

Effective Auditing Programs for Managed Care Plans

Health Care Compliance Institute

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Disclaimer

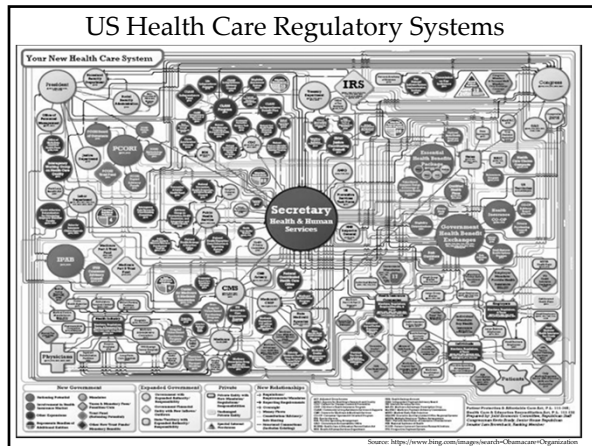
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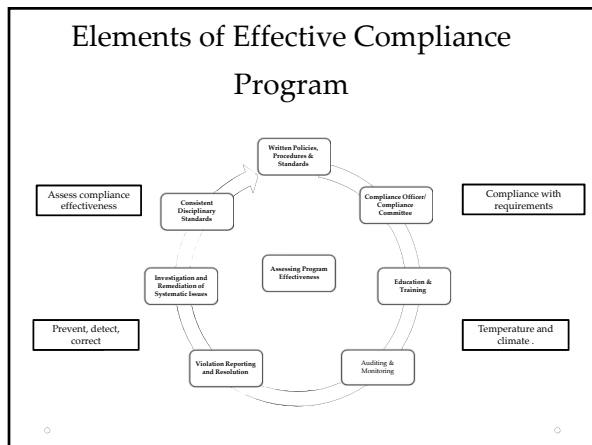
Today's Goals

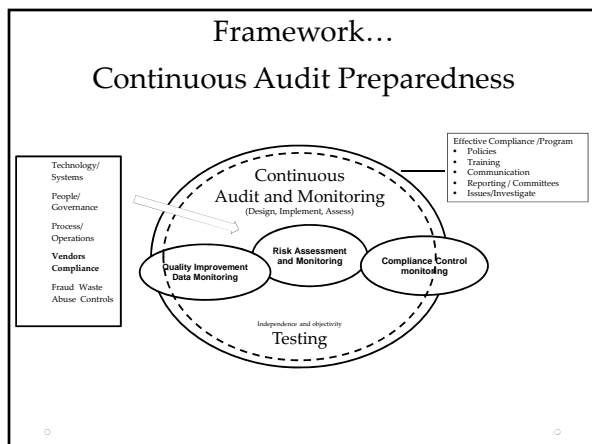
Discuss impact of CMS annually published protocols on Managed Care Plan Auditing Program

Review case scenarios to understand how to audit Medicaid managed care plans

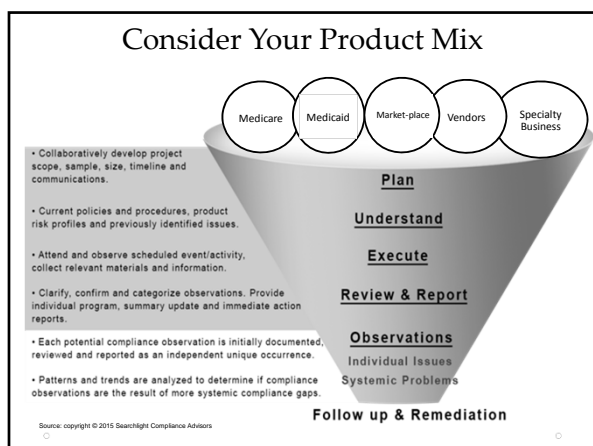
Understand the importance of auditing vendor transactions for compliance











Develop a Comprehensive Annual Audit Plan

CMS Audit Protocols

- o Comments and Responses
- o Past Published Medicare Program Audit Performance

DHHS / CMS HPMS Memoranda

- o Compliance Program Effectiveness Requirements
- o Seven Elements

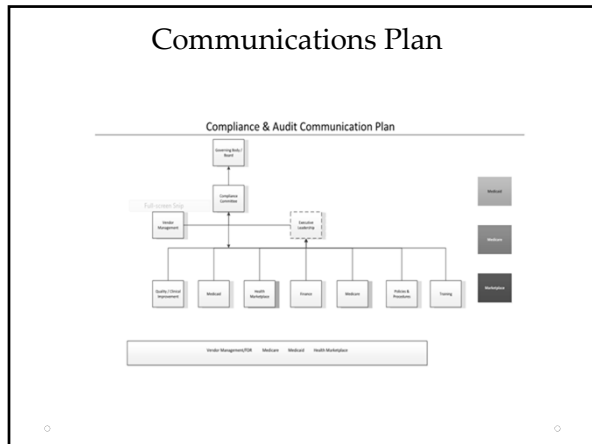
Past Audits Findings and Corrective Actions

- o All Products
 - Performance Outcomes / Risk Areas
 - Quality Improvement / Case Management
 - Risk Assessment Findings
 - Vendor /FDR Findings
 - Leadership and Governance Reporting

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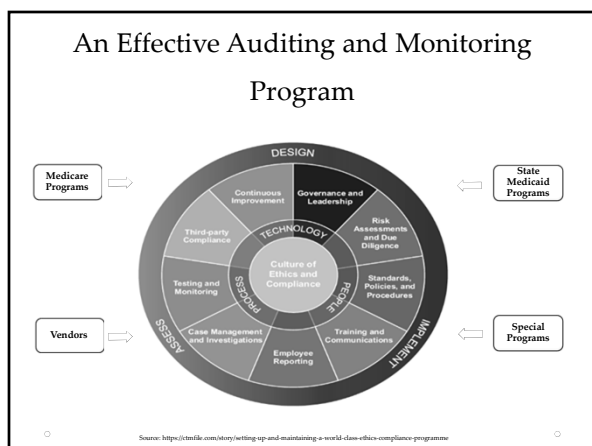
Case Scenario # 1

The management team instructs the Compliance Officer to report all audit risk findings quarterly to the team. The report should only be reviewed with the management team and should not exceed ten minutes because the organization cannot afford to pay employees for non-productive time. "And the Compliance Report is always too long!"



Reporting Tracking and Trending Risks

- Board and Compliance Committee reports on Internal Audit work plan
- Overview of current compliance risks
- Status report of new or revised policies & procedures
- Summary of identified key FWA issues
- HIPAA program audit updates & risks monthly/ quarterly/annual
- Compliance Program assessment results/ risks and corrective action plan
- Vendor performance / compliance monitoring/ identified risks
- Communicate updated State contract requirements/risks
- Monitoring and review of compliance departments responsibilities to ensure resource dedication to core compliance requirements
- Use dashboards, data, and surveillance tools to demonstrate monitoring results



Auditing & Monitoring – Medicaid Managed Care

- Program Structure
 - Foundational to the auditing & monitoring process
- Program Focus
 - What is being audited & monitored
- Program Reporting
 - Key stakeholders



Program Focus

Program Structure

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Auditing & Monitoring Medicaid Health Plan

An effective Compliance Program will include a robust methodology to audit and monitor all functional areas in an organization against the following:



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State and Federal Regulatory Requirements

- Federal Regulations
 - Health Insurance Portability & Accountability Act (HIPAA)
 - Member Rights & Responsibilities
 - Early, Periodic Screening, Diagnostic & Treatment (EPSDT) Services
- State Statutes
 - Primarily an extension of federal regulations
 - State Plan Amendments
 - Physician contracts (Georgia Code§ 33-20A-61 - Physician contracts)
- Recently Passed Legislation
 - House Bills
 - Senate Bills



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State Medicaid Contract Requirements

State Contract Requirements

- Service Level Agreements
- Turnaround Times
- Committee Structures
- Reporting
- Vendor Responsibilities
- Remedial Actions
- Corrective Action Processes



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Historical Findings

Internal /External Audit Review Findings

- External Quality Review (EQRO) Audits
- Internal Audits / Risk Assessments
- Statements on Standards for Attestation Engagements (SSAE)
- Accrediting Body
 - National Committee for Quality Assurance (NCQA)
 - Utilization Review Accreditation Commission (URAC)



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Seven Elements

- Written policies and procedures
- Designation of a Compliance Officer & Compliance Committee
- Effective training and education
- Effective lines of communication
- Internal auditing and monitoring
- Enforcing standards through well-established guidelines
- Responding to identified problems and taking appropriate corrective action
- Assessing Program Effectiveness



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Case Scenario #2

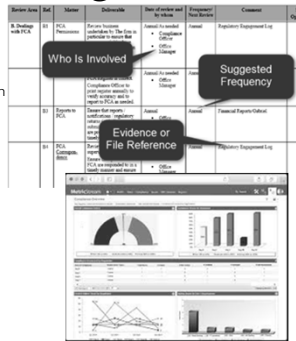
The operation manager recently received your SSAE-16 report that must be submitted to your State agency. Is there anything else you need to do with the report findings other than send the report to the State agency?



The Monitoring Process

Monitoring is:

- An ongoing event
- Conducting analyses and tracking trends to correct issues in "real time"
- Continuously validating risk assessments
- Performed at the lowest level of detection
- Completed regularly during normal operations
- Recording and reporting incidents of non-compliance
- Communicating potential risks



Monitoring Process



The Audit Process

Auditing is

- o Formal retrospective review
- o Methodical
- o Includes sampling
- o Performed periodically (i.e., annually)
- o Performed by un-biased auditors



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Auditing Process

Identify Risks

- Internal controls questionnaire
- Audit scope
- Objectives

Audit Risk Areas

- Fieldwork
- Evaluation
- Testing controls

Review Audit Results

- Assess results
- Communicate findings to stakeholders

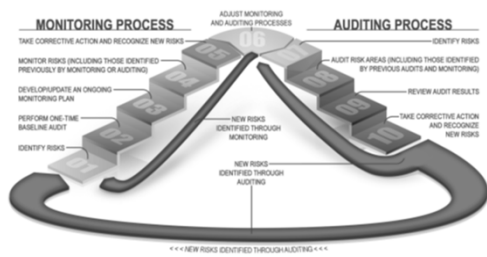
Take Corrective Action

- Issue corrective actions for remediation
- Monitor remediation

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Relationship Between Auditing & Monitoring

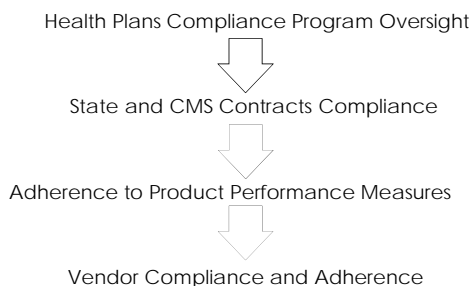


Source: <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/vhr-internal-monitoring-jobaid.pdf>

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Comprehensive Auditing and Monitoring



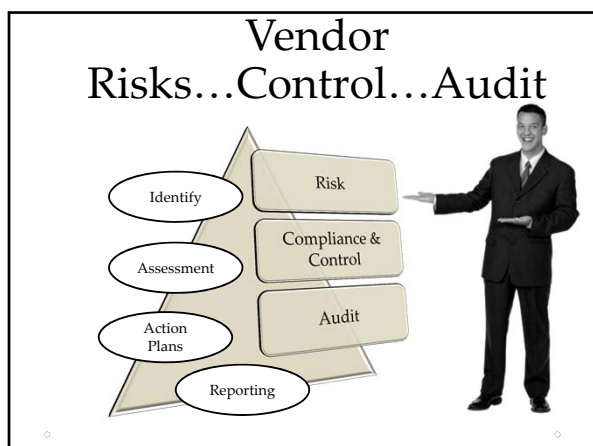
Case Scenario #3

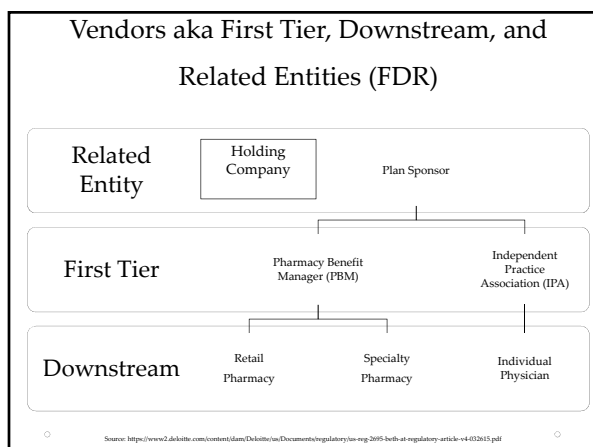
The Compliance Officer received an anonymous call that an executed agreement with a network of providers expired. The agreement was for the Medicare Advantage and Part D plans. However, capitated payments were still being made to the providers.



What's Next?

- Obtain a list of all contracts
- Randomly select and test sample contracts
- Trace payments from accounts payable ledger to agreements and vice versa
- Review authorization and payment process
- Interview staff
- Review previous audits for similar findings
- Summarize findings in a report with recommendations
- Collaborate with the responsible manager to develop a corrective action plan
- Communicate results of audit report with those responsible for contract management and other leaders within organization

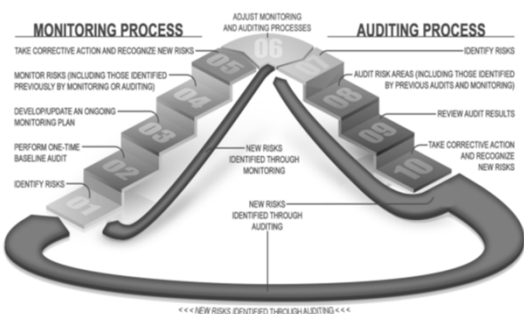




Compliance Risks

- Lack of coordinated compliance oversight
- Incomplete list identifying all vendors and FDRs
- No written agreement with vendor to include CMS expectations for FDR oversight
- Not meeting quality care measurements
- Not performing exclusionary checks
- Poor utilization management
- Lack care coordination
- No credentialing process
- Payment inaccuracies
- Billing errors

Auditing & Monitoring



Source: <https://www.cms.gov/Medicare/Medicare-Coordination/Prevent-Prevention/Medicare-Security-Education/Downloads/44e-internal-monitoring-j04d.pdf>

Auditing & Monitoring

- Prompt assignment of a qualified person to vendor oversight
- Verify and validate that executed and current contracts exist
- Ensure FDR specific CMS requirements are met
- Perform due diligence pre-contractual audits
- Monitor exclusion screenings and credentialing
- Develop audit plan to include performance audits & corrections
- Conduct claim data mining and credentialing evaluations
- Follow up on external/internal audit results and recommendations to ensure compliance with FWA
- Annually evaluate FDRs

Evaluation and Performance

- Annually evaluate FDRs
 - Desk and onsite visits
 - Adherence to plan and regulatory requirements
 - Validate FDRs compliance program
- Performance Maintenance
 - Review contractual established performance metrics
 - Review new state guidance
 - Set rules for downstream
 - Focus on FWA compliance
 - Corrective action plan for non-compliance including contract termination
- Document results in a written report

Continuous Cycle

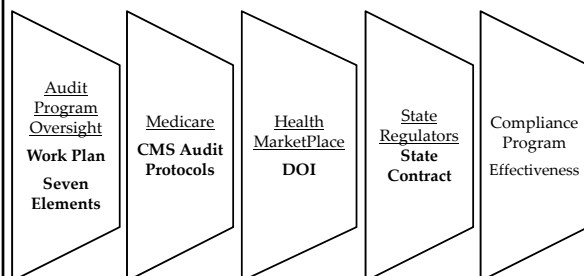


Board, Physicians and Staff Training

- Be brief and detailed
- Use data, trends and performance measures
- Financial data and risks
- Demonstrate any potential risk impact on business operations
- Use examples that are relevant to the audience
- Responsibilities and obligations
- Questions and answers



Auditing and Monitoring Balance





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