

Office of the State Inspector General

Patrick J. Maley



**Review of Program Integrity Operations
At Six Managed Care Organizations
Delivering Medicaid Services under a Contract with the
South Carolina Department of Health & Human Services**

I. Executive Summary

The State contracted with six managed care organizations (MCOs) to deliver Medicaid managed care at an annual cost of \$2.7 billion, representing 10% of the State's annual budget, to 750,000 Medicaid beneficiaries in South Carolina. MCOs were non-governmental entities designed to leverage market forces and managed care techniques to contain costs and improve healthcare outcomes for a State's Medicaid program. Each MCO was contractually required to detect and deter improper payments, including fraud, waste, and abuse, through an internal function known as "Program Integrity (PI)." MCOs generally deployed three operational strategies to reduce fraud, waste, and abuse among its medical providers: (1) screening providers before accepting into the MCO provider network; (2) reviewing claims before paid known as pre-payment review (PreR); and (3) reviewing claims after paid and recovering any improper payments known as post-payment review (PostR). The Governmental Accounting Office (GAO) deemed Medicaid funds a "high risk" for overpayments with a recent study estimating 7% (\$19 billion) of Medicaid dollars were overpayments. This review examined MCO's PreR and PostR operations as required by contract with the State.

PreR was an internal control strategy using the application of "prepayment edits"—instructions programmed into automated claims processing systems that analyze electronic claim information to approve, deny, or flag claims for additional review. From a SCDHHS contract risk perspective, there was little, if any, risk MCOs were not using automated PreR edits. The contract risk was also lowered by this technique being a key driver in MCOs' business model to control costs. However, it was noted MCO PI functions generally did not have an understanding of PreR overpayment risks in claims, adequacy of PreR mitigation tools and coverage on the differing claim categories, or measures of PreR effectiveness.

PostR served as an internal control to examine paid provider claims for overpayments ranging on a spectrum from a benign coding mistake to criminal conduct. Reviews could be initiated from reactive "hotline" tips, referrals from other healthcare entities, and, likely most important, proactively data mining of paid claims for unusual or aberrant patterns. PostR cases conducted a retrospective audit comparing paid claims data with the provider medical records to identify potential overpayments. Sophisticated random sampling could be used to extrapolate overpayments in a sample to the provider's population of similar claims to arrive at an overpayment demand. This review determined MCOs' collective PostR activities lacked effectiveness based on a lack of results.

During the first 17 months of the current contract (7/1/2014 – 11/30/2015), all MCOs reported initiating 182 PI cases resulting in \$45,721 recoveries, all from a single MCO, from an estimated \$2.3 billion of medical claims paid. MCOs reporting PI cases prior to the current contract period reflected this same pattern with \$62,780 recoveries from 201 cases. Three MCOs openly acknowledged a need to improve; one MCO proffered its PreR emphasis mitigated low PostR results; and two MCOs, one with no recoveries, seemed satisfied. Review of these two satisfied MCOs' best cases revealed one MCO had quality cases prior to the contract period with \$1.6 million in demand letters to six providers, yet PI caseloads and recoveries from demand letters stalled during the contract period due to management turnover, legal review, and PI staff constraints. The second satisfied MCO's five best cases all conducted audits with demand letters totaling \$76,000 and recoveries of \$45,721.

Much like PreR, the MCOs' Compliance Officers and PI functions generally did not have an understanding of PostR identified overpayments outside of the PI function, most notably in the areas of hospital, pharmacy, and PreR operations having its own PostR capabilities. The lack of MCOs' PI functions awareness of PostR occurring elsewhere in the MCO does not mean it was not occurring along with other cost containment techniques. However, the SCDHHS contract required MCOs' PI functions to have policy/procedures in place

to mitigate overpayment risk, yet MCOs' PI functions did not take "ownership" of overpayment risks outside of a narrow view of PostR of fraud and abuse cases, generally professional provider claims representing 27% of Medicaid dollars at risk.

This review observed the MCO PI function seemed to have been watered down to only PostR fraud and abuse investigations, yet PI was designed as an enterprise-wide mechanism to detect and deter overpayments from any organizational function, regardless of the perceived waste, abuse, or fraud motive. A million dollar loss from waste exactly equals a million dollar loss from fraud. Both require understanding the loss transaction to continually build upon an individual MCO's and SCDHHS's risk assessment for overpayments, which then serves as the foundation for coordinated mitigation and control strategies. It seems as if the PI function for all overpayments has fragmented within MCOs, which inhibited the SCDHHS's responsibility to maintain both fiscal and fiduciary oversight of Medicaid funds making improper payments.

The SCDHHS had ample business rationale to require MCOs to report all overcharges from retrospective reviews, regardless of an MCO's perception of intent, which included:

- The judgment and experience to discern the intent and patterns for abuse and fraud for overpayments lies in the PI function in MCOs and SCDHHS;
- SCDHHS had potential equities in all recoveries, regardless of intent, due to the contract's capitated rate model;
- Serves as a quality control ensuring overpayments were appropriately factored into setting the subsequent years' capitation rates;
- A complete picture of all MCO overpayments data serves as critical intelligence to support SCDHHS's overall PI effort for all Medicaid dollars, which can be leveraged to stimulate better targeting of high risk providers across all MCOs, as well as provide leads to MCOs based on abuse or fraud cases in another MCO; and
- Full disclosure of all overcharges protects SCDHHS from inappropriate factors potentially impacting the capitation rate seeping into MCO overpayment settlements with providers.

The MCO model was relatively new to the State, and both the SCDHHS and the MCOs were still adjusting to the current contract's (effective 7/1/2014) heightened performance requirements. It was clear most MCOs recognized the need to improve PI as evidenced by heightened activity and planning since the Fall 2015 after SCDHHS increased its contract monitoring inquiry.

The direction to improve is for SCDHHS to fully understand its risks associated with MCO PreR and PostR operations, followed by enhancing specificity in future contracts with pragmatic requirements and performance measures. This will then allow SCDHHS to build an equally pragmatic contract monitoring framework of data indicators/measures and sets expectations for: 1) level of effort; and 2) results. This framework ensures systematic collection of accurate, reliable, relevant, and auditable data that can be increasingly leveraged over time. As the MCO contract gains experience and maturity, SCDHHS should use the MCO model as intended to leverage contract monitoring tools through comparing MCOs' results to discern relative performance levels, establish harder benchmarks in future contracts, and factor results in future contract requirements, to include penalties and incentives.

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II. Background

A. Predicate

In early 2015, the State Inspector General (SIG) conducted a review of the SCDHHS’s contract monitoring of its managed care contract, which included six managed care organizations (MCO) receiving annual state expenditures of \$2.7 billion. This review found SCDHHS had not built a contract monitoring infrastructure needed to optimally operate its managed care contract to fully realize the health outcomes and cost containment potential of the MCO model. Given over 10% of the state’s entire \$25 billion budget was devoted to Medicaid managed care coupled with the risk identified in the contract management review, the SIG self-initiated a review of a tactical component of the state’s managed care contract pertaining to how each MCO executed its Program Integrity (PI) function to address fraud, waste, and abuse, which also had high risk indicators.

B. Scope & Objectives

This review’s scope and objectives were:

- Test the six MCOs’ compliance and effective execution of the SCDHHS’s managed care contract “Section 11 - Program Integrity” focusing on the operational components of pre-payment review (PreR) and post-payment review (PostR).
- Identify opportunities to improve SCDHHS’s biennial managed care contract, contract monitoring, and MCO compliance and effective execution of the contract.

Reviews by the SIG are conducted in accordance with professional standards set forth by the Association of Inspector General, often referred to as the “Green Book.”

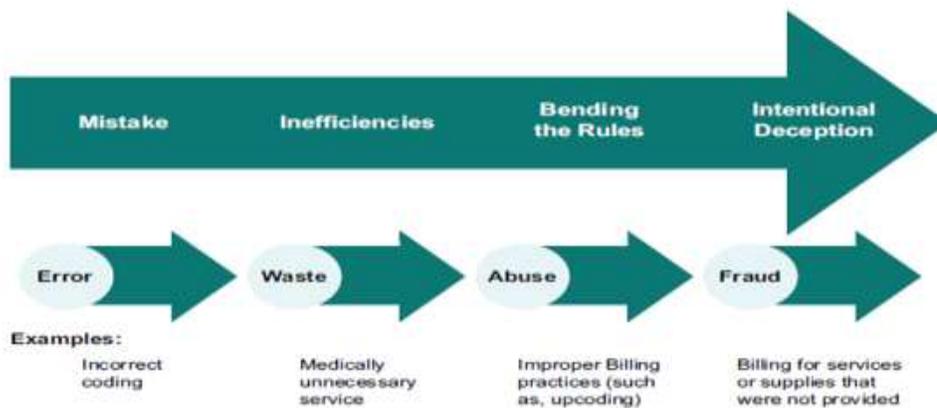
C. Background of Medicaid Managed Care Organizations & the Program Integrity Function

The State contracted with six MCOs to provide Medicaid managed care at an annual cost of \$2.7 billion to 750,000 Medicaid beneficiaries, which accounted for approximately two-thirds of the total Medicaid recipients in South Carolina. MCOs were non-governmental entities designed to leverage market forces and managed care techniques to contain costs and improve healthcare outcomes for a state’s Medicaid program. The MCO model provided the state a mechanism to drive improvement, if optimally operated, through contract goals along with contract controls, incentives, and penalties acting as “levers” to ensure contract goals are achieved.

The State has the following six MCOs under contract:

MCO	Medicaid Enrollees	Percent of Total Medicaid Enrollees	SCDHHS FY14/15 Payment to MCO
Select Health of SC	343,490	46%	\$1,204,000,000
Molina HealthCare of SC	115,247	15%	\$402,000,000
Absolute Total Care, Inc.	107,314	14%	\$428,000,000
BlueChoice HealthPlan	81,926	11%	\$325,000,000
WellCare of SC	68,455	9%	\$236,000,000
Advicare Corp.	31,637	5%	\$122,000,000
Total	748,069	100%	\$2,717,000,000

The State was responsible to protect the integrity of all state Medicaid funds to detect and deter improper payments, including fraud, waste, and abuse (FWA), regardless of the service delivery system. As a result, each MCO was contractually required to establish a FWA program, known as PI. According to Medicaid and Medicare Annual Medical Integrity Report to Congress, “Program Integrity activities target the various causes of improper payments (provider overcharges), ranging from incorrect billing, medically unnecessary services, and erroneous billing practices, to intentional deception by billing for services that were never provided.” These Program Integrity activities are illustrated below:



The spectrum of improper payments ranged from a benign coding mistake to criminal conduct, but each point on the spectrum has a common element being an improper overcharge by a provider which the MCO paid. The difference with points on the spectrum was a provider’s intent at the time of the overcharge.

MCOs had PI compliance requirements for governance and training, and, its PI operational activity generally deployed three strategies to reduce FWA among its providers. These three strategies were: (1) screening providers before accepting into the MCO provider network; (2) reviewing claims before paid known as PreR; and (3) reviewing claims after paid and recovering any improper payments known as PostR.

MCOs have responsibility for identifying improper payments to providers within their plans. However, a background literature scan and several interviews during this review suggested a risk existed that MCOs might not have an incentive to identify and recover improper payments. A May 2014 General Accounting Office (GAO) review of seven states’ oversight of MCOs revealed:

- Two state PI units believed MCOs were not consistently reporting improper payments to the state to avoid appearing vulnerable to fraud and abuse; and
- Three state PI units described a potential conflict of interest because when MCOs report improper payment recoveries, future capitation rates could be reduced because of any improper payments identified. Four state PI units accounted for improper payment recoveries and explained that it negatively impacted the MCO plans’ rates for the following year.

A 2013 report from the Office of the Inspector General, Federal Department of Health & Human Services (OIG-HHS), voiced similar concerns. The report cited managed care entities lacked the incentive to detect and refer potential fraud and managed care entities may have an incentive not to do so. Specifically, managed care entities indicated that (1) they can lose money if their contracts do not allow them to share in fraud-related recoveries and (2) their contracts typically do not include negative consequences for a lack of fraud referrals.

III. MCO Compliance Plans Alignment with SCDHHS Contract Requirements

In 2010, the state required all Medicaid beneficiaries to enroll into a MCO, except for long term care, behavioral health, and dual eligible (Medicare-Medicaid) beneficiaries. Since that time, MCO contracts, which were on a two year cycle, have increasingly become more sophisticated to clarify MCO requirements coupled with specific performance metrics and performance reporting to SCDHHS. Based on other states' MCO experiences, it takes many years and contract cycles to fully mature a MCO contract and its corresponding contract monitoring to reach its optimal performance. Today's MCO contract (7/1/2014 – 6/30/2016) was considered still in an early phase.

The scope of this review pertained to MCOs' PreR and PostR contract requirements, which were contained in contract's "Section 11 - Program Integrity." The MCOs' compliance plans were at a high level overview of a traditional PI function generally meeting the thrust of the contract requirements. However, the majority of plans lacked specificity for certain contract requirements requiring details unique to South Carolina. The best example of omitted details was requirement 11.2.8, "The compliance plan must also outline the contractor's policies, procedures, and performance measures for...data mining...provider audits...audits by recovery audit contractors...quality assurance/utilization reviews of hospital providers...pharmacy audits. Not one compliance plan set forth a performance measure; policies and procedures were light on most of the requested activities; and several of the activities (hospital providers & pharmacy) were not even contained in the plans. Despite some opportunities to improve these compliance plans to fully incorporate specific contract control requirements, the compliance plans were approved by SCDHHS as submitted.

IV. MCO Execution of Pre & Post Payment Operations Requirements

A. Pre-Payment Review

Nationally, PI emphasis has shifted to PreR to prevent improper payments (provider overcharges) from traditional PostR "pay and chase" audits and investigations focused on recovery of improper payments. PI operational experience demonstrates PostR can be difficult and resource intensive to realize recoveries. PreR was an internal control strategy using the application of "prepayment edits"—instructions programmed into automated claims processing systems that analyze electronic claim information to approve, deny, or flag claims for additional review. Prepayment edit programs vary, such as basic National Correct Coding Initiative (NCCI) edits identifying incorrect claim code combinations (claiming more than one appendectomy on the same person), edits tailored to a unique health plan's benefits, and sophisticated predictive analytics (aberrant billing patterns) flagging claims on a real-time basis to review for potential fraud and abuse. PreR also contained a capability to flag a "high risk" provider's claims prior to payment, which could include requesting detail provider medical records to support the claim prior to approving the payment.

MCOs differed in how leads were handled from sophisticated FWA PreR algorithms. Three MCOs had PreR claims personnel conduct retrospective analysis of prior claims to identify overcharges. One MCO had its PI personnel handle this function. All four of these MCOs did not view overpayments identified in this area as abuse or fraud, absent unusual circumstances, which were not reported to SCDHHS.

The MCOs' PI quarterly report to SCDHHS required a metric to identify "cost avoidance," which was a traditional PreR performance metric. Review of each of the six MCOs' five quarterly reports since the inception of the contract (7/1/2014) revealed three MCOs did not report any cost avoidance, while the residual three MCOs claimed \$174,000, \$869,000, and \$4,191,000, respectively. During interview with the six MCO Compliance Officers and PI operational personnel, four MCOs did not have specific knowledge of their PreR prepayment edits or effectiveness measures. Further, there were two different views on the methodology calculating the cost avoidance measure. Most described the metric as claims rejected by PreR, while several described situations where a single claim PreR savings was multiplied by similar future claims to calculate future costs prevented.

Subsequent interviews with MCO subject matter experts on prepayment edits determined MCOs always deploy prepayment edits in operations and carefully track effectiveness through cost avoidance defined as claims adjusted or denied. There was a level of difference on sophisticated predictive analytics (aberrant billing patterns) flagging claims on a real-time basis to review for potential fraud and abuse. Some were planning to add this capability, others were incrementally building, while others demonstrated this as a key tool in addressing FWA.

MCOs closely tracked cost avoidance, often comparing cost avoidance results with the costs of its internal control systems to develop a "return on investment" (ROI). From a SCDHHS contract risk perspective, there was little, if any, risk MCOs were not using automated PreR edits. The contract risk was also lowered by this technique being a key driver in MCOs business model to control costs, which was acutely measured as an internal performance measurement by MCOs. It was noted MCO PI functions generally did not have an understanding of PreR overpayment risks in claims, adequacy of PreR mitigation tools and coverage on the differing claim categories, or measures of PreR effectiveness. A similar pattern will be identified later in this report in MCOs' PostR responsibilities, which when combined, identify a key finding in this review.

Even with a lower contract risk due to PreR's key role in MCOs' business model, the SCDHHS contract should continue to demand assurance of how PreR was specifically deployed on all Medicaid paid claims, inasmuch as claim categories (i.e., professional providers; hospitals; and pharmacy) have nuances which may inadvertently create coverage gaps creating unmitigated risk. Establishing simple performance metrics with a common definition should be specified (i.e., cost avoidance/total claims paid) rather than be deferred to each MCO, which will provide a level of contract assurance, simplicity, and usefulness to compare with other MCOs over time to identify variances to drive logical contract management inquiry. However, even a simple cost avoidance metric's value was problematic because higher cost avoidance results may not correlate with desired results inasmuch as a well-trained provider network should have a proportionately lower PreR cost avoidance dollars results.

B. Post-Payment Review

MCOs initiated PostRs based on a variety of reasons. MCOs educated employees, providers, and beneficiaries on FWA indicators and provided a "hotline" to report suspected FWA. SCDHHS, or others in the healthcare PI field, referred leads to MCOs. Most importantly, MCOs data mined paid claims using automated tools looking for aberrant patterns, often termed "outliers," to identify high risk providers for potential case initiation. Initiated cases conducted a retrospective audit of a provider's claims, which then could, if warranted, lead to obtaining detail medical records from the provider to determine a potential overpayment.

SCDHHS established a monthly reporting format requiring MCOs to add new PostR fraud and abuse cases to an excel spreadsheet maintained on a common SharePoint site. A review of the six MCOs' monthly reports for the first 17 months of the current contract (7/1/2014-11/30/2015) revealed:

MCO	Total Cases Opened 7/1/14-11/30/15	# Pending Cases with Identified Overpayments	\$ of Identified Overpayments in Pending Cases	Recoveries
1	6	0	0	0
2	29	1	\$3,550	0
3	16	0	0	0
4	23	13	\$53,537	\$45,721***
5	79	1	\$32,019	0
6	29	0	0	0
Total	182	15	\$89,106	\$45,721

*** Initial MCO reporting to SCDHHS was \$0; the review identified collections of \$45,721, which the MCO reported to SCDHHS during review.

This review determined MCOs' PostR activities lacked evidence of effectiveness based on a lack of results. During the first 17 months of the current contract (7/1/2014 – 11/30/2015), all MCOs initiated 182 PI yielding \$45,721 in recoveries with 15 pending cases identifying \$89,106 in potential overpayments. During this same period, MCOs paid an estimated \$2.3 billion medical claims. MCOs reporting PI cases prior to the current contract reflected a similar pattern (201 cases; \$62,780 recoveries). A perspective on the effectiveness of these MCO results can be gleaned by comparing to SCDHHS's \$4.6 million recoveries of calendar year 2014, which was derived from its PI function PostR of its fee for service operations (\$3 billion annual paid claims).

Most MCOs recognized the lack of results and had plans to increase focus and effort in the near term. Three MCOs openly acknowledged a need to improve; one MCO proffered its PreR emphasis mitigated low PostR results; and two MCOs, despite no recoveries, seemed satisfied. Review of these two satisfied MCOs' best cases revealed one MCO had quality cases prior to the contract period with \$1.6 million in overpayment demand letters to six providers, yet PI caseloads and demand letter recoveries stalled during the contract period due to management turnover, legal review, and PI staff constraints. The second satisfied MCO's five best cases demonstrated proactive audits, all with demand letters totaling \$76,000 with recoveries of \$45,721.

Review of the quarterly reports demonstrated not all six MCOs were optimally using this reporting vehicle. Issues included claiming cost avoidance as actual recoveries; not submitting cost avoidance data; and detail recovery information contained extraneous data blurring the report's functionality. Reporting cost avoidance and actual recoveries, particularly recoveries on a long-term payment plan, have value, but the report could be simplified and still capture relevant performance data.

The review identified a number of factors likely impacting MCOs' effectiveness in PostR. These included a lack of proactive PI activity/results; capturing and understanding overcharges identified in functions outside of the PI function, as well as a lack of understanding of the MCO's overpayment risks and PI control environment in these areas; MCO PI operational functions were conducted by centralized resources in most MCO headquarters; PI reporting only suspected abuse and fraud cases rather than all overcharges identified; and the lack of clarity of performance metrics.

1. Hospital & Pharmaceutical Claims

The contract element 11.2.8 required MCOs to “outline the contractor’s policies, procedures, and performance measures for...audits by recovery audit contractors...quality assurance/utilization reviews of hospital providers...pharmacy audits.” During interview with the six MCO Compliance Officers and PI operational personnel, all MCOs acknowledged the PI function did not have activities for hospital claims and pharmacy claims, respectively, nor were the PI functions specifically aware of retrospective reviews conducted in these areas potentially identifying overpayments. Subsequent interviews with personnel outside of MCOs’ PI function were able to generically describe PostR audits were occurring for hospitals but verification was beyond the scope of this review. One MCO used a specialty contractor conducting PostR on hospital claims, which operated outside of the MCO’s PI function. In FY 2014-2015, hospital and pharmacy combined represented 70% of all MCO paid claims.

The lack of MCOs’ PI functions’ awareness of PostR and identified overpayments occurring elsewhere in the MCO does not mean it was not occurring, along with other cost containment techniques. However, the SCDHHS contract requires MCOs’ PI functions to have policy/procedures in place to mitigate overpayment risk, yet MCOs’ PI functions did not take “ownership” of risk outside of a narrow view on fraud and abuse cases often in only the professional providers paid claims representing 27% of Medicaid dollars at risk. In addition to not having vision on the overall overpayment risk and dollars recovered, the recoveries outside of the PI function seemed to always be presumed waste thus not referred to the PI function to potentially benefit from its subject matter expertise capable of discerning patterns indicating abuse and fraud.

A review of the six MCOs’ 182 PI fraud and abuse cases for the first 17 months of the contract for hospital and pharmaceutical cases yielded 11 pharmacy related cases and six hospital related cases. The pharmacy cases included allegations of five individual member frauds; two referrals from MCO’s pharmacy contractor; two SC Board of Medicine suspensions of pharmacists; and paid claims to two pharmacists on the exclusion list. The hospital cases included four allegations pertaining to billing issues with 44 patients billing pre & post OP; and two cases of excessive use of in-patient follow-ups. Nine cases were closed with no identified overpayments; seven were pending with no identified overpayments; and a 2012 case remains pending with \$123,000 in identified overpayments yet no recoveries to date.

2. PostR Conducted in PreR Operations

Four MCOs were identified as conducting PostR in their PreR operations. One MCO’s PI function used sophisticated FWA algorithms to identify aberrant billing on a real-time basis to identify specific claims to review and potentially deny for cost avoidance, but it also conducted retrospective reviews to identify overpayments for administrative recovery. These overpayments were considered waste, absent fraud indicators. A second MCO’s PreR operations had a PostR capability operating outside of the PI function and retrospective audit recoveries were considered waste.

A third MCO had its PI function bifurcated between the Compliance Program and the Claims Program. The Compliance Program logged mainly hotline calls, while the substantive PreR and PostR were operated by a Claims Program. A claims manager aptly identified numerous overpayments and recoveries, to include a multi-million dollar overcharge with an expected settlement in excess of a million dollars. None of these overcharges and recoveries were reported to SCDHHS through the Compliance Program responsible for formal abuse and fraud reporting, but, fortunately, this issue was informally reported to SCDHHS. This example also illustrated an MCO’s ability to accept less than the full overpayments identified for business reasons, yet the overpayments

literally forgiven had the potential to adversely impact the State when setting subsequent year's capitation rate, which will be explored later in this review.

3. MCO Program Integrity Functions

The six MCOs' Compliance Officers located in South Carolina were responsible for their respective PI functions. One MCO exclusively operated in South Carolina with its personnel conducting PI operations physically located in the state. However, five of the six MCOs utilized their corporate Headquarters' staff located out of state, commonly known as "Special Investigation Units (SIU)," to conduct PI operations for the South Carolina MCO. These corporate SIUs were similarly structured as a central resource to serve all the corporations' numerous MCO health plans from around the country.

Although the five MCOs used a corporate centralized SIU, MCOs claimed specific investigators were dedicated to South Carolina. However, only one MCO demonstrated its dedicated investigator was "on top of" the South Carolina case portfolio with many MCOs having new personnel assigned or planning to hire. MCOs conducted data mining on claims data from all their plans for outliers and anomalies, and generally did not data mine South Carolina paid claims as a separate population.

Not one MCO, nor SCDHHS, had a methodology to staff the centralized SIU staff for a particular plan, such as South Carolina. Staffing was a function of judgment, risk, and several pointed to their own internal management performance measurements of return on investment (ROI) in staffing decision. Several MCOs advised other contracts with state Medicaid agencies have dedicated staffing requirements based on enrollee population.

4. Program Integrity Versus Abuse and Fraud Investigations

The majority of MCOs' PI functions viewed their role as PostR investigations into suspected abuse and fraud cases. Two MCOs appeared to expand this role by having their PI personnel operate sophisticated FWA algorithms in a PreR role, which then could generate both cost avoidance on a real-time claim and stimulate a sample retrospective review to identify additional potential overpayments. There was no MCO PI function taking ownership for all overpayments identified in operational areas outside of the PI, such as hospital or pharmacy, nor having a holistic view of overpayment risks throughout the MCO to ensure strategies and tactics in different MCO operational areas were coordinated and worked well together. This does not infer a lack of appropriate PreR and PostR activities occurring elsewhere throughout the MCO. However, it seems as if the PI function for all overpayments has fragmented within MCOs, which inhibited the SCDHHS's responsibility to maintain both fiscal and fiduciary oversight of Medicaid funds making improper payments.

Certainly MCOs are profit driven and should arrange operations to meet many competing needs. However, MCOs operate with Medicaid funds which have been deemed "high risk" for overpayments by the GAO with a recent study estimating 7% (\$19 billion) of Medicaid dollars were overpayments. As a result, the State has an affirmative duty to obtain assurance Medicaid dollars used by MCOs have a singular MCO component, PI, with a holistic understanding of overpayment risks and mitigation strategies across the MCO, coupled with robust reporting of all overcharges. Reporting of all overcharges serves both as an MCO performance measure, but equally important has the intelligence value to SCDHHS to leverage this data with other MCO data inasmuch as many MCOs use the same providers.

This review observed the PI function seemed to have been watered down to PostR fraud and abuse investigations, yet PI was designed to detect and deter overpayments from any function regardless of perceived motive. A million dollar loss from waste exactly equals a million dollar loss from fraud. Both require understanding the loss transaction to continually build upon an individual MCO's and SCDHHS's risk assessment for overpayments, which then serves as the foundation for mitigation and control strategies.

The SCDHHS had ample business rationale to require MCOs to report all overpayments from retrospective reviews, regardless of an MCO's perception of intent, which included:

- The judgment and experience to discern the intent and patterns for abuse and fraud for overcharges lies in the PI function in MCOs and SCDHHS, which currently have no situational awareness of overcharges deemed as "waste" outside of the MCO PI function.
- SCDHHS had potential equities in all recoveries due to the contract's capitated rate model. Overcharges occurring and recovered in the same year may have no impact on a MCO's paid medical claims factored into the subsequent years' capitation rate. However, recovery from prior years, which was common in retrospective reviews, indicated those years' paid medical claims were inflated by the recovered amount, which reciprocally likely inflated the following year's capitation rate injuring SCDHHS. Conceptually, overcharges to an MCO impact its profit during the year of the fraud, but it also inflates the following year's capitation rate leading to recovering a like amount; it is a timing difference. Interesting, all MCOs felt any recovery belonged to the MCO. However, several MCOs acknowledged recovery from prior years impacted capitation rates, and contracts with other states have contract terms setting out a methodology for splitting recoveries with the state Medicaid agency, to include the full amount back to the state.
- Serves as a quality control ensuring overpayments were appropriately factored into setting the capitation rate. MCOs consistently advised overpayments resulted in adjusting the original encounter data to maintain accurate data factored into setting annual capitation rates. However, it was later determined encounter data was not adjusted when actual recoveries were less than audit overpayments identified, often involving voluminous encounter records. Currently, SC DHHS does have a potential mitigating control where its actuary surveys MCOs for fraud recoveries not reflected in encounter data impacting the capitation rate, and adjustments are made in the capitation rate for this self-reported data.
- SCDHHS was responsible for the PI of all Medicaid dollars spent, yet its fiduciary field of vision on the key risk factor, overpayments identified, did not include overpayments and recoveries outside of the MCO's PI function, such as routine audits.
- A complete picture of all MCO overpayments data serves as critical intelligence to support SCDHHS's overall PI effort. Overpayments contained in SCDHHS's paid claims were fragmented in six MCOs, as well as SCDHHS's own fee for service operations, yet many providers operate in multiple MCOs. Patterns cannot be discerned if the "dots" (overpayments) are not visible to connect. A complete data set of all overpayments from retrospective reviews from all Medicaid dollars can be leveraged by SCDHHS to stimulate better targeting of high risk providers across all MCOs, as well as provide leads to MCOs based on abuse or fraud found in one MCO.

- Full disclosure of all overpayments protects SCDHHS from inappropriate factors seeping into MCO settlements with providers. If an MCO settles an overpayment for less than full amount to dispose of matter or business reasons despite compelling evidence to the contrary, SCDHHS could be absorbing the difference by its impact in subsequent year's capitation rate. Second, providers may be motivated to settle quickly to avoid a deeper inquiry by PI into potential fraud and abuse, or risk alerting other MCOs working with the same provider to possible overpayments in their respective plans.

5. Clarity of Performance Metrics

The contract required each MCO to establish performance metrics for PreR and PostR, yet each MCO did not. SCDHHS did not demand compliance, likely because it was a secondary issue to the primary problem MCOs were not even reporting any recoveries (results). Cost avoidance was measurable in each MCO, just not reported consistently with a common metric methodology to SCDHHS via quarterly reports.

This review attempted to identify an industry benchmark for PI recoveries with nominal success due to a wide variety of views on this issue. The best approach for a way forward would be to focus on accurately collecting the relevant indicators of performance for both results and the level of effort using accepted PI best practices. It may not be the time for hard performance benchmarks inasmuch as the MCO model was relatively new to the state and many new MCOs were still maturing their PI functions/processes specific to South Carolina. Still, the MCO collective recoveries were not effective by any measure, and SCDHHS emphasis should focus on measuring level of effort until results normalize. Key level of effort indicators for PostR include: frequency of audits comparing paid claims with actual provider medical records, as opposed to just an analysis of paid claims data; demand letter to provider for overpayment; actual recoveries; timeliness from case initiation to demand letter to recovery; and case initiations by a MCO leveraged to assist other MCOs' PI efforts.

V. Fraud Referral Process to SCDHHS

There was some confusion as to the criteria to justify a fraud case requiring notification to SCDHHS within one day. MCO PI cases initiated for potential abuse or fraud only get referred to SCDHHS after sufficient evidence collection accumulates to cross some evidentiary threshold, not specifically defined. Further, upon referral, the MCO was to stop all investigation until advised by SCDHHS to re-initiate its investigation. The review could not identify sound reasoning for either requirement which both added unnecessary coordination and reporting. Certainly, notification should be required to SCDHHS in an expedited fashion for abuse and fraud cases with the risk of patient harm/safety issues or unique situations that could substantially assist law enforcement, normally involving a unique witness. However, reporting all overpayment cases in monthly reports with the MCO's preliminary assessment as waste, abuse, or fraud, should serve as sufficient notice to SCDHHS. This also empowers the MCO to take ownership of its reviews unless advised to the contrary by SCDHHS.

VI. Direction for Improvement

The current state of MCO PI results and reporting were not flattering. However, South Carolina MCOs were not alone. In addition to the 2013 OIG-HHS and 2014 GAO reports set forth in the background section of this report, a recent December 2014 Florida Inspector General report highlights similar issues. Florida's \$21 billion MCO plans, which were ten times larger than South Carolina, recovered only \$536,000 over a two year period on \$8 million identified fraud and abuse, which yielded a 6.6% recovery rate. Florida MCOs did collectively

report overpayments (waste), unlike South Carolina, recovering \$32 million over a two year period on \$56 million overpayments identified, which yielded a 57% recovery rate.

MCOs generally recognized the need to improve. This was evidenced by MCOs' motivation to address these shortcomings through increased program activity and planning since the Fall 2015, after SCDHHS became more engaged in evaluating MCO results.

The way forward starts with the recognition there is no simplistic benchmark to track providing assurance MCOs have effective PreR and PostR operations, particularly measured over a short-time frame, such as a single year. Rather, it starts with SCDHHS assessing PI contract risks developed in this report to build a pragmatic contract monitoring framework of data indicators/measures which sets expectations for 1) level of effort and 2) results. This framework ensures systematic collection of accurate, reliable, relevant, and auditable data that can be increasingly leveraged over time. As the MCO contract gains experience and maturity, use the MCO model as intended to leverage contract monitoring tools through comparing MCOs' results to discern relative performance levels, harder performance benchmarks in future contracts, and this data is incorporated in future contract requirements, to include penalties and incentives.

VII. Findings & Recommendations

Finding #1: The MCOs' PreR is not a significant contract risk, but still requires due diligence monitoring of MCOs' risk based coverage on **all categories of paid claims** (SIG emphasis), as well as performance reporting allowing SCDHHS to identify unusual variances over time to stimulate logical performance based inquiry.

Recommendation #1: The SCDHHS should consider requiring MCOs provide an integrated risk based PreR plan for all categories of paid claims, as well as a simple monitoring metric for PreR, such as actual cost avoidance per medical spend on a quarterly basis.

Finding #2: The MCOs' PI function did not have an understanding of overpayments identified through PostR retrospective reviews of paid claims by MCO functions outside of the PI function (i.e., hospital and pharmacy), nor the MCO's overall overpayment risk and controls to mitigate the risk.

Recommendation #2: The SCDHHS should consider requiring MCOs have a singular MCO component, PI, with a holistic understanding of overpayment risks and mitigation strategies across the MCO, coupled with robust reporting of all overcharges.

Finding #3: The current monthly MCO case report can be enhanced with better performance indicators measuring the PI function's level of effort and results, which also serves as a mechanism to clarify contract expectations and an efficient contract monitoring tool.

Recommendation #3a: The SCDHHS should consider requiring all overpayments identified through retrospective reviews considered as waste, rather than abuse or fraud, provide an explanation for MCO's determination the overcharge was a good faith error/mistake causing waste.

Recommendation #3b: The SCDHHS should consider specifically discerning those abuse and fraud cases only conducting a review of claims data from cases collecting/auditing provider medical records in order to distinguish differing levels of effort.

Recommendation #3c: The SCDHHS should consider the formal MCO overpayment demand letter to a provider as a key result metric, as well as serve as the definition for quantifying “overcharges identified.”

Recommendation #3d: The SCDHHS should consider the recovery of funds from overpayments identified as a key result metric and defined as only those funds physically received by the MCO.

Recommendation #3e: The SCDHHS should consider requiring an explanation when overpayments identified result in a lesser recovery settlement to discern if the difference was based on a negotiated factual dispute or MCO forgiveness of identified overpayments for business reasons inasmuch as this rationale could potentially have an adverse impact on subsequent year’s capitation rate.

Recommendation #3f: The SCDHHS should consider MCOs’ ability to initiate overpayment cases which the SCDHHS has leveraged to assist other MCOs identifying new abuse and fraud cases as a priority performance metric, which is indicative of a proactive MCO PI function.

Recommendation #3g: The SCDHHS should consider requiring, at a minimum, all pending cases on the monthly report be updated at the close of each quarter.

Recommendation #3h: The SCDHHS should consider incorporating its contract monitoring indicators into future contracts and require MCOs compliance plans also incorporate this level of detail to clarify expectations within MCOs inasmuch as PI operations were geographically separated from South Carolina with a pattern of using a variety of contractors to support the overall PI efforts.

Finding #4: The MCOs quarterly report submission data were not consistently accurate and the report had questionable value.

Recommendation #4: The SCDHHS should consider simplifying this quarterly report to collect basic cost avoidance and cost recovery information using common definitions, as well as provide timely feedback for submissions with errors or extraneous data to mature this report as an effective performance tool.

Finding #5: The contract’s required notification protocols for abuse and fraud cases could be streamlined to increase value.

Recommendation #5: The SCDHHS should consider requiring MCOs notify SCDHHS in an expedited fashion for only those abuse and fraud cases with the risk of patient harm/safety issues or unique situations that could substantially assist law enforcement, normally involving a unique witness; otherwise, reporting in monthly reports when a case escalates to a formal fraud referral should be sufficient timely notice to SCDHHS, which also empowers the MCOs full authority to continue its review unless advised to the contrary by SCDHHS.

Finding #6: SCDHHS has not established a policy addressing MCO's overpayment recoveries from prior years that could potentially have an adverse impact on subsequent year(s) capitation rate.

Recommendation #6: The SCDHHS should consider establishing a policy to address MCOs' overpayment recoveries from prior years potentially negatively impacting a subsequent year(s) capitation rate to protect taxpayers while also properly incentivizing MCOs to seek these recoveries.

Finding #7: Neither SCDHHS nor MCOs had a staffing model to optimally staff MCO PI functions to meet the risks and needs generated by its provider and enrollee populations.

Recommendation #7a: The SCDHHS should consider annually reviewing MCO PI functions' reporting of level of effort and results, and comparatively lower performing MCO PIs should potentially be addressed in subsequent contracts with mandatory staffing, to include a requirement of being physically located in South Carolina.

Recommendation #7b: The SCDHHS should consider requiring each MCO designate a front line investigator as the single point of contact for day-to-day interactions with SCDHHS on PI investigative matters.

Finding #8: MCOs' PostR operations executed by a corporate central PI resource generally conducted data mining on claims from all of its affiliated plans from across the country, rather than data mining initiatives focused only on the claims population data from South Carolina plans.

Recommendation #8: The SCDHHS should consider requiring MCOs data mine South Carolina plans separate from all other corporate plans, as well as SCDHHS should take a leadership role in assessing state risk and national trends and then affirmatively task MCOs with focused data mining initiatives.

Finding #9: The lack of all overpayment being visible to SCDHHS undermined its ability to have a robust centralized intelligence mechanism to understand the overall MCO PI risk of overpayment, as well as a mechanism to leverage overpayment intelligence to identify leads and trends to support MCOs' PI efforts and SCDHHS's contract risk management.

Recommendation #9a: The SCDHHS should consider using MCOs reporting of all overpayments as the foundation of a centralized intelligence function to be enhanced with additional data mining and referrals to MCOs with similar patterns or subject provider(s), and periodic face-to-face meetings should be considered supplemental to this formal central intelligence mechanism.

Recommendation #9b: The SCDHHS should consider establishing the expectation within SCDHHS and MCOs that improvement with a contract monitoring framework will lessen SCDHHS's MCO PI program manager's need for oversight engagement and increase its role as an analyst to leverage MCO overpayment intelligence to identify leads and trends to support MCOs' PI efforts.

Finding #10: There was a level of frustration by both SCDHHS and MCOs on PI expectations and reporting, which has improved recently with more frequent communications.

Recommendation #10: The SCDHHS should consider using this report to meet with MCO representatives to further refine a mutual understanding of the PI contract risks, followed by soliciting MCO input on appropriate contract reporting and performance measurements to control these risks.

Finding #11: State program managers throughout State government are not well versed in risk based contract monitoring planning and tools.

Recommendation #11: The SCDHHS should consider using its internal audit team for a consulting engagement to review SCDHHS program managers' current contract monitoring plans and reporting tools for opportunities to improve.

Administrative: The SC DHHS reviewed a DRAFT report and provided oral comments, which were incorporated into the final report as appropriate. The SC DHHS accepted the findings and recommendations.