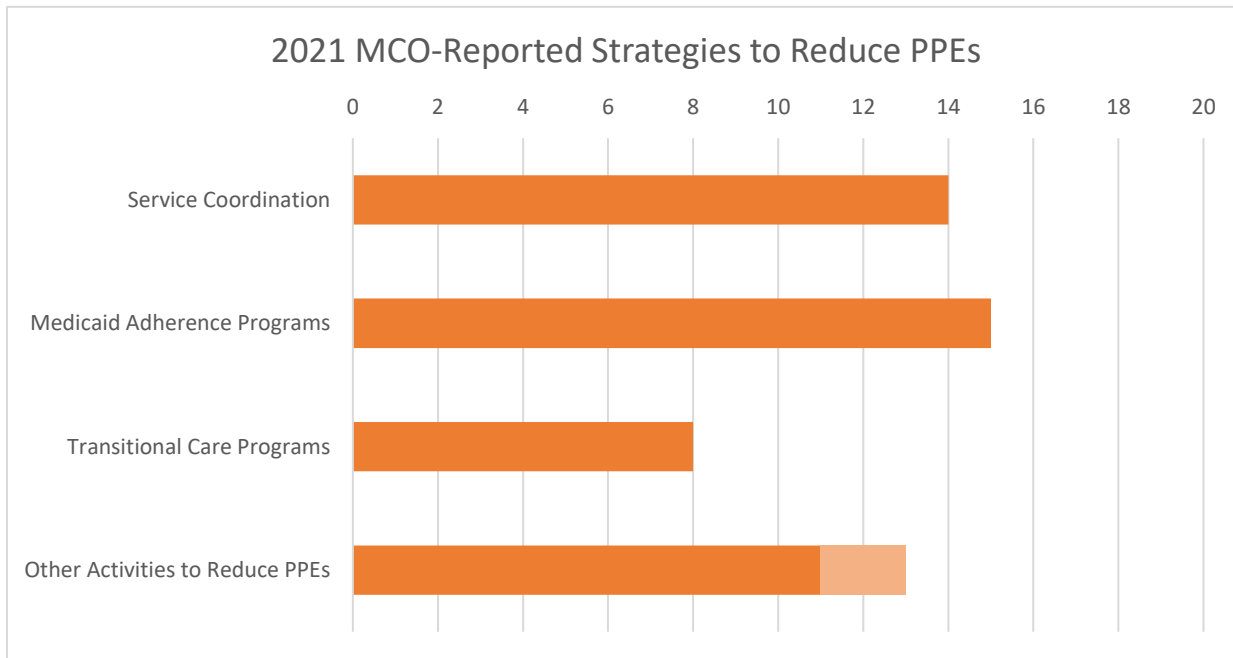
Note: DMO responses are indicated by the lighter color segments at the end of each bar.

OIG Approach to Measure MCO Program Integrity Cost Avoidance

In previous iterations of the MCO cost avoidance and waste prevention workgroup, the OIG collaborated with MCOs and MCS to develop a framework for evaluating the effectiveness of MCO activities (see Figure 9 below). The framework incorporates specific definitions, criteria and guidelines for the evaluation of cost avoidance and waste prevention. The OIG continues to incorporate the framework in the OIG's efforts to quantify MCOs' cost avoidance and waste prevention activity results. Specifically, 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.

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[5] Instead of 'service coordination,' the term 'case management' was utilized in the 2017 and 2019 iterations of the *MCO Cost Avoidance and Waste Prevention Activities Survey*.

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 MCO reporting to HHS. Therefore, it 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.

While explicit program integrity cost savings are not the only type of MCO cost avoidance, the OIG's approach focuses on 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 Activities[6]

MCO Cost Saving Activities		
Explicit Cost Savings	**Currently Reported Explicit Cost Savings**	**Implicit Cost Savings**
Prepayment review	Third Party Liability (TPL) cost avoidance	Strategies to reduce potentially preventable events (PPEs)
Front-end claim edits		Service coordination
Claims prepay programs		Transitional care programs
Ambulatory payment classification (APC) or diagnosis related group (DRG) edits		Medication adherence programs
Post-payment review		Utilization management
Surevillance and utilization reviews (SUR)		
Data mining		

OIG Explicit Program Integrity Cost Avoidance Definition, Criteria and Guidelines

The OIG uses the above-mentioned definitions and the below criteria and guidelines developed in collaboration with the MCO Cost Avoidance Workgroup as a framework.

Criteria:
1. **Tangible**: Clear and definite.

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[6] Please note this figure includes examples and is not a comprehensive representation of all the cost avoidance and waste prevention activities utilized by MCOs.

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,li]
4. **Not otherwise captured by HHS reporting**.

The OIG developed these criteria to refine which activities to consider in a further review of effectiveness. The criterion of 'tangible' is meant to ensure activities are clearly 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,[lii] TPL cost avoidance,[liii] the P4Q Program; [liv] and MCO contractual requirements-such as those for value-based contracting with providers,[lv] the Hospital Quality Based Payment Program,[lvi] and the Pharmacy Lock-in Program.[lvii] 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 the development of the 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. This includes 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.[lviii] This time parameter is within range of the approach of other states and MCOs, from 3 up to 36 months and aligns with other HHS reporting requirements for 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. In both the 2019 and 2021 Workgroups,

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[7]**Fraud**: 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 a reasonably prudent person would deem careless or would allow inefficient use of resources, items, or services.
Abuse: A practice by a provider inconsistent with sound fiscal, business, or medical practices and results in an unnecessary cost to the Medicaid program; the reimbursement for services that are not medically necessary or 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.

multiple MCOs noted limitations related to the feasibility of determining the dollar value of denied claims using solely the Medicaid allowable amount.

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

In its efforts to respond to the requirements of Rider 104, the OIG proposed applying the previously stated definitions, 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**

Note: The *MCO Cost Avoidance and Waste Prevention Activities Survey* continues to inquire about explicit and implicit cost savings.

Since FY 2020, MCOs are required to report the Medicaid allowable amount for TPL cost avoidance.[lix] OIG received feedback through the MCO Cost Avoidance Workgroup that multiple MCOs utilized claims management systems do not retain information about denied claims, hindering the ability to report both the Medicaid allowable fee associated with a denial and the MCO's contracted rate.

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, as the activities do not involve reducing or eliminating an improper payment before the payment is made. Efforts focusing on improving quality through reducing PPEs also would not meet the definition requirement as other HHS metrics currently capture the impact of these activities.[lx]

In response to Rider 104, and in continuation of previous work related to cost avoidance, the OIG reconvened the MCO Cost Avoidance Workgroup to standardize a methodology for

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[8] The term 'potentially' is used when some activities in the category may be considered under the proposed approach but others within the same category would be excluded.

quantifying cost avoidance. The OIG proposed focusing on explicit program integrity cost avoidance to narrow the focus of these efforts.

Prepayment review strategies most closely satisfy the parameters outlined above. Accordingly, the OIG selected prepayment review strategies as the foundation to initiate quantifying the impact of MCO cost avoidance activities. The OIG sought to identify activities which all MCOs reported utilizing and thus selected front-end claims edits based on MCO response to the 2021 *MCO Cost Avoidance and Waste Prevention Activities Survey*.

The OIG developed a proposal to standardize front-end claims edit data reporting across Texas Medicaid MCOs and presented the information to the 2021 MCO Cost Avoidance Workgroup.

Quantifying MCO Cost Avoidance

All MCOs reported using one or more cost avoidance strategies. However, the lack of standardization in defining, organizing and evaluating the different approaches creates significant challenges in quantifying the impact of the cost avoidance strategies. The MCOs that measure the impact of cost avoidance activities employ a variety of techniques to evaluate effectiveness.[lxi] Based on the results of the *MCO Cost Avoidance and Waste Prevention Activities Survey*, the most commonly reported evaluation measure was calculating the dollar-value of activities, using methodologies such as:

- The value of claims denied through front-end claim edits or prepayment review.[lxii]
- 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, MCOs may attribute savings from claims not submitted to the intervention.

MCOs also reported the use of artificial intelligence models that fulfill various functions in their program integrity activities. More than one MCO reported evaluating 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 the measure had been successful.

Establishing a Baseline Measurement

Further review of the effectiveness of cost avoidance 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.

As these parameters are not currently in place, OIG worked with the MCO Cost Avoidance Workgroup to develop an approach to capture the value of certain MCO cost avoidance and

waste prevention activities in Medicaid and CHIP managed care. The OIG asked workgroup members to consider and provide feedback on the feasibility of establishing a baseline measurement limited to MCO front-end claim edits. 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.

The OIG developed a template based on NCCI code edits[9,lxiii] and standardized definitions, to collect data (frequency of claims denied and amount of cost avoided) associated with front-end claim edits intended to prevent reimbursement of inappropriate claims. These edits included contractually required NCCI edits as well as edits unique to the MCO.

Ultimately, quantifying costs avoided from the use of front-end claim edits was not feasible. The challenges outlined below continue to impede development of a standard cost avoidance calculation methodology and implementation of a reporting system for standard MCO cost avoidance measures.

Challenges and Limitations

OIG identified the following challenges in quantifying the impact of MCO cost avoidance activities based on MCO responses and information obtained through the MCO Cost Avoidance Workgroup and research on other states' practices:

- **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.
- **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.

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[9] The National Correct Coding Initiative (NCCI), originally developed by the federal Centers for Medicare and Medicaid Services (CMS), promotes correct coding methodologies and is designed to control improper coding and reduce inappropriate claims payments.

MCO contracts and the Texas Medicaid Provider Procedures Manual (TMPPM) require MCOs to utilize NCCI code edits. These edits are first classified as Procedure-to-Procedure (PTP) or Medically Unlikely Edits (MUE).[9] PTP edits capture pairs of procedure codes that should not be paired on claims, while MUEs define the maximum allowable units of service that would generally be reported on a single service date.[9] PTP edits and MUEs are then organized by provider type: practitioners and ambulatory surgical centers, outpatient hospital services, and durable medical equipment (DME) providers each have a specific set of edits within PTP/MUEs for a total of six separate reporting tools.

- **Increasing focus on innovative payment strategies.** As HHS and MCOs transition to paying for value vs. volume,[lxiv] determining how to approach cost avoidance and waste prevention in alternative payment models presents new complexities and continues to be examined.
- **Elements of front-end claim edit data are not uniform across MCOs.** MCOs report the retrieval of the required data and format would require several months and custom configuration within the claims processing software. MCOs indicated use of multiple claims edit classifications, preventing the use of standard categories such as National Correct Coding Initiative (NCCI) code edits. Additionally, MCO feedback listed several challenges to establishing standardization, including the alignment of multiple software programs for code edits within an MCO and across MCOs, consolidating edits from different sources within a software program, different classification of code edits between individual MCOs and the OIG's proposed standard, an inability to retrieve dollar-amounts or the number of claims denied for a particular edit and the resource-intensive process to configure the initial data retrieval.

Given the feedback provided by the MCOs and DMOs, the administrative burden associated with collection of data for analysis is prohibitive at this time. The feasibility of obtaining data at the level of detail needed for meaningful comparison and potential HHS action is not able to be determined. Additionally, reported data may require manual review to assess accuracy and completeness. Based on this feedback, refined assessment of the effectiveness of cost avoidance strategies employed by the MCOs and the adequacy of those functions is not feasible within the required timeframe. Numerous obstacles remain in creating standards to assess and evaluate cost avoidance practices between MCOs and within the managed care environment.

3. OIG Efforts in Medicaid Managed Care

Background

The OIG is charged with preventing, detecting and deterring FWA 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 54,000 employees. [lxv] Of that total, approximately $27 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 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	Provider Field Investigations (PFI)	• Providers	Medicaid	• Recovery of overpayments • Sanctions • Referral to Medicaid Fraud Control Unit (MFCU) at OAG
Reviews	Surveillance Utilization Review	• Providers • Clients (substance abuse only)	Medicaid	• Recovery of overpayments • Provider education • Client lock-in[10]
Third Party Recoveries and Cost Avoidance	Third Party Recoveries	• Providers	Medicaid	• Recoveries • Cost Avoidance
Recovery Audit Contractor (RAC) Oversight	Investigations and Reviews	• Providers	Medicaid	• 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 division 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.

Figure 11: OIG Programs – Medicaid & Non-Medicaid

OIG Programs – Medicaid & Non-Medicaid				
Tool	**OIG Program Area**	**Focus**	**Programs**	**Potential Outcome(s)**
Audits	Audit and Inspections	• Providers • MCOs • HHS agencies • HHS contracts	All HHS Programs	• Recovery of overpayments • Audit findings and recommendations
Investigations	Benefits Program Integrity (BPI)	• Clients	SNAP Medicaid	• Recovery of overpayments

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[10] When a Medicaid client is a "lock-in", they are restricted to a designated pharmacy or health care provider by HHS.

OIG Programs – Medicaid & Non-Medicaid				
Tool	**OIG Program Area**	**Focus**	**Programs**	**Potential Outcome(s)**
			TANF WIC CHIP	• Disqualification from program participation • Referral for local prosecution
Inspections	Audit and Inspections	• Providers • MCOs • HHS agencies • HHS contracts	All HHS Programs	• Inspection report findings and recommendations • Recovery of overpayments
Data Analytics	Fraud, Waste, and Abuse Research and Analytics (FWARA)	• Providers • MCOs • Clients • Services	All HHS Programs	• Data analysis that drives and reinforces OIG work
Enrollment	Provider Enrollment Integrity Screenings (PEIS)	• Providers	Medicaid CHIP Other HHS Programs	• Screening for providers seeking to enroll in certain HHS programs
Internal Affairs (IA)	Investigations and Reviews	• HHS Staff	All HHS Programs	• 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)	• State Supported Living Centers (SSLCs) • State Hospitals	Financial Assistance Program	• Findings related to allegations of abuse, neglect and exploitation • Referrals to local law enforcement
Investigations	Electronic Benefit Transfer (EBT) Trafficking Unit	• Retailers • Clients	SNAP	• Recovery of overpayments • Referrals to local law enforcement
Investigations	Cooperative Disability Investigations	• Claimants • Providers	Disability Determination Services (DDS)	• Timely and accurate disability determinations • Referrals to OIG for recovery

Non-Medicaid Only				
Tool	**OIG Program Area**	**Focus**	**Programs**	**Outcome(s)**
Investigations	WIC Vendor Monitoring Program	• Vendors	Women, Infants, and Children (WIC)	• 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 and Performance	• Policy research, analysis, writing and training • Research and review of internal functions • Strategic opportunity identification • Project management • Continuous process improvement
General Law and Litigation	• Legal support • Provider appeals for investigations and audits
External Relations and Office of Chief of Staff	• External stakeholder communication • Outreach with legislators, recipients, MCOs and the media • Leading OIG-wide initiatives and special projects
Operations	• Budget • Purchasing and contract management • Fraud hotline • Program Support and Training • Ombudsman

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 FY 2022 - FY 2023 Biennium

In November 2021, the OIG had 592.5 full-time equivalent employees (FTEs). The OIG estimates it dedicates 320.6 FTEs (54.1 percent) directly or indirectly to detecting, deterring and preventing FWA in Medicaid 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.[11] Figure 14 shows the actual allocation for FY 2022 and planned allocation for FY 2023 of OIG FTEs by program area.

Figure 14: OIG FTE Allocation by OIG Program Area in FY 2022 – FY 2023 Biennium

	Medicaid Managed Care FTEs	Total FTEs	% of FTEs in Medicaid Managed Care
OIG Programs – Medicaid Only			
Provider Field Investigations	66.56	71.0	93.7%
Surveillance Utilization Review	68.29	90.0	75.8%
Third Party Recoveries	6.51	8.0	81.4%
Recovery Audit Contractor	0.00	2.0	0.0%
OIG Programs – Medicaid & Non-Medicaid			
Audit	51.15	71.0	72.0%
Benefits Program Integrity	14.70	112.0	13.1%
Inspections	6.30	10.0	63.0%
Fraud, Waste & Abuse Research & Analytics	24.20	25.0	96.8%
Provider Enrollment Integrity Screenings	14.40	16.0	90.0%
OIG Programs – Non-Medicaid Only			
Special Investigations	0.00	51.0	0.0%
Internal Affairs	0.05	26.0	0.2%
WIC Vendor Monitoring Program	0.00	8.0	0.0%
OIG Supporting Program Areas			
Chief Counsel	31.73	36.5	86.9%
Operations	15.28	36.0	42.4%
Clinical Subject Matter Experts	3.55	4.0	88.8%
Policy and Performance	10.52	13.0	80.9%
Chief of Staff	6.81	12.0	56.8%
Executive Management	0.57	1.0	57.0%
Total	**320.6**	**592.5**	**54.1%**

As indicated by Figure 14, OIG programs spend approximately 54.1 percent of their resources combatting FWA in Medicaid managed care. This is a 6.3 percent increase over FYs 2020 and 2021. The OIG anticipates utilizing approximately 72.5 percent of the overall budget for Medicaid related efforts, a 12.9 percent increase from the previous biennium.

For those programs that work across the HHS system, there are still significant resources spent on Medicaid managed care. The Fraud, Waste and Abuse Research & Analytics (FWARA) division spends 96.8 percent of its resources on managed care, with Audit (72.0 percent) and

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[11] 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.

Inspections (63.0 percent) also completing work in this area. Both Third Party Recoveries (54.2 percent to 81.4 percent) and Audit (54.5 percent to 72.0 percent) saw the largest increases in the percentage of FTE resources utilized in managed care. As discussed above, the BPI division is focused on SNAP recoveries.

Special Investigations (inclusive of the EBT Trafficking Unit, Cooperative Disability Investigations (CDI), and SCIT) 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 66.8 percent of its staff to Medicaid managed care. Policy and Performance, Clinical Subject Matter Experts (CSME) and Chief Counsel use at least 80 percent of their FTEs in managed care, while the remainder of the supporting program areas spend around half of their time in support of managed care.

OIG Expenditures in Medicaid Managed Care in the FY 2022 - FY 2023 Biennium

In FY 2022 and FY 2023, the OIG's projected operational biennial budget[lxvii] totals approximately $116.8 million ($58.4 million in FY 2022, $58.4 million in FY 2023). Of this, the OIG projects dedicating roughly 72.5 percent (more than $84.6 million in the biennium) to combating FWA in Medicaid.[12]

Within its efforts in Medicaid, the OIG estimates approximately 72.0 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 FY 2022 – FY 2023 biennium.

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[12] 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 FY 2022 - FY 2023 Biennium by Percentage in Medicaid, Medicaid Managed Care and HHS Programs (Non-Medicaid)
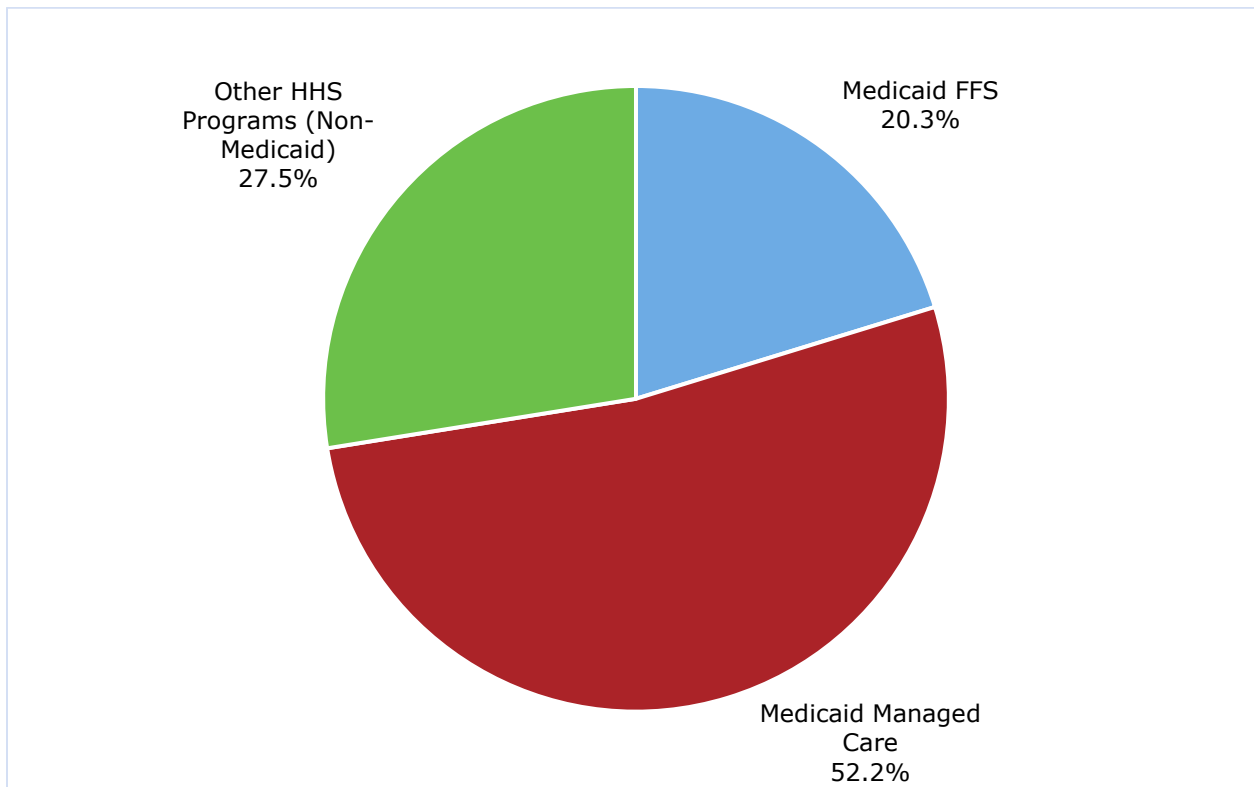
As discussed above, the OIG has some required FFS activities, and may also pursue referrals or other FWA identified in FFS Medicaid. Although most persons with Medicaid receive covered services through managed care, some populations continue to receive services through the FFS delivery model.[lxviii] The OIG may also investigate providers that serve both FFS and managed care clients.

The OIG also dedicates 27.5 percent of its FY 2022 – FY 2023 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. Additionally, several OIG areas 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 FY 2022 – FY 2023 biennium, delineating resources related to Medicaid and Medicaid managed care. Within Medicaid, the OIG has allocated 72.0 percent of its budget for the FY 2022 – FY 2023 biennium directly or indirectly to Medicaid managed care.

Figure 16: Summary of OIG Projected Budget in Medicaid Managed Care, FY 2022 – FY 2023 Biennium
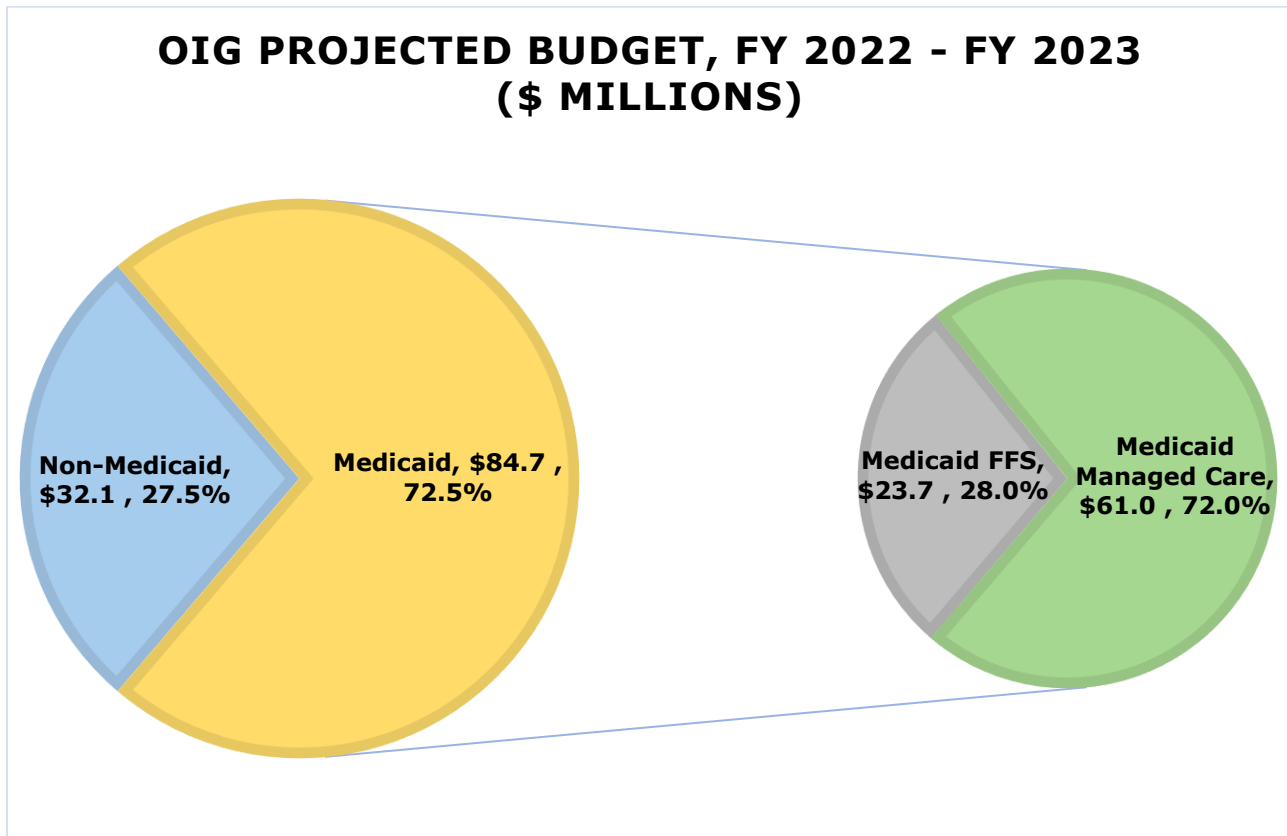
Figure 17: OIG Projected Operational Budget, FY 2022 – FY 2023 Biennium

	FY 2022	FY 2023	Biennium
OIG Budget	$58,377,746	$58,377,746	$116,755,493
OIG Medicaid Budget	$42,305,522	$42,305,522	$84,611,043
OIG Medicaid Managed Care Budget	**$30,480,250**	**$30,480,250**	**$60,960,499**[13]
% Medicaid of OIG Budget	72.5%	72.5%	72.5%
% Managed Care of OIG Budget	52.2%	52.2%	52.2%
% Managed Care of OIG Medicaid Budget	**72.0%**	**72.0%**	**72.0%**

As actual expenditures for FY 2022 were not final at the time of this report's preparation, the OIG operational budget is used as a proxy for FY 2022 actual expenditures. Actual year-to-date expenditures for FY 2022 as of December 2021 totaled $14,081,752.79. Of these expenditures, the OIG estimates 52.2 percent ($7,350,674.96) to be related to Medicaid managed care.

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[13] The biennium budget differs from the sum of the FY 2022 and FY 2023 budgets by $1 due to rounding.

In summary, the OIG found 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 FY 2021

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: This is a measure of the total monetary recoveries resulting from activities of the OIG. These recoveries include cash collected as well as completed offsets. Offsets, or recoupments, are payments that are set up out of future benefit allotments.[lxix]

Dollars identified for recovery: This is a measure of the total potential overpayments resulting from activities of the OIG. These potential overpayments have not actually been collected at this point (and notice not necessarily sent to providers, contractors and/or managed care organizations). These potential overpayments are estimates prior to further analysis or additional information submitted by the subject of the potential recovery.[lxx]

Cost avoidance: Cost avoidance may arise from administrative actions/sanctions against a provider or recipient, policy changes initiated at the behest of OIG, and/or education efforts to providers, recipients, consultants, contractors, and vendors. 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 FY 2021, the OIG recovered $424.2 million in improper payments, of which the OIG estimates more than $381.7 million was in Medicaid, including both FFS and managed care. The OIG also identified a potential $754.5 million for future recoveries and achieved $155.7 million in cost avoidance.

FWA Incidences Identified by the OIG in Medicaid Managed Care in FY 2021

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 172,877 total incidences of FWA in Medicaid managed care in FY 2021. The vast majority (169,682) of these incidences was related to waste from a liable third party resulting from work conducted by the OIG.

FWA Incidences Identified by Third Party Recoveries in FY 2021

TPR works to ensure 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 $327.6 million in FY 2021. In managed care, TPR work resulted in 169,682 FWA incidences associated with third party recoveries, including 156,232 incidences related to individual claims adjustments for recoveries of waste (74,784 MCO encounter claims, 81,448 pharmacy encounter claims) and 13,450 subrogation (tort) cases. The responsible entity for the 74,784 MCO encounter recoveries was from other health insurance carriers, the 81,448 pharmacy encounter recoveries was from Pharmacy Benefit Managers (PBMs), and the 13,450 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 FY 2021.

Figure 18: FWA Incidences Identified by Third Party Recoveries in Medicaid Managed Care in FY 2021

	Insurance Carriers	Pharmacy Benefit Managers (PBMs)	Other Liable Third Parties	Total
Third Party Recoveries	74,784	81,448	13,450	**169,682**

Other OIG Program Areas Identified FWA Incidences in FY 2021

As demonstrated in Figure 19, several other OIG program areas identified incidences of FWA in Medicaid managed care in FY 2021. Other OIG program areas reporting identified incidences of FWA included Surveillance Utilization Review (2,676), Chief Counsel (370), PFI (97), BPI (25), Audit (23) and Inspections (4). 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 FY 2021.

Figure 19: Summary of FWA Incidences Identified not Related to Third Party Recoveries in Medicaid Managed Care in FY 2021 by OIG Program Area and Entity

	Surveillance Utilization Review (SUR)	Chief Counsel	Provider Field Investigations (PFI)	Benefits Program Integrity (BPI)	Audit	Inspections
■ Clients	1854	0	0	25	0	0
■ Providers	427	178	80	0	7	0
■ Hospitals	120	11	14	0	3	0
■ Nursing Homes	275	2	2	0	0	0
■ MCOs	0	0	1	0	10	3
■ Other	0	179	0	0	3	1
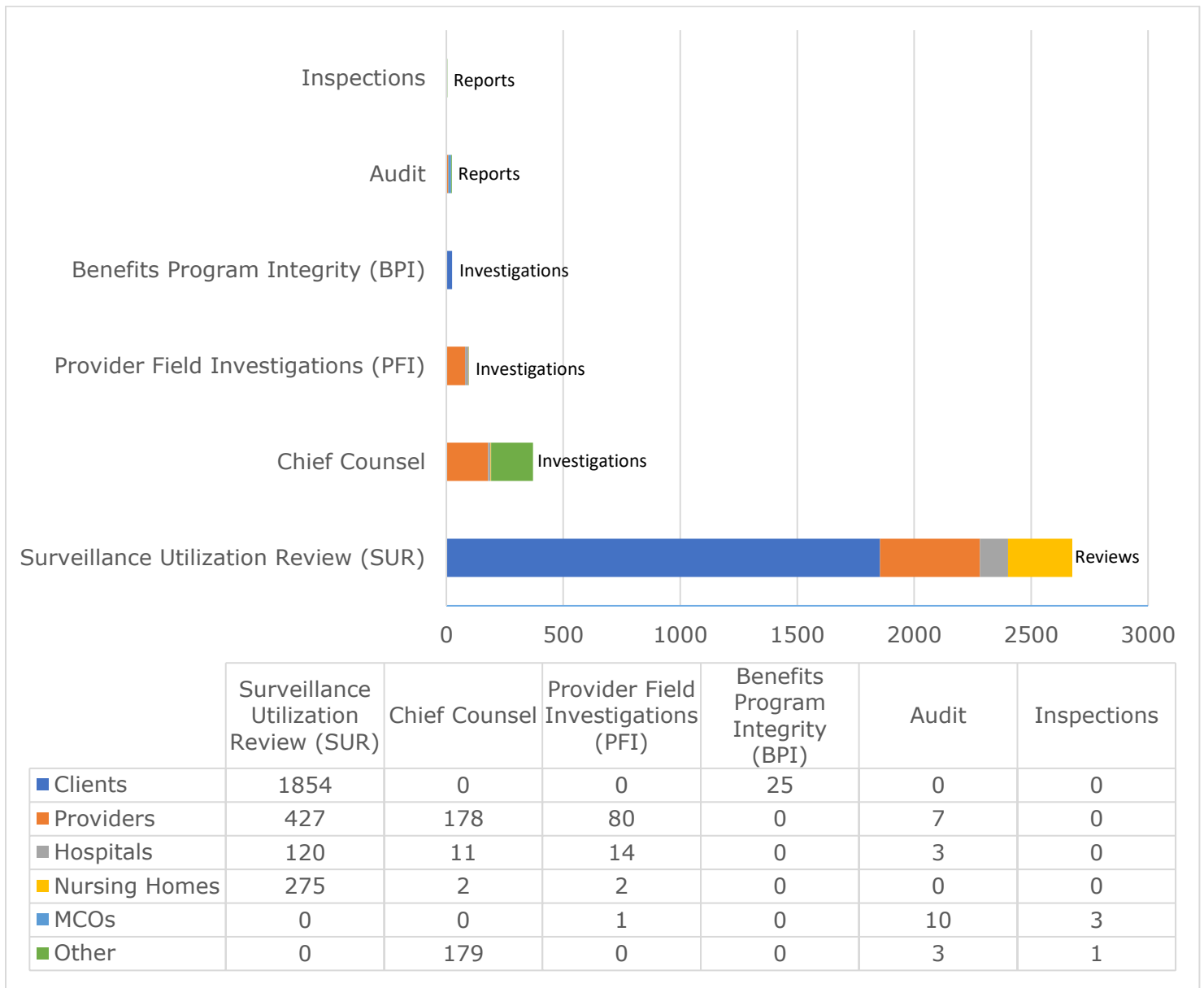
Surveillance Utilization Review

Surveillance Utilization Review (SUR) conducts claims and medical record reviews in Medicaid FFS and managed care. In FY 2021, Surveillance Utilization Review conducted 16,700 hospital claims reviews and 220 nursing facility reviews. Additionally, Lock-In enrollment increased by 1,854 members. The average Lock-In enrollment for FY 2021 was 34 percent higher than FY 2020.

Of the reviews completed, 2,676 identified incidences of FWA in Medicaid managed care. The responsible entity for 69.3 percent (1,854) of these incidences was a Medicaid client, 16.0 percent (427) a provider, 10.3 percent (275) a nursing home, and 4.5 percent (120) a hospital.

It is important to note the reviews of providers and nursing homes involve multiple claims and/or forms, but only one incidence is counted per entity. Figure 20 shows the incidences of FWA identified by Surveillance Utilization Review in Medicaid managed care by entity in FY 2021.

Figure 20: FWA Incidences Identified by Surveillance Utilization Review in Medicaid Managed Care in FY 2021

	Clients	Providers	Hospitals	Nursing Homes	MCOs	Other	Total
Surveillance Utilization Review	1,854	427	120	275	-	-	**2,676**

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 FY 2021, Chief Counsel closed 532 cases. All 532 cases related to Medicaid managed care. Chief Counsel reported a finding of FWA in 370 of the 532 cases closed in FY 2021. The responsible party for 48.1 percent (178) of Chief Counsel's identified FWA incidences was a provider, 3.0 percent (11) a hospital and 0.5 percent (2) a nursing home. Additionally, 48.4 percent (179) of the identified incidences were related to exclusions. Figure 21 shows the incidences of FWA identified by Chief Counsel in Medicaid managed care by entity in FY 2021.

Figure 21: FWA Incidences Identified by Chief Counsel in Medicaid Managed Care in FY 2021

Program	Clients	Providers	Hospitals	Nursing Homes	MCOs	Other	Total
Chief Counsel	-	178	11	2	-	179	**370**

Provider Field Investigations (PFI)

PFI investigates allegations of FWA committed by Medicaid providers in FFS and managed care. In FY 2021, PFI closed a total of 138 cases, 136 of which were related to Medicaid managed care. PFI reported 97 cases related to Medicaid managed care in FY 2021 with incidences of FWA. Figure 22 shows the incidences of FWA identified by PFI in Medicaid managed care by entity in FY 2021.

Figure 22: FWA Incidences Identified by PFI in Medicaid Managed Care in FY 2021

	Clients	Providers	Hospitals	Nursing Homes	MCOs	Other	Total
Provider Field Investigations (PFI)	-	80	14	2	1	-	**97**

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 FY 2021, BPI conducted 18,954 investigations. Of those investigations, 593 were related to Medicaid managed care. BPI closed 25 cases with identified incidences of FWA related to Medicaid managed care. Figure 23 shows the incidences of FWA identified by BPI in Medicaid managed care by entity in FY 2021.

Figure 23: FWA Incidences Identified by BPI in Medicaid Managed Care in FY 2021

	Clients	Providers	Hospitals	Nursing Homes	MCOs	Other	Total
Benefits Program Integrity (BPI)	25	-	-	-	-	-	**25**

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 FY 2021, Audit issued 38 audit reports. Of these audits, 23 were related to Medicaid managed care and identified an incidence of FWA. MCOs were the responsible party for 43.5 percent (10) of these identified incidences. Seven incidences involved a provider and three a hospital. Figure 24 shows FWA incidences identified by Audit in Medicaid managed care by entity in FY 2021.

Figure 24: FWA Incidences Identified by Audit in Medicaid Managed Care in FY 2021

	Clients	Providers	Hospitals	Nursing Homes	MCOs	Other lxxi	Total
Audit	-	7	3	-	10	3	**23**

Inspections

Inspections conducts inspections of HHS programs, systems and functions focused on FWA, and systemic issues to improve the HHS System. In FY 2021, Inspections performed nine inspections related to Medicaid managed care and identified incidences in four of the nine inspections. Seventy five percent (3) of the identified incidences involved MCOs. Figure 25 shows the incidences of FWA identified by Inspections in Medicaid managed care by entity in FY 2021.

Figure 25: FWA Incidences Identified by Inspections in Medicaid Managed Care in FY 2021

	Clients	Providers	Hospitals	Nursing Homes	MCOs	Other	Total
Inspections	-	-	-	-	3	1	**4**

In total, the OIG identified 172,877 incidences of FWA. Again, it is important to note 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 FY 2021 compared to other OIG areas 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 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 proposal to standardize cost avoidance and waste prevention activity reporting. The OIG used the framework, definitions, criteria and guidelines recommended previously as the foundation of this proposal and attempted to capture MCO and DMO data from front-end claims edits for the period of FY 2020.

In reconvening the MCO Cost Avoidance Workgroup and presenting the proposal detailed above, the MCOs identified several challenges to quantifying the impact of cost avoidance activities. Any evaluation of the efficacy of cost avoidance activities in Medicaid managed care using front-end claims edit data would be incomplete given the variety of challenges and limitations, such as not tracking the number of claims denied, the dollar value associated with those claims, lack of consistency in front end claim edit data and use of multiple claims management systems. The OIG anticipates similar challenges in capturing standardized cost avoidance data from other MCO activities.

Additionally, the OIG does not anticipate significant changes in its focus on Medicaid managed care. Of all Texas Medicaid clients, approximately 94 percent are enrolled in managed care.[lxxii] The OIG will continue its work and dedicate the necessary resources to prevent, detect and deter FWA in the provision of health and human services.

The OIG continues to engage in data-driven and strategic work to enhance its work in and out of Medicaid managed care. For the FY 2022 – FY 2023 biennium, the OIG has allocated 52.2 percent of its operational budget and 54.1 percent of its FTEs to combating FWA in Medicaid managed care. Within Medicaid, the OIG allocates 72.0 percent of its budget and 74.7 percent of its FTEs to work related to managed care. This resulted in 172,877 total incidences of FWA in Medicaid managed care identified by the OIG in FY 2021. The vast majority (169,682) of these incidences were related to 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
AHCCCS	Arizona Health Care Cost Containment System
APC	Ambulatory Payment Classification
APM	Alternative Payment Model
BPI	Benefits Program Integrity
CDI	Cooperative Disability Investigations
CHIP	Children's Health Insurance Program
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
FY	Fiscal Year
FWA	Fraud, Waste and Abuse
FWARA	Fraud, Waste and Abuse Research and Analytics
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
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
PDC	Performance Data Compiler
PEIS	Provider Enrollment Integrity Screenings
PERM	Payment Error Rate Measurement
PMPM	Per Member Per Month
PBM	Pharmacy Benefit Manager
PFI	Provider Field Investigations
PPE	Potentially Preventable Event
PSI	Policy & Strategic Initiatives
RAC	Recovery Audit Contractor
SCIT	State Centers Investigations Team
SIU	Special Investigative Unit
SNAP	Supplemental Nutrition Assistance Program
SUR	Surveillance 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 Recoveries
UMCC	Uniform Managed Care Contract
UMCM	Uniform Managed Care Manual
UPIC	Unified Program Integrity Contractors
US HHS	United States Department of Health and Human Services
VBP	Value Based Payment
WIC	Women, Infants and Children

Appendix A. Report Methodology

To address the requirements of Senate Bill 1, 87th Legislature, Regular Session, 2021 (Article II, HHS, Rider 104), 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 August 2021 about their cost avoidance and waste prevention activities and had a 100 percent response rate.
- Distributed an updated version of the OIG Cost Avoidance and Waste Prevention 24-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 104. This report details the aggregate findings from survey responses and provides a comparison of MCO and DMO survey responses from 2017, 2019 and 2021. The survey questions can be found in **Appendix B**.
- Researched and reviewed national practices about cost avoidance, waste prevention strategies and documented practices used by various states.
- Re-established the 'MCO Cost Avoidance Workgroup' with stakeholders from the OIG, Associations, MCOs and DMOs. Facilitated a meeting with MCO stakeholders to present a data collection proposal and solicit feedback 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 (592.5) 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 FY 2022 or planned expenditures for FY 2023 are not yet available. The OIG used the operational budget for FY 2022 and FY 2023 as of December 2021 as a

proxy. To determine the budget for Medicaid managed care in FY 2022 and FY 2023, the percent of FTE time reported by each OIG program area was applied to that program area's budget for FY 2022 and FY 2023. FY 2022 actual expenditures and expenditures in Medicaid managed care as of December 2021 are also included using this methodology.

- To determine the incidences of FWA identified by the OIG in Medicaid managed care in FY 2021, each OIG program area reported the number of closed activities (investigations, audits, reviews, inspections, claims, etc.) in Medicaid managed care in FY 2021 with findings of FWA. It is important to note 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 unrelated to Medicaid or Medicaid managed care. See **Appendix C** for more detailed descriptions of OIG program areas and their efforts.

Appendix B. MCO Cost Avoidance and Waste Prevention Activities Survey

Purpose

This survey is an opportunity for your organization to collaborate with the Office of Inspector General (OIG) and to document the program integrity cost avoidance and waste prevention activities your organization uses. It provides the chance to share success stories and suggestions about how the OIG could better support your managed care organization's (MCO) 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. Waste is defined in Texas Administrative Code. Title 1, Part 15, Chapter 371 Subchapter B, Rule §371.1 Definitions.

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 most effective cost avoidance and waste prevention activities for your MCO. Select all that apply.

   [] Prepayment Reviews

   [] Post-payment Reviews

[] Potentially Preventable Event Reductions (i.e. hospital readmission, etc.)

[] Conduct Internal Monitoring and Internal Audits

[] Other Activities (please specify):

4. Please explain why your MCO finds these activities the most effective in avoiding costs and/or preventing waste.

5. How does your MCO evaluate the effectiveness of its cost avoidance and waste prevention 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 by your MCO? Please identify why you indicated this activity and include an example of how they could be expanded or strengthened, as applicable.

Prepayment Review Activities:

7. Please identify the Texas Medicaid products to which your responses in this section apply. Select all that apply.

[] 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 (FWA).

[] Front-End Claim Edits

[] Claims Prepay Programs

[] APC/DRG Editing

[] Other Activities (Please Specify):

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

Post-payment Review Activities:

10. Please identify the Texas Medicaid products to which your responses in this section apply. Select all that apply.

   [] 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 FWA.

   [] Surveillance & Utilization Reviews

   [] Data Mining

   [] Duplicate Payment Detections

   [] Other Activities (Please Specify):

12. What actions and activities does your MCO take to ensure that overpayments from FWA 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 the Texas Medicaid products to which your responses in this section apply. Select all that apply.

   [] STAR   [] STAR Health

   [] Star +PLUS   [] Medicare-Medicaid Dual Demonstration

   [] Star Kids   [] CHIP

   [] Dental

15. For which diagnosis groups and populations does your MCO focus its efforts to reduce Potentially Preventable Events?

   [] Asthma

   [] Chronic Obstructive Pulmonary Disease

[] Diabetes

[] Heart Failure

[] Other Diagnosis Groups/Populations (Please Specify):

16. What activities does your MCO use to reduce Potentially Preventable Events beyond the disease management provisions required by the Texas Administrative Code (1 TAC §353.421) and the HHSC Uniform Managed Care Manual (Chapter 9: Disease Management)?

[] Service Coordination

[] 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 cost avoidance or waste prevention success story from a recommendation implemented as the result of an internal audit:

Further Questions:

20. 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 FWA?

21. Are there planned cost avoidance or waste prevention activities (new or expansion of existing activities) not otherwise identified in this survey your organization will use in state fiscal years 2022-2023?

22. If your organization is contracted for multiple Texas Medicaid and CHIP products, please describe how cost avoidance and waste prevention activities differ between products.

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

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

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 & Reviews

Investigations

Provider Field Investigations (PFI), within Investigations & Reviews, investigates and reviews allegations of FWA committed by Medicaid providers. Once PFI receives a referral, it is legislatively required to complete each investigation within 180 days. PFI 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.

PFI investigations may result in referral to OIG Chief Counsel or, when PFI detects criminal Medicaid fraud, a referral to the OAG'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

Surveillance Utilization Review, within Investigations & Reviews, 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.

Surveillance Utilization Review (SUR) is made up of several units, including:

- Acute Care Surveillance (ACS): The ACS team develops and runs data queries on acute care billing outliers to identify patterns of aberrant billing.

- 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.

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

Reviews conducted by SUR 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 Medicaid is the payer of last resort by recovering and avoiding third party liability payments. TPR also 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)

Investigations and Reviews 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 select Medicaid claims for review to determine whether a potential overpayment exists. The Health and Human Services Commission (HHSC) pays the RAC vendor 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 in collaboration with OIG Centralized Risk Review (OCRR) 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, Managed Care Organizations, and contractors with an elevated potential for FWA.

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 PFI 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 fraud, waste, or abuse 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 by 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 designed to be expeditious, targeted examinations into specific programmatic areas to

identify systemic trends of fraud, waste, or abuse. 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.

OIG Audit & Inspections Division in collaboration with OIG Centralized Risk Review (OCRR) conducts a continuous risk assessment to select potential audit and inspection topics for including in its rolling audit and inspections plans. Through a variety of methods, Audit and Inspections determines the best approach for a topic, either through an audit or an inspection. Inspections may perform follow-up work on a prior audit or inspection to determine if recommendations have been implemented.

Inspections may identify areas of non-compliance, overpayments, disallowed costs or other issues, and may offer recommendations to improve performance, mitigate risks, and address process weaknesses. Inspections refers potential fraud to PFI or Internal Affairs. Inspections may result in reports, which include observations and recommendations. Final reports are published on OIG's website. If an inspection results in no observations, the OIG issues a no-findings letter to the inspection client.

Data Analytics

Fraud, Waste and Abuse Research and Analytics (FWARA) implements tools and innovative data analytic techniques that streamline OIG operations and increase the identification of FWA in HHS programs. FWARA 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 FWARA unit develops targeted algorithms to allow OIG business areas to focus their work on areas with higher risk for Medicaid fraud, waste or abuse. Using data as a starting point helps the OIG more efficiently manage their work and realize a higher success rate in fraud, waste and abuse detection. FWARA also works with MCOs on deconfliction to ensure duplicative efforts do not occur.

FWARA also develops the methodology and algorithms for the Fraud Detection Operations (FDO). 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 Investigations and Reviews conducts federal and state-required screening activities for providers seeking to enroll in Medicaid, CHIP and other state health care programs.

Providers who are not eligible are prevented from participating in Medicaid.

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 and Performance, General Law and Litigation, External Relations, Office of Chief of Staff, 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 and Performance

The Policy and Strategic Initiatives unit within the Policy and Performance Division serves as the health care policy subject matter expert and liaison across the OIG. PSI makes recommendations for contract and policy changes, liquidated damages and corrective action plans that promote program integrity.

PSI 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.

The **Results Management (RM)** unit within the Policy and Performance Division reviews the structure and performance of programs and services within the Office of Inspector General (OIG) with the goal of enhancing and strengthening the following:

- Staffing and infrastructure supporting pursuit of excellence throughout OIG

- Performance and quality outcomes

- Business operations to reduce constraints and increase efficiency

- Cross-divisional coordination

- Program are policies, procedures, and processes for increased transparency and support OIG divisions in achieving their objectives.

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 resolution of investigations and audits that identify providers who have received Medicaid funds to which they may not be entitled or other available administrative actions or sanctions, e.g. Written Educational Contact or Exclusion/Termination.

External Relations and Office of Chief of Staff

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.

Office of Chief of Staff leads OIG-wide initiatives and special projects.

Operations

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

Purchasing and Contract Management helps to ensure compliance with HHS purchasing and contracting laws, rules and policies by coordinating with HHS procurement and contracting team and OIG divisions throughout the procurement and contracting lifecycle and processing of invoices prior to submission to Accounts Payable.

The Fraud Hotline receives allegations of fraud, waste and abuse, screens them and refers them for further investigation or 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.

The ***Ombudsman*** provides an independent and neutral process for OIG employees to address concerns and work towards resolution.

Appendix D. Endnotes

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