

## HCCA Managed Care Compliance Conference

# The Auditors are Coming — Is Your Medicaid Managed Care Plan Ready?

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Senior Associate, Phoenix

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Principal, Minneapolis

**Holly Dolgaard, MBA, CHC, CHPC**  
Principal, Phoenix



welcome to brighter

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## Your Mercer team



**Holly Dolgaard, MBA, CHC, CHPC**  
Principal

Holly's expertise includes managed Medicaid and Medicare regulations and comprehensive experience with healthcare delivery systems and health plan operations and information systems.

At Mercer, she leads the design and delivery of systems-related solutions with a focus on improving data quality, promoting interoperability and advancing performance outcomes.



**Scott Banken, CPA, MBA**  
Principal

Scott worked for both regional and national MCOs for ten years, focused on Medicare and Medicaid prior to joining Mercer in 2012.

His masters of business administration includes a concentration in database design and data operations.



**Christine Babcock**  
Senior Associate

Chris has over 30 years of involvement working with healthcare data. She has experience with systems implementations, managing a billing office, reporting, analyzing and helping MCOs improve the quality of their encounter data.

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## What we will cover

**1** Overview of 42 Code of Federal Regulations

**3** Leveraging the Findings to Improve Organization Performance

**2** Preparing your Medicaid Managed Care Plan for the Audit

**4** Q&A



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## Scope and Purpose of the Periodic Audits

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## Additional program integrity safeguards

### Regulation 42 CFR § 438 Subpart H

#### 42 CFR §438.602 — State responsibilities

##### (e) Periodic audits.

The State must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP, or PAHP.

##### (g) Transparency.

The State must post on its Web site, as required in §438.10(c)(3), the following documents and reports:

- (1) The MCO, PIHP, PAHP, or PCCM entity contract.
- (2) The data at §438.604(a)(5).
- (3) The name and title of individuals included in §438.604(a)(6).
- (4) The results of any audits under paragraph (e) of this section.

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## Overview of actuarial rate setting



**Rates are set** by analyzing self-reported, historical base data for the population

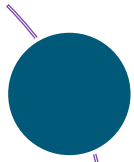
- Encounter data to track expenses and utilization
- Financial information to complete the encounter data and identify non-claims medical expenses and the administrative expense load



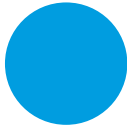
**Historical data** is also used to analyze inflationary trends and the impact of program changes

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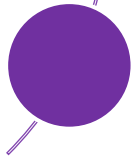
## Definition of the term “audit”



Typical Financial Audit analyzes and produces audited financial statements that follow Generally Accepted Audit Standards or Governmental Accounting Standards. These standards define who can perform the audit and specific protocols to performing the audit. Opinions and statements are given at a high-level, taking materiality into account.



Operational audits focus on the process used to produce and output. This includes tracing and analyzing each step in the process to ensure integrity, e.g., reviewing policies and procedures around maintaining complete and accurate encounter data. No standards are set for this type of audit and anyone with competency can perform the audit.



The key is understanding the Risk. Risk = What is the impact if something is not correct in financials or encounters? In this case, capitation rates are directly impacted. CMS has **not** issued guidance on format, process or content of required audits or audit reports.

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## Encounter data triad



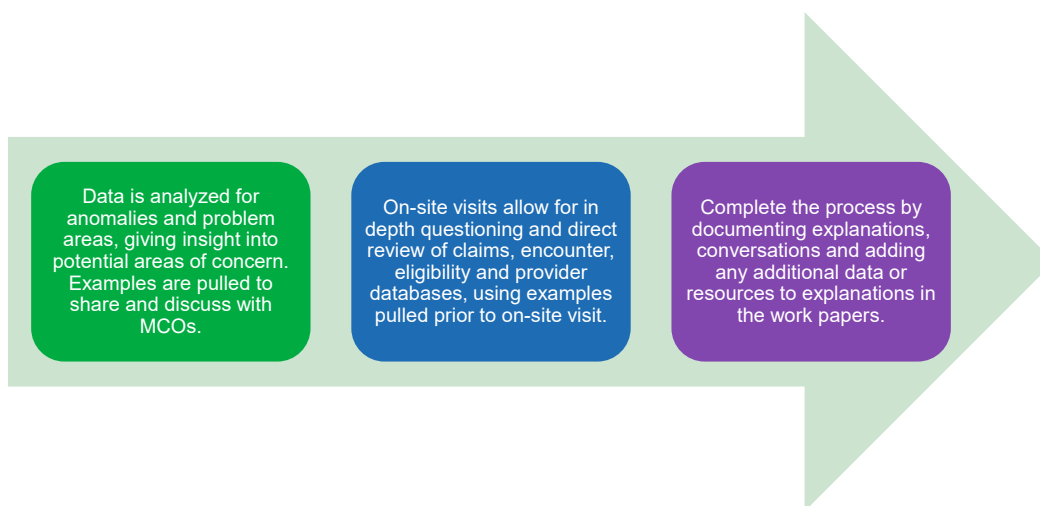
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## CMS encounter data validation protocols



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## EDV audit insights



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## EDV audits

### Data research examples

- Diagnosis codes fully populated (26 possible)
- Overuse of “unlisted” codes, e.g., 94499
- Received date versus paid date
- Use of generic IDs or values
- Fields present but not populated
- Lack of void and/or adjustment data
- Lack of TPL data
- Encounter dollars versus reported financials
- Items specific to state



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## Preparing the MCOs for the Audit



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## Audit process



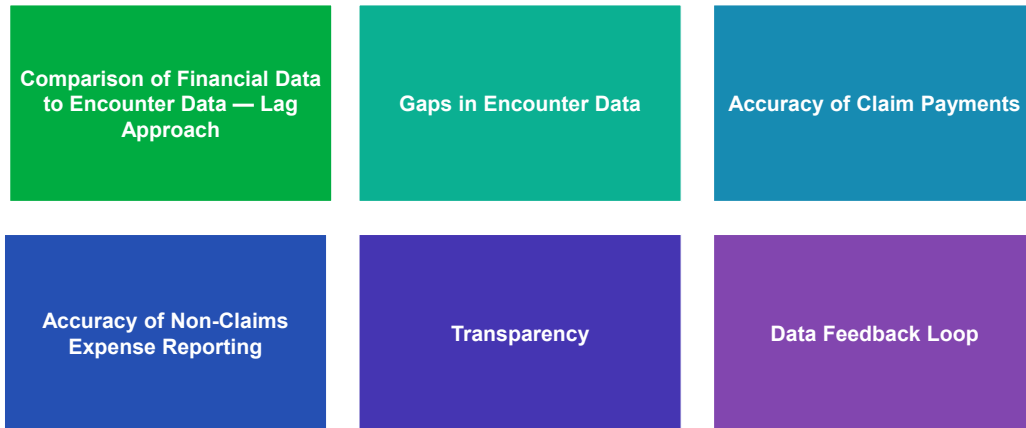
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## Risk assessment



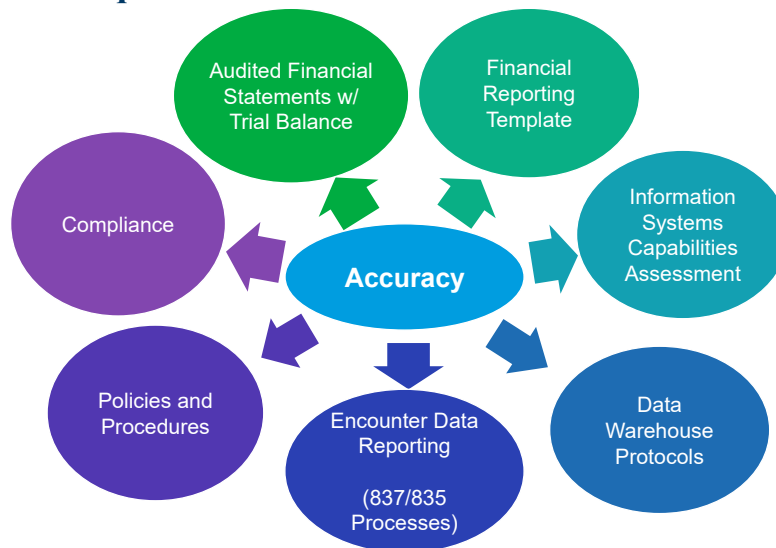
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## Data consistency analysis



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## Information request



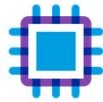
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## Analysis of submitted data/audit procedure



**Specific tests of accuracy** in reporting and encounter data submission. Includes tracing back to source of data such as claims, invoices, purchase orders or other source documents.



**Calculation** of error rates in number and in dollars.



**Documentation** of findings in work papers.



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## Clarification questions



- Clarification to complete documentation in work papers.
- May include additional testing if errors found during testing.
- Often includes on-site visits and system demonstrations.
- Staff interviews to ensure policies and procedures are followed.
- Can be helpful with sharing of expectations and best practices.

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## Draft audit report

- Senior audit staff thoroughly review work papers and draft list of findings, observations.
- State review of draft to determine possible corrective actions.
- Plan review of findings and opportunity for comment and/or correction.



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## Final audit report



- Completed audit report and summary of results for publishing on state's website.
- Summary of findings may also be included in the state Medicaid agency's annual external quality review organization technical report.

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## Leveraging the Findings to Improve Organization Performance and Compliance

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## Using the audit to gain an understanding of needs



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## 42 CFR § 438.66 b – state monitoring requirements

The state's monitoring system must address all aspects of the managed care program, including performance of each MCO, PIHP, PAHP and PCCM entity in at least the following areas:

- Administration and management
- Appeal and grievance systems
- Claims management
- Enrollee materials and customer services, including the activities of the beneficiary support system
- Finance, including medical loss ratio reporting
- Information systems, including encounter data reporting
- Marketing
- Program integrity
- Medical management, including utilization management and case management
- Provider network management, including provider directory standards
- Availability and accessibility of services, including network adequacy standards
- Quality improvement
- Areas related to the delivery of LTSS not otherwise listed above
- All other provisions of the contract, as appropriate



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Q&A

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## Q&A



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## Key takeaways



### Proactive Planning

- Engage health plan teams to assess current processes, systems and resources related to encounter data management.
- The assessment of current capabilities should include subcontractor activities related to encounter data management.
- Review state Medicaid agency contracts along with claims and encounters-related guidance and technical specifications.
- Review prior findings from financial audits and encounter data validation activities to ensure remediation activities were completed and deemed effective.



### Leverage Audit Findings for Continuous Improvement

- Begin planning now for how your organization will support the audit(s) and respond to issues and questions during the audit cycle.
- Ensure that management and teams that support functional areas that impact encounter data quality are involved in the review and remediation of audit findings.
- Develop performance metrics to ensure the remediation activities will bring the intended results.
- Remember that improving encounter data quality is a journey not an event.



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## Featured resources

### Hot Topics



Check out the Mercer Government website for hot topic updates, contacts and resources

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