Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Texas Focused Program Integrity Review

Medicaid Managed Care Oversight

July 2025

Final Report

Table of Contents

I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a focused program integrity review to assess Texas' program integrity oversight efforts of its Medicaid managed care program for the Fiscal Years (FY) 2020 – 2022. This focused review specifically assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid managed care.

To meet the objectives of this focused review, CMS reviewed information and documents provided in response to the CMS managed care review tool provided at the initiation of the review. CMS also conducted in-depth interviews with the State Medicaid Agency (SMA) and evaluated program integrity activities performed by selected managed care organizations (MCOs) under contract with the SMA.

This report includes CMS' observations that were identified during the focused review.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified **no** findings that create risk to the Texas Medicaid program related to managed care program integrity oversight.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid managed care program. CMS identified **eight** observations related to Texas' managed care program integrity oversight. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observations identified during this review include the following:

State Oversight of Managed Care Program Integrity Activities

Observation #1: CMS encourages Texas to consider the inclusion of MCO general contract language addressing Special Investigations Unit (SIU) staffing ratios to the number of members and other staffing requirements, such as experience of the SIU manager.

Observation #2: CMS encourages Texas to amend the Memorandum of Understanding (MOU) with the Medicaid Fraud Control Unit (MFCU) and seek a Texas Government Code modification that includes clear written policies on payment suspensions and good cause exceptions.

Observation #3: CMS encourages Texas to consider the inclusion of contract language that addresses conducting investigative provider site visits, both announced and unannounced, to ensure that all MCOs are utilizing this practice.

MCO Contract Compliance

Observation #4: CMS encourages Texas to develop and distribute detailed guidance for standard, appropriate member verification procedures (and supporting this guidance with modified MCO general contract language, if applicable).

Observation #5: CMS encourages Texas to monitor the oversight of the MCO compliance with regulatory requirements by ensuring that the MCOs establish written policies related to the False Claims Act, including protection for whistleblowers.

MCO Investigations of fraud, waste, and abuse

Observation #6: CMS encourages Texas to work with the MCOs to improve the quality and quantity of case referrals through routinely providing specific program integrity training and frequent feedback to the MCOs regarding their case referral performance. Also, CMS encourages Texas to collect or track referrals that are sent to the MFCU from the MCOs.

Observation #7: CMS encourages Texas to ensure that the MCOs have sufficient corrective action plan procedures in place per contract requirements and utilize corrective action plans appropriately to address non-compliant Medicaid providers.

Observation #8: CMS encourages Texas to track and collect information regarding provider self-audits.

II. Background

Focused Program Integrity Reviews

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[1] This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

As a part of these efforts, CMS conducts focused program integrity reviews on high-risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and personal care services (PCS). These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and to identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

Medicaid Managed Care

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between SMAs and MCOs that receive a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

Overview of the Texas Managed Care Program and the Focused Program Integrity Review

The Texas Health and Human Services Commission (HHSC) is responsible for the administration of the Texas Medicaid program. Within HHSC, the Office of Inspector General (HHSC-OIG) is the organizational unit tasked with oversight of program integrity-related functions for the managed care program. During the review period, Texas contracted with sixteen MCOs to provide health services to the Medicaid population. As part of this review, four of these MCOs were interviewed: Amerigroup Texas (Amerigroup), Community Health Choice (CHC), Molina Healthcare of Texas (Molina) and Superior HealthPlan (Superior). Appendix C provides enrollment and expenditure data for each of the selected MCOs.

In July 2023, CMS conducted a focused program integrity review of Texas' managed care program. This review assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. As a part of this review, CMS also evaluated program integrity

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

activities performed by selected MCOs under contract with the SMA. CMS interviewed key staff, including the MCO SIUs, as well as reviewed other primary data. CMS also evaluated the status of Texas' previous corrective action plan that was developed in response to a previous focused program integrity review of Texas' PCS program conducted by CMS in 2018, the results of which can be found in Appendix A.

During this review, CMS identified a total of **eight** observations. CMS also included technical assistance and educational resources for the state, which can be found in Appendix B. The state's response to CMS' draft report can be found in Appendix D, and the final report reflects changes CMS made based on the state's response.

This review encompasses the following five areas:

A. **State Oversight of Managed Care Program Integrity Activities** - CMS established requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas. These areas include, but are not limited to: data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under §§ 438.608.
B. **MCO Contract Compliance** - Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, such as implementing compliance plans, payment suspensions based on credible allegations of fraud, and overpayment reporting.
C. **Interagency and MCO Program Integrity Coordination** - Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars. Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA.
D. **MCO Investigations of Fraud, Waste, and Abuse** - Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state Program Integrity Unit (PIU) or any potential fraud directly to the state's MFCU. Similarly, as required by § 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.
E. **Encounter Data** - In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO.

III. Results of the Review

A. State Oversight of Managed Care Program Integrity Activities

State oversight of managed care program integrity activities is critical to ensuring that MCOs are meeting all CMS requirements and state contractual requirements. CMS established state monitoring requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas, including but not limited to, data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under §§ 438.608.

CMS determined that the oversight and monitoring requirements set forth at §§ 438.66 and 438.602 were addressed within the HHSC MCO general contract (Uniform Managed Care Contract or UMCC). According to Texas Government Code 531.102(a)[2], HHSC-OIG is responsible for the prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services in the state. The HHSC-OIG works with the Texas Office of Attorney General's MFCU for matters involving criminal fraud. The HHSC-OIG also partners with the contracted MCOs that are contractually required to implement measures through their SIUs to prevent, detect, and deter fraud, waste, and abuse. The HHSC-OIG conducts onsite reviews of MCOs to verify compliance with its fraud and abuse contract requirements. These audits involve looking at MCO SIUs and/or third-party subcontractors that perform SIU functions on behalf of the MCOs. In addition, the MCOs must submit deliverables on a monthly, quarterly, or annual basis to ensure contractual performance standards are met. Guidance and deliverable templates and formats are posted to the Uniform Managed Care Manual. The HHSC conducts operational reviews no less than every 2 years, procurement readiness reviews, and desk and/or targeted reviews occur as needed. Risk assessments are conducted annually, and MCOs noted as high risk are subject to third party performance audits or additional enhanced monitoring as appropriate.

Compliance with the MCO contract is a shared responsibility across HHSC. The HHSC Medicaid and CHIP Services' Managed Care Contract Oversight (MCCO) division coordinates the assessment of corrective action plans, liquidated damages, and other contract remedies, as well as provides technical assistance to areas regarding oversight. Many areas within HHSC monitor compliance, including MCCO, Financial Reporting and Audit Coordination, Utilization Review, and the Office of Policy.

The HHSC-OIG also contracts with external entities to conduct program integrity activities. The HHSC-OIG works under a Joint Operating Agreement with Qlarant Integrity Solutions, LLC (Qlarant), the Unified Provider Integrity Contractor for the South-Western Jurisdiction. The HHSC-OIG and Qlarant coordinate investigative activities to identify potential fraud, waste, and abuse in Texas Medicaid.

[2] In 2023, the Texas Legislature enacted a non-substantive revision of portions of the Texas Government Code, which took effect on April 1, 2025; however, this revision was not in effect during the review period.

UMCC Attachment B-1, Section 8.1.19.1 (1), requires the MCO to maintain adequate staff and resources to effectively process Texas fraud cases based on objective criteria, including total MCO member population, claims processes, risk exposure, current caseload, and other duties as described in 1 Tex. Admin. Code §§ 353.501-353.505, and 1 Tex. Admin. Code §§ 370.501-370.505. UMCC Attachment B-1, Section 8.1.19.1(2), requires the MCOs to maintain a full-time SIU manager dedicated solely to Texas Medicaid to direct oversight of the SIU and fraud, waste, and abuse activities. Lastly, the contract requires MCOs to employ or subcontract, at minimum, one full-time investigator, in addition to the SIU manager, dedicated solely to the services provided under the Texas Medicaid contract. CMS observed that there is no contract language that includes number of SIU staffing ratios to the number of members. There are also skill requirements for one full-time investigator, however; there are no skill requirements for the SIU manager. Per contract regulations, the HHSC-OIG does not require MCO SIU staff to reside in the state of Texas.

CMS observed that HHSC-OIG is required to adhere to the Texas Government Code 531.102, which contradicts the federal regulation at 455.23, specifically at section f. In addition, CMS observed that the state's MFCU has not requested a good cause exception in lieu of a payment suspension since 2015 due to specifications made by Texas Government Code 531.102 G3, which imposes significant situational limitations for HHSC-OIG in the potential use of good cause exceptions.

CMS observed that, although the review period coincided with the COVID-19 Public Health Emergency (PHE), which restricted MCOs' ability to perform unannounced investigative site visits, all four of the MCOs did not conduct unannounced site visits prior to the start of the PHE. As such, the MCOs did not perform any investigative provider site visits during the review period. Investigative provider site visits are an effective tool in the detection of fraud, waste, and abuse within the Medicaid program.

Observation #1: CMS encourages Texas to consider the inclusion of MCO general contract language adopting SIU staffing ratios specific to the number of members served. In addition, CMS encourages Texas to revise its MCO general contract to include language that specifies staffing requirements, including experience of the SIU manager, and requiring staff that is physically located within the state of Texas.

Observation #2: CMS encourages Texas to amend the MOU with the MFCU and seek a Texas Government Code modification that includes clear written policies on payment suspensions and good cause exceptions.

Observation #3: CMS encourages Texas to consider the inclusion of contract language that addresses conducting investigative provider site visits, both announced and unannounced, to ensure that all MCOs are utilizing this practice.

B. MCO Contract Compliance

Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and

prevent fraud, waste, and abuse. These requirements extend to any subcontractor that is delegated responsibility for coverage of services and payment of claims under the contract between the state and the MCO. As part of this review, the MCO general contract was evaluated for compliance with several of these requirements, which are described in greater detail below.

The MCO general contract for Texas is developed by HHSC Medicaid and CHIP Services. The MCO general contract is primarily overseen by HHSC Medicaid and CHIP Services; however, program integrity is primarily the responsibility of the Medicaid PIU, the HHSC-OIG.

Compliance Plans

In accordance with §§ 438.608(a)(1)(i)-(vii), states must require MCOs to implement compliance programs that meet certain minimal standards, which include the following:

1. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable requirements and standards under the contract, and all applicable federal and state requirements.
2. Designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors.
3. Establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program and its compliance with the requirements under the contract.
4. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the contract.
5. Effective lines of communication between the Compliance Officer and employees.
6. Enforcement of standards through well-publicized disciplinary guidelines.
7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

UMCC Attachment B-1, Section 8.1.19.5, does explicitly address the requirement that all seven compliance plan elements listed above be addressed. The contract requires the MCO to submit a written fraud, waste, and abuse compliance plan to HHSC-OIG for approval each year in accordance with Title 1 Texas Administrative Code § 353.502. A review of the MCOs' compliance plans and programs found that each MCOs' compliance plan contained the required elements in accordance with §§ 438.608(a)(1)(i)-(vii).

CMS did not identify any findings or observations related to these requirements.

Beneficiary Verification of Services

In accordance with § 438.608(a)(5), the state, through its contract with the MCO, must require a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

In Texas, this requirement is met. The MCO general contract stipulates that each MCO must meet all requirements within the Texas Administrative Code including §353.502, which states that there is verification that MCO members received services that were billed. Each of the four MCOs were observed to have a beneficiary verification process in place; however, CMS observed that the contract language does not specifically address method(s) to verify the services, the number of verifications to be completed annually, or the services that should be verified with the beneficiaries. There is also no reporting requirement for the MCOs to submit to HHSC-OIG the number of completed beneficiary verifications, and the state does not have reporting mechanisms to ensure that this is being completed by the MCOs.

> **Observation #4:** CMS encourages Texas to develop and distribute detailed guidance for standard, appropriate member verification procedures (and supporting this guidance with modified MCO general contract language, if applicable).

False Claims Act Information

In accordance with § 438.608(a)(6), the state, through its contract with the MCO, must require that, in the case of MCOs that make or receive annual payments under the contract of at least $5,000,000, there are written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

UMCC, Attachment B-1, Section 8.1.19.6, specifically addresses this requirement. The four MCOs interviewed during the review did have written policies regarding the False Claims Act, including whistleblower protection. Although the state demonstrated compliance in meeting this requirement, CMS noted that HHSC-OIG does not currently monitor MCO compliance.

> **Observation #5:** CMS encourages Texas to monitor the oversight of the MCOs compliance with regulatory requirements by ensuring that the MCOs establish written policies related to the False Claims Act, including protection for whistleblowers.

Payment Suspensions Based on Credible Allegations of Fraud

Pursuant to § 438.608(a)(8), states must ensure that MCOs suspend payments to a network provider for which the state determines there is a credible allegation of fraud in accordance with § 455.23.

Texas Medicaid MCOs are contractually required to suspend payments to providers, but only at the state's request. UMCC, Attachment B-1, Section 8.1.19.4, requires the MCOs to cooperate with HHSC-OIG when HHSC-OIG imposes payment suspensions or lifts a payment hold. When HHSC-OIG notifies the MCO that payments to a provider have been suspended, the MCO must suspend payments to the provider within 1 business day.

CMS did not identify any findings or observations related to these requirements.

Overpayments

Regulations at §§ 438.608(a)(2) and (d) require states to maintain oversight of MCOs' overpayment recoveries. Specifically, § 438.608(a)(2) requires states to ensure that MCOs promptly report all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. In addition, § 438.608(d) requires states to specify in MCOs' contracts how the MCOs should treat overpayment recoveries. This must include retention policies for recoveries of all overpayments, including overpayments due to fraud, waste, and abuse; the process, timeframes, and documentation requirements for reporting the recovery of all overpayments; and the process, timeframes, and documentation requirements for payment of recoveries to the state in situations where the MCO is not permitted to retain some or all of the recoveries. States must also ensure that MCOs have a process for network providers to report to the MCO when it has received an overpayment (including the reason for the overpayment), and to return the overpayment to the MCO within 60 calendar days. Each MCO must report annually to the state on their recoveries of overpayments, and the state must use the results of the information in setting actuarially sound capitation rates, consistent with the requirements in § 438.4.

The state adequately addressed the requirements at §§ 438.608(a)(2) and (d) in the MCO contract. UMCC, Attachment B-1, Section 8.1.19.5, requires the MCO to have internal policies and procedures for the documentation, retention, and recovery of all overpayments, and specifically for the recovery of overpayments due to fraud, waste, and abuse. In addition, Section 8.1.19.5 requires the MCO to report at least annually, or at the request of the HHSC-OIG, as to the status of their recoveries of overpayments, in the manner specified by the HHSC-OIG.

CMS did not identify any findings or observations related to these requirements.

C. Interagency and MCO Program Integrity Coordination

Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars and beneficiaries. Each of these entities performs unique functions that are critical to providing effective oversight of the Medicaid program. The ability to reduce fraud in Medicaid managed care will be greatly enhanced as these entities develop methods and strategies to coordinate efforts. Ineffective collaboration can adversely affect oversight efforts, putting taxpayer dollars and beneficiaries at risk.

Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA. Texas has a MOU with the MFCU that meets the regulatory criteria. Specifically, there is a MOU that contains procedures by which the MFCU will receive referrals of potential fraud from MCOs as required by 455.21(c)(3)(iv). Additionally, the state does meet with the MFCU at least quarterly to discuss case referrals.

While there is no requirement for SMAs to meet on a regular basis with its MCOs for collaborative sessions to discuss pertinent program integrity issues regarding fraud, waste, and abuse and relevant contractual concerns, such collaborative sessions are an effective and important process to ensure open communication and strong partnerships. The HHSC-OIG does hold quarterly collaborative sessions with its MCOs to discuss program integrity issues, such as case referrals, leads, and administrative actions.

CMS did not identify any findings or observations related to these requirements.

D. MCO Investigations of Fraud, Waste, and Abuse

State Oversight of MCOs

Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state PIU or any potential fraud directly to the state's MFCU. Similarly, as required by §§ 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

Texas has such a process in accordance with §§ 455.13-17 and 438.608(a)(7). UMCC Attachment B-1, Section 8.1.20.2, requires MCOs to utilize the HHSC-OIG fraud referral form through the Waste, Abuse, and Fraud Electronic Reporting System (WAFERS). The MCO's assigned officer, or director must report and refer all possible acts of fraud, waste, or abuse to the HHSC-OIG within 30 business days of receiving the reports of possible acts of fraud, waste, or abuse from the MCO's SIU.

Referrals must be submitted through the online portal as required by HHSC-OIG. The referral must also be submitted to the MFCU. There is an expedited referral process when the MCO has reason to believe: that a delay may result in harm or death to the patient; there is a possibility for loss, destruction, or alteration of valuable evidence; there is a potential for significant monetary loss that may not be recoverable; or that a delay may result in the hindrance of an investigation or criminal prosecution of the alleged offense.

CMS observed a lack in the quality and quantity of case referrals from the MCOs. The MFCU also indicated during the interview with CMS a concern in the quality and quantity of fraud referrals for the review period.

Observation #6: CMS encourages Texas to work with the MCOs to improve the quality and quantity of case referrals through routinely providing specific program integrity training and frequent feedback to the MCOs regarding their case referral performance. Also, CMS encourages HHSC-OIG to collect or track referrals that are sent to the MFCU from the MCOs.

MCO Oversight of Network Providers

CMS verified whether each Texas MCO had an established process for conducting investigations and making referrals to the state, consistent with CMS requirements and the state's contract requirements.

All four MCOs reported use of an internal or contracted SIU tasked with identifying and conducting investigations of potential fraud, waste, and abuse. Indicators of potential issues were identified through various sources including but not limited to data analytics, hotline calls, internal department referrals, externally from providers, or members. Cases that are determined to be credible are documented and reported to the HHSC-OIG and MFCU simultaneously.

CMS determined that Amerigroup, Molina, and Superior did have a policy and utilized corrective action plans during the review period. However, CHC did not have an adequate corrective action plan policy specifically addressing communication with the state in cases involving the use of the adverse action escalation process and termination of the provider.

CMS also noted HHSC-OIG does not track or collect information on provider self-audits.

Overall, CMS found the reported MCO processes for the investigation of suspected fraud, waste, and abuse to meet CMS requirements and state contract requirements.

Figure 1 below describes the number of investigations referred to Texas by each MCO. As illustrated, the numbers below in Table 1 only represent overpayments reported by the MCOs due to fraud and abuse.

Figure 1. Number of Investigations Referred to Texas by each MCO

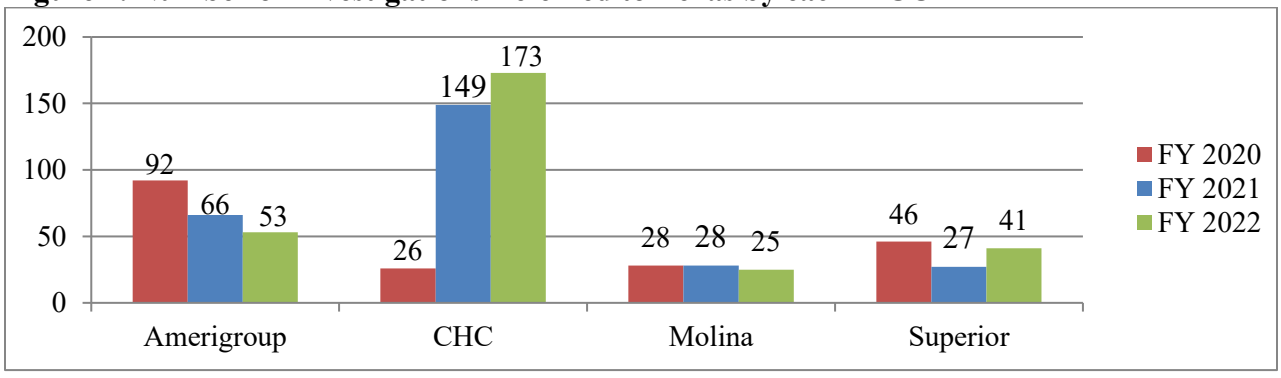

Table 1, below, describes each MCO's recoveries from program integrity activities. The state

must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process (§ 438.608(d)(4)). Without these adjustments, MCOs could be receiving inflated rates per member per month.

Table 1: MCO Recoveries from Program Integrity Activities

Amerigroup's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	110	342	$11,462,668.84	$659,343.59
2021	147	442	$9,986,879.72	$1,780,092.72
2022	177	506	$5,377,713.60	$3,040,440.27

CHC's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	108	86	$962,869.60	$755,040.63
2021	213	198	$763,689.52	$1,144,201.75
2022	237	214	$1,885,767.08	$1,176,501.58

Molina's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	106	58	$ 528,680	$ 13,889
2021	404	317	$ 3,114,490	$ 650,553
2022	183	149	$ 1,506,479	$ 456,699

Superior's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	157	96	$ 2,887,062.00	$ 169,472.94
2021	158	94	$ 4,437,705.01	$ 1,302,799.74
2022	218	137	$ 6,248,009.42	$ 1,616,954.07

Observation #7: CMS encourages Texas to ensure that the MCOs have sufficient corrective action plan procedures in place per contract requirements and utilize corrective action plans appropriately to address non-compliant Medicaid providers.

Observation #8: CMS encourages Texas to track and collect information regarding provider self-audits.

E. Encounter Data

In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. Additionally, § 438.242 further states that state MCO contracts must specify the frequency and level of detail of beneficiary encounter data, including allowed amount and paid amount, that the state is required to report to CMS under § 438.818. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

Through a review of Texas' MCO general contract and interviews with each of the MCOs, CMS determined that Texas was in compliance with § 438.242. Specifically, the contract language states the MCOs must have a system(s) that will provide information on areas including, but not limited to, utilization, claims, grievances, appeals, and disenrollment for other than loss of Medicaid eligibility.

In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO. Texas was in compliance with § 438.602(e). Specifically, HHSC contracted for independent agreed upon procedure reviews of the Medicaid and CHIP Financial Statistical Reports. These reviews are conducted retroactively for every state fiscal year. An HHSC contracted external quality review organization (EQRO) reviews encounters and publishes the reports. The HHSC was in compliance with § 438.602(e) for the review period.

In addition, while it is not a requirement, regularly analyzing the encounter data submitted by MCOs will allow the state to conduct additional program integrity activities, such as identifying outlier billing patterns, payments for non-covered services, and fraudulent billing. Texas has a process to regularly analyze MCO encounter data for program integrity purposes. Specifically, UMCC Attachment B-1, Section 8.1.19.3, requires the submission of complete, unredacted, and accurate data for all fields required on standard billing forms or electronic claim formats. Should the MCO deny a provider's claims, either as Adjudicated-Denied Claims or Deficient-Denied Claims, the MCO must submit all available claims data, for such denied claims, to the HHSC-OIG without alteration or omission.

CMS did not identify any findings or observations related to these requirements.

IV. Conclusion

CMS supports Texas' efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified eight observations that require the state's attention.

The state is not required to develop a corrective action plan for any observations included in this report. However, CMS encourages the state to take the observations into account when evaluating its program integrity operations going forward.

CMS looks forward to working with Texas to build an effective and strengthened program integrity function.

V. Appendices

Appendix A: Status of Prior Review

Texas' last CMS program integrity review focused on PCS and was in February 2018, and the report for that review was issued in January 2019. The report contained ten recommendations. The findings from the 2018 Texas focused PI review report have all been satisfied by the state.

Appendix B: Technical Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCUs.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address overpayment and recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. https://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Appendix C: Enrollment and Expenditure Data

Table C-1 and Table C-2 below provide enrollment and expenditure data for each of the selected MCOs.

Table C-1. Summary Data for Texas MCOs

Texas MCO Data	Amerigroup	CHC	Molina	Superior
Beneficiary enrollment total	965,293	364,891	268,886	1,245,945
Provider enrollment total	49,231	22,459	26,534	60,211
Year originally contracted	1999	1999	2006	1999
Size and composition of SIU	22**	5	6*	14
National/local plan	National /Local	National	National	National /Local

***** - Molina Healthcare of Texas is managed locally but is supported at the national level by Molina Healthcare Inc. SIU.
** - Amerigroup is supported at the national level by Anthem's SIU.

Table C-2. Medicaid Expenditure Data for Texas MCOs

MCOs	FY 2020	FY 2021	FY 2022
Amerigroup	$87,165,769	$90,304,392	$89,530,267
CHC	$63,603,496	$63,268,529	$59,441,736
Molina	$13,154,870	$11,707,601	$13,372,704
Superior	$153,142,173	$148,707,024	$142,611,834
Total MCO Expenditures	$317,066,308	$313,987,546	$304,956,541

Appendix D: State Response

State PI Review Response Form

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
N/A	No recommendations are included in this report.	**X**	

Acknowledged by:

Emily Zalkovsky, State Medicaid Director

_____
[Name], [Title]

08/12/2025

_____
Date (MM/DD/YYYY)