MACPAC

Medicaid Managed Care Program Integrity

Medicaid and CHIP Payment and Access Commission
Moira Forbes and Jessica Morris

January 26, 2017

Overview

- Background
- MACPAC study
- Findings
- Next steps

Managed Care Program Integrity

- Managed care is a large and growing delivery system within Medicaid
  - $230 billion in spending in 2015
  - 60 percent enrolled in comprehensive managed care
- Program integrity activities ensure that federal and state dollars are spent appropriately
  - Deliver quality, necessary care
  - Prevent fraud, waste, and abuse
- Differences between fee-for-service and managed care require dedicated PI approach

Program Integrity Risks under FFS and Managed Care

FFS	Managed Care	Potential Program Integrity Risk
State pays providers for services	State pays MCOs a capitated payment	• Incorrect or inappropriate rate setting • Underutilization
State processes claims	MCO processes claims	• Inaccurate encounter or claims data • Coordination with investigations and prosecutions of fraudulent claims • Focus on avoidance, not recoupment
State oversees individual providers and contracts	State oversees MCO contract; MCO can subcontract	• Incomplete or inaccurate information on contract requirements • Lack of access to subcontractor information or falsification of information • Underutilization
State pays providers on a fee for service basis	MCO can subcapitate providers or use other incentives	• Underutilization • Inappropriate physician incentive plans
State covers all Medicaid beneficiaries	MCO covers only assigned/enrolled beneficiaries	• Payment to MCOs for non-enrolled individuals • Marketing or enrollment fraud
State contracts with all qualified providers	MCO contracts with a select provider network	• Lack of adequate provider network • Tension between removing risky providers and maintaining network adequacy

Managed Care Program Integrity Oversight

- Prior to 2016, there was limited federal rulemaking specifically addressing managed care program integrity
  - Federal requirements for state oversight included many elements, not just program integrity
  - State requirements for MCOs varied
  - MCOs used program integrity and other activities to manage expenditures within capitated budget
- New rule lays out consistent expectations for Medicaid MCOs and states

Program Integrity at MCO Level

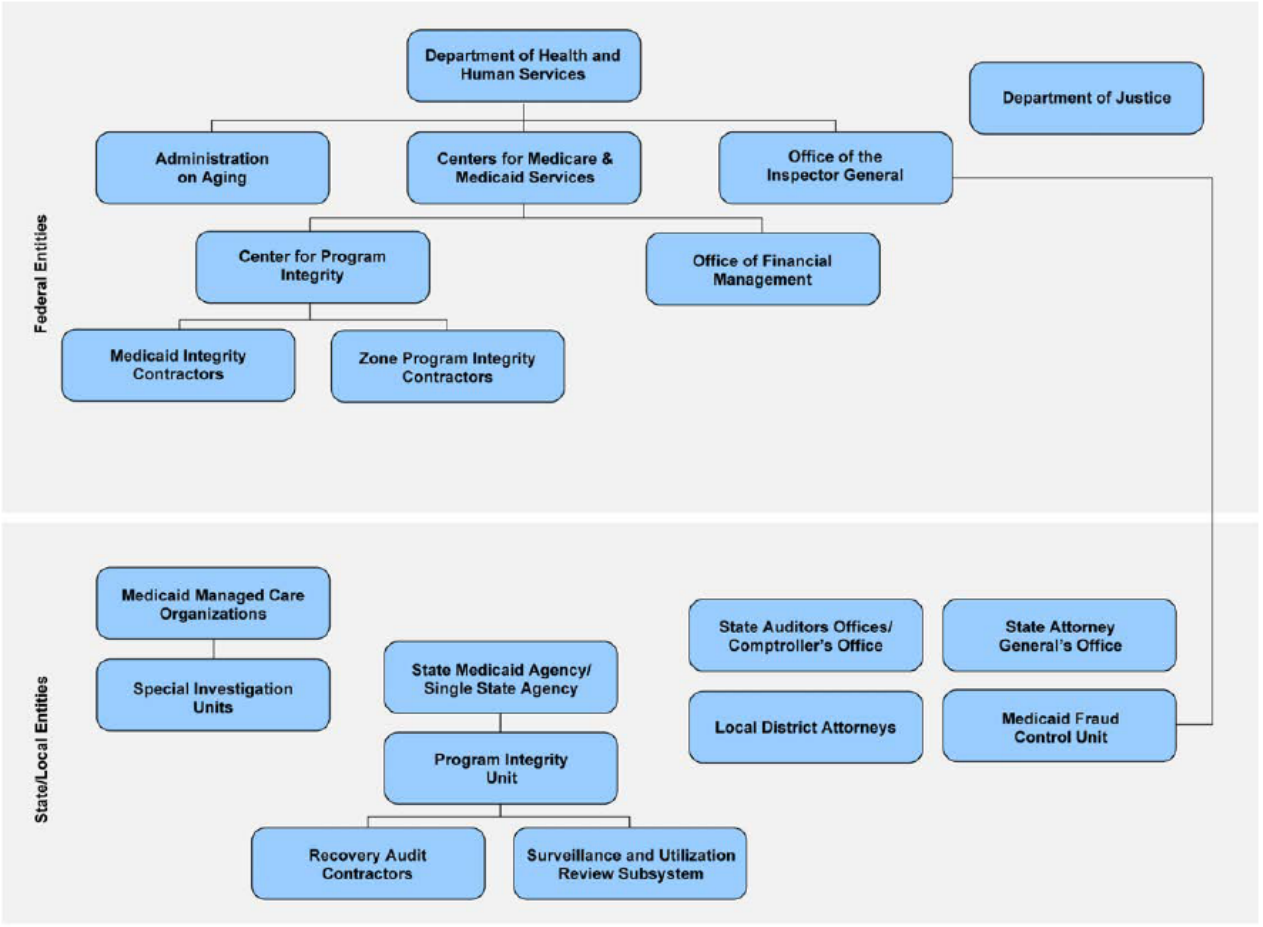
Managed Care Program Integrity Risk	Regulatory Requirements for MCOs
• Incorrect or inappropriate rate setting	• Medical loss ratio reporting • Annual report on overpayment recoveries
• Inaccurate encounter or claims data (from providers and subcontractors) • Coordination with investigations and prosecutions of fraudulent claims • Incomplete or inaccurate information on contract requirements • Lack of access to subcontractor information or falsification of information • Inappropriate physician incentive plans	• Requirements for encounter data submission • Reporting and recovery requirements specified in contracts • Periodic independent audit of encounter data (state or MCO?) • Validate that billed services were received by enrollees • Promptly refer potential waste, fraud, and abuse • Suspend payments to network providers if there is a credible allegation of fraud
• Payment to MCOs for non-enrolled individuals • Marketing or enrollment fraud	• Notify state about changes in enrollee eligibility status
• Lack of adequate provider network/underutilization	• Screen and enroll all network providers • Provide data demonstrating compliance with provider network requirements

Program Integrity at State Level

Managed Care Program Integrity Risk	Regulatory Requirements for State
• Incorrect or inappropriate rate setting	• Provide additional data for capitation rate development, certification, and federal review
• Inaccurate encounter or claims data • Coordination with investigations and prosecutions of fraudulent claims	• Monitor MCO compliance with program integrity provisions • Post MCO data on state website • Subject to partial withhold of federal match for failure to submit encounter data
• Incomplete or inaccurate information on contract requirements • Lack of access to subcontractor information or falsification of information • Underutilization in subcontracted/capitated providers • Inappropriate physician incentive plans	• Review ownership, control, and exclusion status for MCOs and subcontractors • Modify contracts to require that all subcontractors be held to same provisions as MCO
• Payment to MCOs for non-enrolled individuals • Marketing or enrollment fraud	• Establish clear contractual language regarding acceptable marketing
• Lack of adequate provider network/underutilization	• Establish provider network adequacy standards

Program Integrity Entities

Figure 14: Federal and Non-Federal Entities with Primary Oversight Responsibilities for Medicaid Program Integrity



Source: GAO. | GAO-15-677

MACPAC Study

- Environmental scan of existing state and federal program integrity practices
- Summer and fall 2016 interviews
  - 10 state Medicaid agencies
  - 5 state MFCUs
  - 3 MCOs
  - Several federal stakeholders, including HHS OIG
- December panel of federal and state managed care program integrity experts

Study Questions

- What are the current managed care program practices of MCOs, states, and federal oversight agencies?
- What practices are effective in reducing fraud, waste, and abuse?
- Are the elements incorporated in the final rule sufficient to ensure robust oversight?
- Are there still areas where more could be done, or where things could be done differently to be more effective?

Findings: Current Practices

- Managed care oversight lags FFS oversight as an area of state and federal focus
  - Less guidance
  - Poor data
- State oversight of MCO program integrity and MCO program integrity activities vary
  - Contract requirements
  - Reporting requirements
  - Communication and collaboration

Findings: Effective Practices

- Clear and enforceable contract requirements
  - States seek models from other states
  - Specific contract provisions and reporting requirements both important
- Communication and collaboration
  - Frequent direct communication between states and MCOs is helpful
- Guidance and training
  - Training for state staff at Medicaid Integrity Institute

Findings: New Rule

- Final rule strengthens managed care PI
  - Addresses many of the recommendations made by federal oversight agencies
  - Adapts practices of leading states
- States are preparing to implement the final rule
  - States already comply with many PI provisions
  - Some provisions will require significant changes (e.g., provider screening and enrollment)
- States have identified many specific areas where additional guidance is needed

Findings: Remaining Challenges

- Payment and incentives
- Encounter data
- Coordination, role clarity

Payment and Incentives

- Rules about how managed care plans are paid complicates incentives to invest in program integrity
  - MCOs are at risk for total cost of care for enrollees
  - Program integrity counts as administrative expense
  - Encounter data used to set future capitation rates

Payment and Incentives

- Final rule clarified that state contracts with MCOs have to address treatment of recoveries
  - States have the option to require MCOs to return recoveries to the state or to retain them
  - MCOs must report recoveries either way
- Lack of consensus on whether MCOs should return overpayment recoveries to the state or retain them

Encounter Data

- Accurate and complete data needed to support program integrity (e.g., collaboration across MCOs, data analytics, and potential fraud investigations)
- States and federal entities both cite challenges in obtaining accurate, complete and timely encounter data from MCOs
- New rule strengthens reporting requirements but states expressed a need for guidance and best practices for improving encounter data

Coordination

- There are multiple entities involved in program integrity—especially in reducing provider fraud, waste, and abuse—and clarity of roles and coordination among entities is needed
  - Avoid duplication of effort
  - Ensure proper credit
- MCOs, states, and federal oversight agencies identified the need for more guidance on referrals and coordination among entities

Considerations

- States expressed a need for additional guidance as the PI role is delegated to MCOs
  - Payment and recoveries
  - Encounter data
  - Collaboration
- Difficult to measure the return on investment or to quantify what works and what doesn't
- Variation across states makes it difficult to identify which program integrity approaches work best

Next Steps for MACPAC

- Potential chapter for June 2017 report that discusses these findings
  - Emphasize any themes or findings?
  - Make any directional policy statements or recommendations?
  - Identify additional policy options for analysis?
- Future work in this area could focus on:
  - How to measure effectiveness and impact
  - How to support program integrity in new models such as value based purchasing approaches

MACPAC

Medicaid Managed Care Program Integrity

Medicaid and CHIP Payment and Access Commission
Moira Forbes and Jessica Morris

January 26, 2017