



Department of Medicaid

Managed Care Plan Provider Fraud and Abuse Audit

Audit Period: July through December 2014

Results Summary:

Objective	Conclusion *
Oversight of Managed Care Plans' Fraud and Abuse Safeguards	Improvement Needed
Pay-For-Performance Bonuses to Managed Care Plans	Improvement Needed

* Please refer to Appendix A for classification of audit objective conclusions.



Executive Summary

Background

Most individuals on Medicaid must join a managed care plan to receive health care. Managed Care Plans (MCP) are health insurance companies licensed by the Ohio Department of Insurance and have a provider agreement with the Ohio Department of Medicaid (ODM) to provide coordinated health care. The MCPs work with hospitals, doctors and other health care providers to coordinate care and to provide the health care services that are available with an Ohio Medicaid card. MCPs must have a program that includes administrative and management arrangements or procedures, including a mandatory compliance plan to guard against fraud and abuse. MCPs are required to submit an annual report to ODM summarizing the fraud and abuse activities for the previous year. MCPs are required to promptly report all instances of provider fraud and abuse to ODM.

ODM has established a Pay-For-Performance Incentive System to provide financial rewards to MCPs that achieve specific levels of performance in program priority areas. Standardized clinical quality measures, derived from a national measurement set, Healthcare Effectiveness Data and Information Set (HEDIS), are used to determine incentive payments. Performance bonus payments are funded through the state's managed care program performance payment fund. Performance is assessed on six measures to determine the amount of each MCP's performance bonus payment. MCP performance is assessed using MCP self-reported, audited HEDIS data.

During the audit, OIA identified opportunities for ODM to strengthen internal controls and improve business operations. OIA conforms with the *International Standards for the Professional Practice of Internal Auditing*. OIA would like to thank ODM staff and management for their cooperation and time in support of this audit.

This report is solely intended for the information and use of agency management and the State Audit Committee. It is not intended for anyone other than these specified parties.

Scope and Objectives

OIA staff was engaged to perform an assurance engagement over ODM's oversight of MCPs' Fraud Analysis and Capture Procedures. The work was completed December 2014 through March 2015. The scope of this assurance engagement included key processes related to ODM's oversight of the MCPs, specifically:

1. Fraud and abuse safeguards
2. Pay-for-performance bonuses



The following summarizes the objectives of the review:

- Evaluate the design and effectiveness of ODM's controls to oversee the Managed Care Plans' fraud and abuse safeguards.
- Evaluate the design and effectiveness of controls over pay-for-performance bonuses to Managed Care Plans.

Detailed Observations and Recommendations

The Observations and Recommendations include only those risks which were deemed high or moderate. Low risk observations were discussed with individual agency management and are not part of this report. However, the low risk observations were considered as part of the audit objective conclusions.



Observation 1 – Fraud/Abuse Detection Activities and Analysis

The primary responsibility for program integrity in the Medicaid program lies with the state and federal governments. In managed care, the MCPs and Medicaid Fraud Control Units (MFCU) play important supporting roles to prevent, detect, and control fraud and abuse. 42 CFR section 438.724 requires states to give the CMS Regional Office written notice whenever it imposes or lifts sanctions on MCPs. 42 CFR section 1002.3 requires states to notify the Health and Human Services Office of the Inspector General (OIG) of any actions it takes to limit providers' participation in the Medicaid program.

ODM does not conduct any MCP provider fraud and abuse detection activities. Instead, ODM relies on MCPs to identify, investigate, and refer suspected cases of provider fraud and abuse to ODM; ODM then refers cases to the MFCU at the Ohio Attorney General's Office for investigation. MCPs are also required to submit annual reports to ODM, summarizing the MCP's fraud and abuse activities for the previous year. However, there are weaknesses in these processes. For example:

- ODM tracks MCP referrals of suspected cases of fraud and abuse on a spreadsheet and records the referral date, MCP, provider name and number, and whether the case is considered fraud or abuse. ODM routinely receives investigation outcomes from the MFCU. However, ODM does not reconcile referred cases to investigation outcomes to ensure all cases referred to MFCU have a corresponding outcome, nor does ODM track the outcome on the spreadsheet. Additionally, ODM does not use the referral data for any provider fraud or abuse analysis purposes.
- ODM does not have procedures to review the MCPs' annual fraud and abuse activity reports to help ensure MCPs are completely referring suspected cases of provider fraud or abuse to ODM, or to use the data in the reports for any provider fraud or abuse analysis purposes. This is largely due to the report's narrative format which makes reviews of the information or comparisons between MCPs difficult. ODM is in the process of revising the report's format.

Relying on MCPs to identify all suspected cases of provider fraud and abuse, along with weaknesses in tracking and reconciling MCP case referrals and reviewing MCPs' annual fraud and abuse activity reports, results in vulnerabilities in ODM's oversight of MCPs' fraud and abuse safeguards. This increases the likelihood that cases of MCP provider fraud and abuse are not identified or suspected cases of fraud and abuse are not completely reported to ODM, or that ODM does not comply with CMS and OIG notification requirements. Additionally, it increases the likelihood that other ODM programs (i.e. fee for service or waiver) in which MCP providers suspected of fraud or abuse also provide services are not timely notified to conduct reviews or



data analysis to determine any potential impact to those programs.

Recommendation

To improve oversight of MCPs' fraud and abuse safeguards, ODM should consider the following:

- Develop and implement a policy over MCP provider fraud and abuse oversight. Such a plan should outline the roles and responsibilities of ODM, MCPs, MFCU, and other internal or external parties (i.e. ODM's Surveillance and Utilization Review Section, Network Compliance Unit, and the Ohio Auditor of State) and should outline coordination and information sharing requirements between all parties. A policy may include procedures for conducting a risk assessment to determine the timing and extent of MCP provider fraud and abuse detection activities and to identify problem areas in which to conduct routine reviews.
- Develop and implement procedures to review encounter data submitted by MCPs to identify possible cases of provider fraud or abuse and to identify instances of overutilization and underutilization.
- Track investigation outcomes of suspected cases of provider fraud and abuse from MCP referral through case resolution to ensure each referral is properly addressed, to notify the MCPs of the status of investigations, and to identify opportunities to provide technical assistance to MCPs on the quality of cases if cases do not result in credible allegations of fraud or abuse. Tracking investigation resolutions may help ensure compliance with required notifications to CMS and the OIG.
- Continue to revise the format of the MCPs' annual fraud and abuse activity report to facilitate a comparative analysis of MCPs to identify trends that may require further review. Utilize the annual activity reports to reconcile against the MCP provider fraud and abuse referral spreadsheet maintained by ODM to help verify completeness of MCPs' referrals.
- Develop and implement procedures to utilize the investigation data of suspected cases of provider fraud and abuse referred by MCPs, as well as the annual MCP fraud and abuse activity reports, to facilitate MCP provider fraud and abuse risk assessment processes and to aid in communication of potentially fraudulent MCP providers with other internal and external parties.

Management Response

ODM/Managed Care Operations will review its Tracking of Referrals from MCPs spreadsheet. ODM will immediately augment the spreadsheet by adding Case Resolution and determine whether other areas would assist in fraud and abuse analysis. ODM will develop a formal procedure for tracking referrals from MCPs. The procedure will include at a minimum, when an



allegation is received from the MCPs, whether the provider referred is a waiver provider, whether other entities were notified (e.g. Medical Board), whether other plans employ that provider on their provider network, and investigation outcomes. Implementation Date: June 2015

ODM updated the Fraud and Abuse Activity Report that MCPs must complete annually. ODM will develop and implement a formal procedure to utilize the newly revised Annual Fraud and Abuse Activity Report to conduct analysis and compare MCPs, as well as examine MCPs responses in the annual form and assess whether the suspected fraud and abuse reporting forms parallel the annual form. Implementation Date: June 2015

ODM will develop a policy regarding MCPs provider fraud and abuse oversight. The policy will outline the roles and responsibilities of ODM (including the internal areas of ODM), the MCPs and the relationship with the AGO. The policy will outline coordination and sharing of information with ODM, by ODM, and between MCPs and ODM, as well as, the MCPs and the AGO. Implementation Date: September 2015

ODM will explore conducting a risk assessment to determine timing and extent of MCP provider fraud and abuse detection activities and to identify problem areas in which to conduct routine reviews. ODM will hold preliminary discussions with the MCPs concerning a risk assessment and the process. After the preliminary meetings, ODM will develop an action plan or response that addresses the performance of a risk assessment of MCPs. Implementation Date: September 2015.

ODM is in the process of procuring an advanced data analytics system that will facilitate the analysis of encounter data submitted by the MCPs to identify possible instances of fraud, waste, and abuse and to identify any potential overutilization or underutilization. Once the system is procured, ODM will develop procedures concerning its use. ODM expects to release an RFP and choose a vendor within calendar year 2015. Implementation Date: December 2015.

Risk*	Remediation Owner	Estimated Completion Date
Moderate	Managed Care Contract Administrator	December 2015



Observation 2 – No process to determine if bonus payments affect MCP performance

ODM has established a Pay-For-Performance (P4P) Incentive System to provide financial rewards to MCPs that achieve specific levels of performance in program priority areas. Selected measures align with specific priorities, goals, and focus areas of the ODM Quality Strategy. ODM awards P4P bonuses annually, based on six equally weighted performance measures. For each measure, MCPs are awarded up to 100% of one sixth of the maximum bonus amount.

Evaluation procedures are crucial to determine if the P4P program is working to achieve quality improvements, reduce costs, and determine if bonuses are sufficient to positively affect performance. However, ODM does not have such evaluation policies and procedures. Additionally, causes for MCPs failing to meet performance levels required for bonuses are not identified in order to provide necessary assistance to the MCPs to aid in adjusting practices to affect performance. For example, the maximum possible P4P bonus for state fiscal year 2014 to the five MCPs was \$70.4 million, or one percent of premium payments that ODM paid to MCPs for calendar year 2013. However, the cumulative P4P bonus to the five MCPs was only approximately \$15.3 million, or 22% of the maximum possible P4P bonus. Every MCP failed to achieve the performance level necessary to collect at least a portion of the bonus for at least one of the six performance measures. Furthermore, none of the MCPs were awarded any P4P bonuses for one of the performance measures (appropriate treatment for children with upper respiratory infections), with two MCPs performing below the national HEDIS measures.

Lack of P4P evaluation procedures increases the likelihood that bonuses do not improve outcomes for MCP providers' patients or reduce costs to the MCP program. Furthermore, failure to evaluate the P4P program increases the likelihood that ODM falls short of meeting priorities, goals, and focus areas of the ODM Quality Strategy.

Recommendation

Develop and implement policy and procedures to evaluate the P4P program. Such a policy should outline both short and long-term evaluation procedures. Short-term procedures may include identifying causes for the MCPs failing to meet minimum standards to obtain annual bonuses in order to provide technical assistance to positively affect performance. Long-term procedures may include evaluation of data collected on performance measures over a number of years to identify trends and measure the rate of improvement.

Consider requiring underperforming, regressing, or MCPs that do not demonstrate improved performance at the rate of other MCPs to submit corrective action plans to ODM. Evaluate the size and frequency of P4P bonuses and consider offering bonuses for significant improvements in the P4P areas that MCPs consistently fail to achieve the required levels of performance.



Management Response

ODM would like to clarify that the P4P system was not established to reduce costs to the Managed Care Program. As an incentive based strategy, MCPs’ poor performance on the P4P measures would not be subject to corrective action by the state. However, ODM will develop and implement the following short-term and long-term procedures:

Short-term evaluation procedures

- Establish an operational definition of a ‘low P4P score’ with respect to the annual P4P determination (e.g., a P4P measure rate below the minimum performance standard (MPS));
- Effective with the SFY 2015 P4P determination and on an annual basis thereafter, ODM will require the MCPs to conduct a Quality Improvement Project (QIP) for each P4P measure for which the MCP has a ‘low P4P score.’ For each QIP, the MCP must perform the following activities:
 - 1) conduct a root cause analysis, e.g., pareto chart, failure mode effects analysis, to identify key drivers that may be contributing to their low P4P score,
 - 2) develop and test quality improvement interventions using rapid cycle methodology to address any root causes that may be contributing to the low P4P score,
 - 3) develop a plan to monitor the interventions to assess any changes in the P4P score and to make modifications to the interventions as appropriate and in a timely manner, and
 - 4) submit a summary of their root cause analysis, improvement plan, and monitoring plan to ODM;
- ODM will review all documentation submitted by the MCPs, at a minimum on an annual basis, as applicable;
- ODM will incorporate the above MCP requirements into the *ODM-MCP Provider Agreement* amendment that becomes effective July 1, 2015.

Long-term evaluation procedures

ODM will collect and trend P4P performance data after the new P4P methodology has been in place for 5 years (i.e., 5 data points). This analysis will include performance measure results and P4P bonus payments at the MCP and Ohio Medicaid Program levels, and examine the annual rate of change.

Risk*	Remediation Owner	Estimated Completion Date
Moderate	Measurement & Quality Integration Chief	July 2016



Due to the limited nature of our audit, we have not fully assessed the cost-benefit relationship of implementing the observations and recommendations suggested above. However, these observations reflect our continuing desire to assist your department in achieving improvements in internal controls, compliance, and operational efficiencies.

* Refer to Appendix A for classification of audit observations.



Appendix A – Classification of Conclusions and Observations

Classification of Audit Objective Conclusions

Conclusion	Description of Factors
Well-Controlled	The processes are appropriately designed and/or are operating effectively to manage risks. Control issues may exist, but are minor.
Well-Controlled with Improvement Needed	The processes have design or operating effectiveness deficiencies but do not compromise achievement of important control objectives.
Improvement Needed	Weaknesses are present that compromise achievement of one or more control objectives but do not prevent the process from achieving its overall purpose. While important weaknesses exist, their impact is not widespread.
Major Improvement Needed	Weaknesses are present that could potentially compromise achievement of its overall purpose. The impact of weaknesses on management of risks is widespread due to the number or nature of the weaknesses.

Classification of Audit Observations

Rating	Description of Factors	Reporting Level
Low	Observation poses relatively minor exposure to an agency under review. Represents a process improvement opportunity.	Agency Management; State Audit Committee (Not reported)
Moderate	Observation has moderate impact to the agency. Exposure may be significant to unit within an agency, but not to the agency as a whole. Compensating controls may exist but are not operating as designed. Requires near-term agency attention.	Agency Management and State Audit Committee
High	Observation has broad (state or agency wide) impact and possible or existing material exposure requiring immediate agency attention and remediation.	Agency Management and State Audit Committee