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Medicaid Managed Care and State Compliance

Managed Care Compliance Conference
February 2010



Medicaid Managed Care and State Compliance

Session Goals:

- State expectations of Medicaid Managed Care Organizations (MCOs)
- Methods states use to provide independent oversight of MCOs
- Auditing of MCOs
- Financial attestation of MCOs
- Risks to states
- What states and MCOs can expect from independent oversight



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Who is Clifton Gunderson?

- **14th largest CPA firm in the nation.**
- **Dedicated health care practice serving government.**
- **36% of our business from public sector clients in FY 08.**
- **Provided state HHS clients with audit and consulting expertise for more than 40 years.**
- **Also provide services to OIG, CMS, DOJ, FBI and U.S. Attorneys General.**



State Medicaid Contractors

- Managed Care Organizations
- Fiscal Intermediaries/MMIS Administrators
- Enrollment Brokers
- Electronic Benefits Transfer (EBT) Contractors
- SCHIP Contractors (Insurance Companies, Third Party Administrators, MCOs, FFS)
- EQRO
- This presentation will focus on Managed Care Organizations
- We can have a discussion on other contractors at the end of the presentation

Medicaid Managed Care Penetration



MEDICAID MANAGED CARE TRENDS				
	TOTAL MEDICAID	MANAGED CARE	OTHER	% MANAGED CARE
YEAR	POPULATION	POPULATION	POPULATION	ENROLLMENT
2008	47,142,791	33,427,582	13,715,209	70.91%
2007	45,962,271	29,463,098	16,499,173	64.10%
2006	45,652,642	29,830,406	15,822,236	65.34%
2005	45,392,325	28,575,585	16,816,740	62.95%
2004	44,355,955	26,913,570	17,442,385	60.68%
2003	42,740,719	25,262,873	17,477,846	59.11%
2002	40,147,539	23,117,668	17,029,871	57.58%
2001	36,562,567	20,773,813	15,788,754	56.82%
2000	33,690,364	18,786,137	14,904,227	55.76%
1999	31,940,188	17,756,603	14,183,585	55.59%

Medicaid Managed Care Enrollment – December 31, 2008



STATE	MEDICAID ENROLLMENT	MANAGED CARE ENROLLMENT	PERCENT IN MANAGED CARE
California	6,596,834	3,469,762	52.60%
New York	4,244,695	2,792,409	65.79%
Texas	3,076,366	2,116,074	68.78%
Pennsylvania	1,894,800	1,519,799	80.21%
Illinois	2,043,900	1,430,400	69.98%
Florida	2,297,617	1,419,896	61.80%
Ohio	1,855,908	1,274,565	68.68%
Georgia	1,320,343	1,212,834	91.86%
Tennessee	1,190,621	1,190,621	100.00%
Michigan	1,589,886	1,012,429	63.68%
Arizona	1,090,688	986,479	90.45%
Puerto Rico	998,981	967,422	96.84%
North Carolina	1,397,747	958,089	68.55%
Washington	978,366	900,752	92.07%
Missouri	842,230	818,890	97.23%
Massachusetts	1,144,335	731,533	63.93%
Louisiana	1,078,188	713,150	66.14%
New Jersey	931,776	685,594	73.58%
Kentucky	747,740	673,192	90.03%
Indiana	916,743	669,177	73.00%

Medicaid Managed Care Enrollment – December 31, 2008

STATE	MEDICAID ENROLLMENT	MANAGED CARE ENROLLMENT	PERCENT IN MANAGED CARE
Maryland	732,794	570,362	77.83%
Oklahoma	598,034	531,254	88.83%
Alabama	782,786	517,720	66.14%
Arkansas	629,374	506,361	80.45%
Mississippi	674,734	496,734	73.62%
Wisconsin	907,455	474,168	52.25%
Colorado	449,263	431,685	96.09%
Minnesota	624,115	384,141	61.55%
Oregon	449,777	366,001	81.37%
New Mexico	483,472	314,805	65.11%
Iowa	382,785	312,170	81.55%
Connecticut	445,489	295,274	66.28%
Virginia	778,268	293,911	37.76%
South Carolina	744,229	285,871	38.41%
Kansas	284,198	246,289	86.66%
Nevada	194,873	188,359	96.66%
Utah	216,484	182,832	84.46%
Hawaii	222,921	180,139	80.81%
Nebraska	211,283	172,917	81.84%
Maine	258,751	164,285	63.49%

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Medicaid Managed Care Enrollment – December 31, 2008

STATE	MEDICAID ENROLLMENT	MANAGED CARE ENROLLMENT	PERCENT IN MANAGED CARE
Idaho	188,513	151,341	80.28%
West Virginia	314,390	141,408	44.98%
Vermont	145,331	137,712	94.76%
Delaware	156,723	116,054	74.05%
Rhode Island	172,349	108,436	62.92%
South Dakota	106,626	102,420	96.06%
Dist. of Columbia	149,059	97,897	65.68%
New Hampshire	119,739	89,635	74.86%
Montana	78,202	50,653	64.77%
North Dakota	56,686	34,989	61.72%
Alaska	95,819	0	0.00%
Virgin Islands	7,728	0	0.00%
Wyoming	62,625	0	0.00%
TOTALS	47,962,639	33,488,890	69.82%

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What are States Looking For From Independent Monitoring?

- Service Delivery
- Value
- Contract Compliance
- Performance Measurement
- Avoidance of Failure
- Statutory Compliance (e.g., HIPAA)
- Sensitivity to political environment



Medicaid Managed Care Organizations

- Deficit Reduction Act requires Medicaid MCOs and related parties receiving > \$5m in Medicaid funds to develop a compliance policy.
- 42 CFR §438.602 and 42 CFR §438.604
- **§ 438.602 Basic rule.** As a condition for receiving payment under the Medicaid managed care program, an MCO, PCCM, PIHP, or PAHP must comply with the applicable certification, program integrity, and prohibited affiliation requirements of this subpart.
- **§ 438.604 Data that must be certified.** (a) *Data certifications.* When state payments to an MCO or PIHP are based on data submitted by the MCO or PIHP, the state must require certification of the data as provided in §438.606. The data that must be certified include, but are not limited to, enrollment information, encounter data, and other information required by the state and contained in contracts, proposals, and related documents.



Medicaid Managed Care Organizations

- Certification is by CEO or CFO
- Is certification adequate for a state's protection? History relating to hospital cost reports suggests that the answer is no.



Medicaid Managed Care Organizations

- Risks to a State Medicaid Agency
 - Administrative costs
 - Complex organizational structure
 - Related party transactions
 - Contractor oversight/quality of care
 - HIPAA
 - Contract compliance
 - Performance reporting



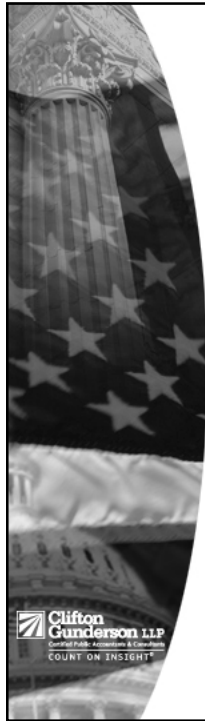
Medicaid Managed Care Organizations

- Risks to a State (cont'd)
 - Provider network adequacy
 - Provider network geography
 - Utilization Management
 - IT systems (e.g. enrollment, eligibility, provider availability, encounter/claims)
 - Complaints
 - Data reporting



Medicaid Managed Care Organizations

- Risks to a State (cont'd)
 - Costs (Financial and Statistical Reporting)
 - Enrollment/denial of service
 - Data interfaces
 - Prompt payments to providers
 - Risks related to size and geographical coverage
 - Rapid growth in Medicaid managed care has meant that MCO internal controls has not kept pace with their own growth



Medicaid Managed Care Organizations

- Risks to a State (cont'd)
 - Compliance with state insurance commission requirements
 - Contract compliance
 - E.g. call centers, marketing, carve-outs (behavioral health, value adds, vision, dental, outreach, websites)
 - Organizational risks (internal control environments, risk response systems, identification of adverse events, internal risk assessment activities, attention to detail by staff, tone at the top, other COSO ERM components)
 - Vulnerable populations - EPSDT



Medicaid Managed Care Organizations

- Examples of items some states have issues with:
 - Medicaid MCOs have been known to charge up to 15% (including a markup on their affiliates/ subsidiaries)
 - Policies and procedures in conflict with contract
 - Low provider reimbursements/ use of leased networks
 - Ineffective compliance with HIPAA Privacy and Security Rule standards to safeguard PHI



Medicaid Managed Care Organizations

- Examples of items some states have issues with (cont'd):
 - Use of subcontractors that did not comply with HIPAA, e.g. disclosing PHI without authorization in call centers and in UM; maintenance of documentation requirements
 - Not notifying state of HIPAA violations (contractual requirement)
 - No risk analysis or assessment of risks and vulnerabilities related to electronic PHI as required in the Security Rule
 - Logical access control deficiencies that could lead to inadequate safeguards against unauthorized modification, disclosures, loss of ePHI at TPAs



Medicaid Managed Care Organizations

- Examples of items some states have issues with (cont'd):
 - Lack of review of system logs
 - Lack of review to ensure backup tapes are properly maintained or tracked
 - Incorrect or incomplete disaster recovery plans
 - Lack of encryption when transmitting ePHI over external networks



Medicaid Managed Care Organizations

- Examples of items some states have issues with (cont'd):
 - Inadequate HIPAA training
 - Outdated BAAs
 - Deficiencies in privacy notices
 - Inadequate monitoring of material subcontractors, e.g. noncompliance with NCQA sample sizes for oversight audits and infrequent audits



Medicaid Managed Care Organizations

- Examples of items some states have issues with (cont'd):
 - Lack of effective organizational and IT systems and controls to comply with contract, e.g. timely mail out of member materials, ensuring provider availability, utilization management and quality improvement processes
 - Incorrect reporting of provider availability to the state



Medicaid Managed Care Organizations

- Examples of items some states have issues with (cont'd):
 - Overreliance on self-reported data from subcontractors
 - Inadequate review of subcontractor's provider credentialing
 - State not being informed of subcontractor lapses (despite this being a contractual requirement)
 - Lack of follow-up to member complaints



Medicaid Managed Care Organizations

- Examples of items some states have issues with (cont'd):
 - Inadequate UM program, policies and procedures, e.g. ensuring quality is not adversely impacted by financial and reimbursement related processes and decisions
 - No management tools to monitor UM requests status. E.g. in SFY 2009, we found 139 cases from SFY 2008 pending
 - Ineffective IRR
 - Error rates of up to 42% in reporting PCP encounter data (state's acceptable criteria is less than 10%)



Medicaid Managed Care Organizations

- Examples of financial items we have identified

State A

- Reconciliation of financial and statistical data reported on the regional and statewide financial monitoring reports back to supporting claims data
- Calendar years 2000 through 2006
- Administrative costs
- Related party costs
- Individual MCO reports and cumulative report



Medicaid Managed Care Organizations

- Examples of financial items we have identified

State A (cont'd)

- Reduced related party management fees to actual cost
- Excluded lobbying expenses, contributions and income taxes
- Excluded administrative fees for services provided by a parent organization, which did not represent a pass through of actual costs
- Management fees relating to other state's operations were excluded



Medicaid Managed Care Organizations

- Examples of financial items we have identified

State A (cont'd)

- Impact of Audit Findings:
 - *FY 2004* – Administrative expenses reduced by \$18m (13%)
 - *FY 2003* – Administrative expenses reduced by \$29.4m (20%)
 - *FY 2002* – Administrative expenses reduced by \$25.9m (20%)
 - *FY 2001* – Administrative expenses reduced by \$18.5m (15%)



Medicaid Managed Care Organizations

- Examples of financial items we have identified

State B

- Tested the accuracy and allowability of administrative expenses reported by Medicaid MCOs in their annual reporting to the state insurance department



Medicaid Managed Care Organizations

- Examples of financial items we have identified

State B (cont'd)

- Excluded lobbying expenses, contributions and income taxes (\$6.5 million)
- Excluded administrative fees for services provided by a parent organization, which did not represent a pass through of actual costs (\$700,000)
- Excluded administrative expenses that were inadvertently overstated (\$1.3 million)
- Excluded expenses related to Securities and Exchange Commission reporting (\$4,414)



Medicaid Managed Care

Examples of other work – cost settlements and pricing reviews (cont'd):

Entity	Time Period	Sum Recoupable by the State
State Medicaid Fiscal Intermediary	Year Ended Aug. 31, 2003	\$220,844
State Medicaid Fiscal Intermediary	Sept. 1, 2003-Dec. 31, 2003	\$576,393
State Medicaid Fiscal Intermediary	Year Ended Aug. 31, 2007	\$3,477,143
Medicaid Enrollment Broker	14-Month Period Ended Oct. 31, 2005	\$84,358
Medicaid Enrollment Broker	Year Ended Aug. 31, 2002	\$128,487
Medicaid Enrollment Broker	Year Ended Aug. 31, 2003	\$202,989
Medicaid Enrollment Broker	Year Ended Aug. 31, 2004	\$129,655
Total		\$4,819,869



Medicaid Managed Care Organizations

Other Reasons for Vigilant State Oversight:

- Amerigroup Illinois – was paid \$243M in Medicaid managed care between 2000 and 2004
- August 2002 whistleblower alleged Amerigroup and its Illinois subsidiary
 - followed policy of not enrolling high risk individuals (AIDS, cancer, third trimester of pregnancy)
 - Falsified certification on compliance with anti-discrimination
 - Submitted false claims



Medicaid Managed Care Organizations

Other Reasons for Vigilant State Oversight (cont'd)

- 2005 – U.S. and Illinois sues Amerigroup
- March 2007 - \$334M in penalties assessed
- August 2008
 - Amerigroup pays \$225M to feds and Illinois to settle lawsuit
 - Paid additional \$9M in legal fees
 - Enters into corporate integrity agreement (that extends to all states it does business in)



Medicaid Managed Care Organizations

- Other cases
 - Wellcare in Florida enters into a Deferred Prosecution Agreement in May 2009 for defrauding Medicaid – pays \$80M in restitution and civil forfeiture
 - Healthfirst pays \$35M in September 2008 to settle a suit by the NY AG for giving bonuses to marketing reps based on the number of members they enroll (which contravened their contract with the State)

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State's Oversight Responsibilities for Medicaid Managed Care

- Reporting and oversight
- Independent verification of reporting
- Mitigate the risks that it is assuming
 - Commonly accepted in Medicaid managed care that the MCO assumes the risk – that is only partially correct
 - The state assumes a large risk because it bears the public responsibility for failings and shortcomings of an MCO's performance
 - OIG conducts independent reviews – best to be prepared

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Medicaid MCOs and Fraud

- Trust but verify – partnerships between Medicaid agencies, MCOs and auditors help keep each other honest
- Current environment favors fraud more than ever:
 - Incentive: Poor economic climate; profit goals
 - Opportunity: Growth and large numbers of Medicaid enrollees
 - Rationale: Health Care reform and potential limits on medical loss ratios (rationale); greater competition



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