Program Integrity in Managed Care

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House Human Services Committee
May 9, 2018

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Agenda

Program Integrity in Managed Care

- Program integrity issues unique to managed care
- Program integrity issues across different states
- Current OIG efforts
- Discussion topics going forward

Program Integrity Challenges in Medicaid Managed Care

FFS Characteristics	Managed Care Characteristics	Program Integrity Risks Specific to Managed Care Systems
State pays providers for services	State pays MCO a capitated payment	• Incorrect or inappropriate capitation rate setting for MCO payments • Underutilization of services by MCO enrollees
State processes claims	MCO processes claims	• Inaccurate encounter (claims) data submitted by MCO • Failure of MCO staff to cooperate with state investigations • Focus on cost avoidance, not recoupment of state dollars
State oversees individual providers and contracts	State oversees MCO contract, MCO can subcontract	• MCO submits incomplete or inaccurate information on contract performance • Lack of access to subcontractor information on contract performance or falsification of information
State pays providers on a FFS basis	MCO can subcapitate providers or use other incentives	• Underutilization by MCO enrollees • Inappropriate physician incentive plans

Source: MACPAC. Report to Congress on Medicaid and CHIP. June 2017. Chapter 3. Program Integrity in Medicaid Managed Care. Table 3-1. Characteristics of Fee-for-Service and Managed Care Delivery Systems and Program Integrity Risks Specific to Managed Care.

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Federal Study of Program Integrity Practices Findings

- Managed care oversight lags FFS oversight as an area of state and federal focus
  - Less direction - Federal Medicaid Managed Care rule was only adopted in 2016
  - Poor data
- State oversight of MCO program integrity and MCO program integrity activities vary
  - Contract requirements
  - Reporting requirements
  - Communication and collaboration
- Difficulty in measuring success of program integrity efforts in managed care

Source: MACPAC. Report to Congress on Medicaid and CHIP. June 2017. Chapter 3. Program Integrity in Medicaid Managed Care.

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CMS Program Integrity Reviews in Other States

CMS conducts a focused review of states to determine the extent of program integrity oversight of the managed care program at the state level.

State	CMS Recommendations (not all inclusive)
Florida (2018)	• Develop and provide PI training to develop and enhance quality of referrals to MCEs. • Require a detailed compliance plan that includes a fully-developed process for the beneficiary verification of services. • Continue efforts to improve the state's ability to analyze encounter data
Arizona (2017)	• Establish regularly scheduled meetings between the state and the MCOs to discuss the volume of and quality of cases referred, and program integrity contract requirements. Meetings should focus on MCOs with low overpayments identified and collected.
Alabama (2017)	• The AMA should include contract language to ensure that their managed care entities build program integrity units with sufficient resources and staffing commensurate with the size to conduct the full range of program integrity functions including the review, investigation, and auditing of provider types where Medicaid dollars are most at risk.

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Texas Medicaid Program Integrity Focused Managed Care Review (2016) – CMS Recommendations

- Ensure that the MCOs establish and maintain a special investigative unit (SIU) that meets contractual requirements.
- Obtain evidence from MCOs in support of statements attributing a decline in overpayments as the direct result of cost avoidance activities or proactive measures in place.
- Improve communication between HHSC MCS and HHSC OIG through attendance and participation at regularly scheduled meetings that facilitate the active sharing of program integrity information.

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OIG Managed Care Focused Activities

Primary Tools

- Audits
- Reviews
- Inspections
- Investigations

Other Tools

- Data Analytics
- Program Integrity Subject Matter Experts
- Provider Enrollment

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OIG Report Recommendations

Cost Avoidance Report (Rider 151)

a. Require MCO reporting of performance measures based on the dollar value of costs avoided and the value of costs avoided as a percent of total paid claims.

b. Require MCOs to use standard methodologies to calculate and evaluate their cost avoidance related to fraud, waste and abuse prevention activities.

Special Investigative Units Report (Rider 152)

a. Recommendations regarding specific staff, training and use of data analytics

b. Improve efforts for member verification of services

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Moving Forward in Managed Care

Cost Avoidance

Value Based Purchasing

Data

Referrals/ Complaints

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Questions?

Cost Avoidance and Waste Prevention Activities

Rider 151, Article II, Health and Human Services Commission

OIG reviewed cost avoidance and waste prevention activities employed by managed care organizations and as a result made the following recommendations:

- Require reporting of performance measures based on the dollar value of costs avoided and the value of costs avoided as a percent of total paid claims.
- Require managed care organizations to use standard methodologies to calculate and evaluate their cost avoidance related to fraud, waste, and abuse prevention activities.
- Establish a workgroup with stakeholders to develop standardized methodologies for performance measure reporting managed care organizations to the state.

Special Investigative Units Review

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Rider 152, Article II, Health and Human Services Commission

The OIG reviewed the managed care organizations' fraud, waste, and abuse activities and their special investigative units. As a result, the OIG made the following recommendations:

- Managed care organizations should employ an SIU manager whose time is 100 percent dedicated to direct oversight of their SIU and fraud, waste, and abuse activities.
- Meet contract requirements that will be developed by the state for the method and frequency of member verification of services.
- Employ or subcontract SIU staffing that includes, at minimum, a full-time equivalent position who is either an accredited investigator or an investigator who's a certified fraud examiner.
- Use standardized methodologies developed by the state, with stakeholders input, to calculate and evaluate their cost avoidance savings related to fraud, waste, and abuse prevention activities.
- Require SIU staff, including those employed by a third party to conduct SIU activities, to attend national organizations' fraud, waste, and abuse focused trainings to learn and adopt innovative techniques for the prevention, detections, and investigation of fraud, waste, and abuse.
- Ensure program integrity activities are integrated into each business area responsible for providing support to the SIU and/or executing fraud, waste, and abuse activities through documented and up to date policies and procedures that clearly define roles, responsibilities and performance expectations.
- Periodically review and revise algorithms for fraud, waste, and abuse detection focused data analytics.
- Use non-traditional third-party resources to gather information to aid in fraud, waste, and abuse detection and investigation efforts.