Medicaid Program Integrity
10 Common Challenges

Myers and Stauffer’s program integrity experts present common challenges – and solutions – to ensure your program is prepared for anything.

State Medicaid programs and Children’s Health Insurance Programs (CHIP) continue to grow and become increasingly complex. This is due, in large part, to the expansion of managed care and alternative payment methods. Plus, legislators, oversight agencies and other stakeholders insist that scarce Medicaid/CHIP dollars be used to deliver high quality services at reasonable costs. It has never been more important to ensure that state program integrity (PI) systems remain flexible and adaptable to the changing health care landscape.

Myers and Stauffer has spent nearly 40 years working with government health programs. We have the experience and expertise to ensure your PI approach stays ahead of the curve. Our impressive team of PI subject matter experts (SME) has real world experience dealing with the challenges you face each and every day. That experience, and the desire to help PI programs get ahead of most issues, led us to put together this list of 10 common challenges PI programs face. How robust is your program? How flexible? Does it provide a significant return on your state’s investment? If the answers to these questions leave you feeling uncertain, Myers and Stauffer can help you enhance your PI program to better address today’s rapidly changing health care environment.
1. Enrolling providers: Safeguarding the front door

Ask almost any program integrity staff about the most critical points for safeguarding their Medicaid program and they are likely to start with provider enrollment (PE) and the need to do better in this area. So what does better look like for your program and how do you make that happen?

The Centers for Medicare & Medicaid Services (CMS) has urged States to work towards addressing provider enrollment risks. Through federal regulations (42 CFR Part 455), CMS requires that all participating providers be screened according to their categorical risk level, upon initial enrollment and upon re-enrollment or revalidation of enrollment.

In 2015, CMS issued seven reports which outlined risks and recommendations observed during triennial State Program Integrity Reviews and of these, more than half of the recommendations focused on correcting PE deficiencies. Some key recommendations that every PI unit should be prepared to address include:

- Compliance with all federal regulations, including:
  - Provider screening and enrollment requirements.
  - Provider ownership and control disclosures.
  - Adverse action reporting and provider notification requirements.
  - A requirement that providers and employees be searched against all exclusion databases and that no federal payments be made to excluded providers.

- Development and implementation of processes to:
  - Provide increased scrutiny of all providers categorized as moderate and high risk.
  - Adjust the risk levels of providers who have been assessed with adverse actions.

To determine the readiness of your provider enrollment system to withstand not only the scrutiny of external review but also to ensure that you are effectively screening and enrolling current and prospective providers, consider the following questions:

- Can information be extracted from your system on all fields in a manner that produces accurate, reliable results and meets user needs?
- Are you able to respond to inquiries about the adequacy of provider/member ratios using various criteria (e.g. geographic region, provider type, etc.)?
- Do you have a provider naming convention that safeguards the integrity of single provider number assignment while allowing flexibility in searching the PE database by provider or business name?
- Is verification of provider eligibility logically and appropriately mapped to support payment of claims, provider profiling, and other system processes?
- Does your PE system cross-reference license and sanction information with all appropriate state and federal agencies?
- Is your PE system able to maintain multiple provider-specific reimbursement rates consistent with state policies?
- Does your PE process ensure the quality of the provider network and accuracy of payments while maintaining provider information in a manner fully compliant with the Health Insurance Portability and Accountability Act (HIPAA)?

Becoming compliant with all federal regulations, while developing an airtight provider enrollment process which is capable of producing various information and data, can be challenging to any PI department. This is where our team can help. Our experts are ready to discuss where you are with provider enrollment integrity and compliance, where your program needs to be, and map out a logical plan to make that happen.
2. Protecting the Medicaid managed care environment

More than one-half of Medicaid members nationally now receive their health services from managed care organizations (MCO) which contract with state programs to deliver such services. It is therefore critical that program integrity units meet the challenges posed by this new health care environment. States must adapt their oversight resources and systems from the fee-for-service model to managed care’s capitation system. CMS has learned from numerous reviews and studies that MCOs are currently not fulfilling their PI requirements. Just as importantly, CMS has found that states are not prepared to effectively monitor and review the MCOs’ efforts.

CMS has identified various deficiencies in states’ oversight of managed care program, including:

- Inadequate review of MCO compliance plans.
- Not ensuring that MCOs check for debarred or excluded individuals.
- Insufficient monitoring of contract compliance.
- Not requiring MCOs to report all cases of fraud, waste and abuse (FWA) to the state.
- Failing to stay informed of ongoing MCO investigations.

According to CMS, a general lack of oversight of managed care services makes state Medicaid programs particularly vulnerable to fraud and abuse in their managed care programs. In response to these concerns, in 2016 CMS finalized a comprehensive rule to improve oversight of managed care organizations including specific program integrity requirements. A few key provisions of the rule include:

- Requiring managed care contracts to address treatment of recovered overpayments by managed care plans
- Requiring that states enroll all MCO network providers who are not otherwise enrolled with the states
- Requiring the MCOs to:
  - Certify their data, information and documentation, including encounter data and other rate setting data, medical loss ratio (MLR) data, and data used to ensure that solvency standards are met.
  - Take affirmative action, such as routine auditing and monitoring, to detect and prevent fraud, waste and abuse.

In its 2016 Work Plan, HHS-OIG has also indicated that it intends to review various aspects of states’ oversight activities with respect to managed care plans.

It is important to understand that financial loss to your health care program does occur when a managed care plan suffers fraud, waste or abuse. A comprehensive evaluation will allow you to identify improper expenses which may ultimately inflate an MCO’s capitation rate.

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It is important to review and strengthen MCO contract language in order to drive compliance and facilitate oversight.

Other areas at financial risk include:

- Incomplete or inaccurate encounter data.
- Member file issues.
- Duplicate payments (FFS and managed care).
- Overlapping eligibility.
- Supplemental payment programs.

In summary, you must be prepared to address these important challenges, including:

- Holding plans accountable for the prevention and detection of fraud, waste and abuse.
- Ensuring the validity of encounter data provided by the MCOs.
- Improving communication between government agencies and MCOs program integrity units.
- Notifying the MCOs when the provider is enrolled and is eligible to receive funds.
- Recovering overpayments resulting from compliance issues or contractual violations.
• Auditing financial statements and assessing administrative costs to identify cost savings opportunities.

The need to develop effective program integrity programs and contract compliance in managed care has become one of the most important issues facing states today. Myers and Stauffer can help your program understand managed care capitation and the federal and contractual requirements to establish a comprehensive oversight plan for your MCOs. We can provide guidance as you face the challenge of shifting from fee-for-service to managed care delivery systems and beyond to the alternative payment models of the future. For more information, see our publication, “Critical Questions State Medicaid Agencies Should Be Asking About Their Managed Care Organizations” which may be found at: http://www.mslc.com/Services_What_Managed_Care.aspx.

3. Identifying vulnerabilities and fraud through predictive and data analytics

The phrase predictive analytics should not be just another marketing slogan or buzzword, but should be one of the multitude of tools that you use to identify vulnerabilities in your program and to assist you to fight health care fraud, waste and abuse. The use of predictive analytics allows the states to take faster administrative action and prevent program losses.

The goal of predictive analytics is to move beyond statistics and historical findings to providing a best practice assessment of what may happen in the future. Data analytics can enhance the capabilities of your post-payment reviews to make recoveries. To best protect your program, both predictive and traditional data analytics can be valuable assets.

According to a 2014 report, CMS identified or prevented more than $210 million in healthcare fraud in one year using predictive analytics. CMS has identified four types of predictive analytic models being used to detect fraud, waste and abuse: rules-based, anomaly, predictive and social networking.

• Rules-based models flag certain charges automatically (e.g. charges originating from a stolen health insurance identification number would be flagged as suspect).
• Anomaly models trigger review based on factors that are improbable (e.g. billing for more time-based services than can be rendered in a day).
• Predictive models compare charges against a historical fraud profile (e.g. a provider’s billing pattern which is similar to those of known fraudsters would be flagged as suspicious).
• Social networking models raise suspicion based a provider’s associations. Link-analysis may be used to identify providers who are connected to known fraudulent providers. This form of predictive analytics is currently be used during the screening of providers with risk scoring techniques.

By using historical data, you will be able to increase the numbers of investigative leads and recoveries, detect emerging fraud and abuse schemes and trends, and prevent improper payments. By using aggressive analytical tools, you will effectively target audits and evaluations to identify program vulnerabilities and recommend systemic solutions. The results of these efforts can also lead to the creation and implementation of edits which will prevent improper payments.

Will CMS use predictive analytics to fight Medicaid fraud in your state?

In early 2016, CMS reported that the Medicaid improper payment rate has increased from 5.8%, or $14.4 billion, in fiscal year 2013 to 9.78%, or $29.12 billion, in FY 2015. CMS has stated, “…there are opportunities to transfer techniques learned through our experience with the implementation of CMS’ Fraud Prevention System and assist states with identifying program integrity risks using predictive analytics...
technologies in protecting their Medicaid programs from fraud, waste, and abuse.”

Prior to 2013, state Medicaid Fraud Control Units were prohibited from using federal funding for data mining initiatives. In 2013, HHS-OIG published a final rule allowing fraud units, subject to certain conditions (e.g. training requirements), to draw federal funding to pay for data mining tools. Myers and Stauffer can assist your state agency and MFCU with this application process and help your MFCU implement and use an effective data mining system.

4. Developing and maintaining an effective audit program

An effective and comprehensive audit program is essential to ensure that limited Medicaid dollars are spent appropriately. Such a program should include both post-payment reviews to recover overpayments and pre-payment reviews to prevent overpayments from occurring. A program should be comprehensive by subjecting a wide variety of provider categories to potential review, while at the same time targeting those areas (e.g. durable medical equipment, home health) which historically have been prone to mispayments due to system issues, policy issues or provider fault. Effective programs also efficiently utilize audit resources to deliver the most “bang for the buck”. Some resources available to the State include the Medicaid Integrity Contractor (MIC), the Medi Medi contractor and in the near future the Unified Program Integrity Contractor (UPIC).

Is your prior authorization process working with – rather than against – your retrospective review process to provide the highest possible level of payment integrity?
In addition to pre-payment and post-payment reviews, the effective use of prior authorization (PA) can be a key tool in the avoidance of improper payments. PA is required to document the medical necessity for certain services, in particular, high cost services, and can be used to ensure that a member’s medical condition warrants the requested service under your coverage guidelines.

Myers and Stauffer can assist you in evaluating and making recommendations to improve your prior authorization process.

Other questions to ask about your audit program:
- Are you achieving cost savings through your pre-payment review efforts?
- Do your audits include automated reviews, complex reviews for medical necessity and other clinical issues, onsite reviews and provider self-audits?
- Is your audit program capable of reviewing a variety of reimbursement models, e.g. fee-for-service, capitation, cost-report based rates, hospital DRGs and others?
- Have you considered the use of sampling plans and extrapolation, particularly in categories of service (e.g. clinical laboratory) with “high volume/ low dollar claims” where 100% reviews are impracticable or impossible?
- Does your program include review of specialized and complex areas such as hospital reimbursement, the upper payment limit program and others?
- Does your program include effective risk assessment and use of data analytics to identify “credible allegations of fraud” and other high risk claims involving waste and abuse?
- Are you considering new vulnerabilities that may result from the adoption of alternative payment models?
CMS is funding states to develop alternative payment models (APMs) to replace or supplement traditional fee-for-service models.

1 Department of Health and Human Services OFFICE OF INSPECTOR GENERAL THE FRAUD PREVENTION SYSTEM INCREASED RECOVERY AND PREVENTION OF IMPROPER MEDICARE PAYMENTS, BUT UPDATED PROCEDURES WOULD IMPROVE REPORTED SAVINGS June 2015 A-01-14-00503.
As these models develop and supplement or gradually replace traditional fee-for-service models, it will be critical for states to identify potential new vulnerabilities. (For more information on APMs, see item 10 below).

Myers and Stauffer has a unique combination of audit knowledge and hands-on program experience to assist states in developing effective audit programs which are tailored to your particular circumstances.

5. Ensuring contract compliance with all vendors

Many states contract with vendors for a variety of services, such as:

- Eligibility systems.
- Medicaid management information systems (MMIS).
- Pharmacy benefits management systems (PBMs).
- Dental management organizations (DMOs).
- Behavioral health organizations (BHOs).
- State health plans.
- MCOs.
- Broker services (ex. non-emergency transportation).

Management of these contracts includes the process of systematically and efficiently managing contract creation, execution, and analysis for the purpose of maximizing financial and operational performance and minimizing risk. Many states have benefited from outsourcing the management and oversight of these contracts on a short or long term basis.

Do you have a structure in place to ensure contract compliance?

During the post-award phase, it is important for you to not only ensure that contract conditions and terms are met, but also to take a close look at such items as unrecorded liabilities, under-reported revenue and overpayments. If these items are overlooked, margins may be negatively impacted. A contract compliance audit will often commence with a risk assessment. Having a dedicated contract compliance program in place has been shown to result in recoveries ranging from two to as high as twenty percent of expenditures.

**MMIS Claims and System Testing**

An often overlooked but critical function of program integrity is MMIS claims and system testing, also referred to as “benefits testing.” Such testing may be defined as a targeted, systematic policy-based analysis of claims to identify MMIS issues, policy issues and provider-generated errors.

Key components of such testing include:

- Review and validation that fee-for-service payments and financial transactions are made in accordance with policy.
- Analysis of electronic claims process, including system edits and audits.
- Analysis of encounter claims process for completeness and accuracy.
- Identification of required system modifications and system corrections.
- Recoupment of overpayments when reprocessing is not appropriate.
- Accuracy of reporting systems and reports used by state PI staff.

Recommendations to improve policies or processing rules. Myers and Stauffer offers specialized assurance services that can address the risks of managing your various contracts and ensuring contract compliance. Our staff of experts can analyze operations and conduct performance audits to answer questions critical to your success, including:

- Is your state achieving the results it sought by outsourcing?
- For your MCO contracts, is your state receiving the provider network that it sought, or has the availability of providers actually been reduced?
- Is the vendor self-reporting its performance accurately according to the terms of its contract?
- Are the services billed to your state by the vendor fully allowable under the contract?
- If a vendor’s operational plan includes a complex organizational structure and related-party contracts, are they effective?
management controls in place to ensure cost effective operations?

Myers and Stauffer can ensure accountability and contract compliance. Our audit services can provide crucial insight into MCO issues including:

- Are provider network lists accurate and up-to-date?
- Are providers properly credentialed prior to being included in a provider network?
- Are provider inquiries and prior authorizations handled in a timely manner?
- Do call centers operate in accordance with contractual requirements?
- Are complaint and appeal processes adequate?

6. Reviewing member eligibility

Since enactment of the Affordable Care Act in 2010, there has been a significant increase in Medicaid and CHIP enrollment, which currently totals approximately 72 million Americans. Viewed another way, over 72 million eligibility determinations are being made by eligibility systems collectively. Incorrect eligibility decisions can have a serious “domino effect,” potentially causing significant financial losses to your program. PI plays an integral part in evaluating the eligibility process, from the point of online application to continued analysis of membership rolls to identify inaccurate determinations or potential duplicate enrollments. Both CMS and HHS-OIG consider eligibility to be a top program integrity priority for states’ Medicaid and CHIP programs.

In addition to the capabilities of your state’s own eligibility system, additional ways of reviewing eligibility determinations include: payment error rate measurement (PERM) studies and MMIS claims and system testing (see item 5).

PERM

The Improper Payments Information Act of 2002 (IPIA) identified Medicaid and CHIP as two of various government programs which were susceptible to improper payments and for which actions were required to reduce improper payments. The PERM studies, including eligibility reviews, were designed and initiated as a response to the requirements of this legislation. Through an eligibility sample review process, PERM determines the accuracy of eligibility and payment decisions. An error rate is calculated for each component and then an aggregate error rate is calculated for both the Medicaid and CHIP programs, reported annually to Congress. A subset of states participate in the PERM review process on a rotating three-year cycle.

Whether approached as agency eligibility review, PERM eligibility review or eligibility system testing, the following functions are essential or required elements for any review:

- Analysis of eligibility determinations based upon federal and state regulations, policies, and manuals.
- Preparation of sampling plans, stratification of data and selection and validation of monthly samples.
- Ability to work with data obtained from external sources, such as the Department of Labor, Social Security Administration, and the Public Assistance Reporting Information System.
- Interaction with Medicaid/CHIP members and other information sources to obtain missing or outdated information.
- Analysis of member eligibility systems to determine compliance with HIPAA and other security standards.
- Identification and calculation of payment errors resulting from member eligibility issues.
- Preparation of corrective action plans, observations, and recommendations to improve eligibility policies and procedures.
- Collection, preparation, and submission of claims data for PERM reviews or claims testing.

Other factors to consider when thinking about developing program integrity reviews of eligibility include:
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- How often are audits performed to determine if eligibility determinations have been made correctly per state and federal guidelines?
- Does the eligibility system verify eligibility against electronic sources or is a more manual process involved?
- Can all services provided to a single member be linked regardless of changes in eligibility status?
- Are audits performed on the security protocols of the eligibility system?
- Is your system able to track federally-assisted program participants separately from other categories of assistance?
- Is there flexibility to provide reports that vary by time period and are capable of analyzing members by peer group, treatment modality, diagnosis or range of diagnosis codes?
- Is member utilization analyzed for the purposes of both improving the delivery of health care services and preventing and reducing fraud, waste and abuse?
- Do you have a system to identify unreported information or changes in member circumstances so that adjustments to eligibility are being made in advance of annual reviews? Do you actively investigate potential fraud or seek retrospective recovery when eligibility is impacted by such information?

Myers and Stauffer has extensive experience advising State Medicaid agencies on their eligibility system issues. We have also performed PERM eligibility reviews and system testing services for federal, state and local government clients since IPIA was enacted. This includes assistance to states with off-cycle, state specific mini-PERM or eligibility quality improvement initiatives. In addition, on the national level, we perform eligibility pilot studies that will impact future PERM eligibility review guidance and procedures. We have also assisted states in investigating eligibility fraud.

7. Collaborating with Medicaid fraud control units and other law enforcement agencies

State Medicaid Fraud Control Units (MFCUs) exist in 49 States and the District of Columbia and are funded with Federal and State dollars to investigate and prosecute criminal and civil cases involving fraud against the Medicaid program. Thirty states have enacted State “whistleblower” statutes to authorize false claims cases against providers and others who commit Medicaid fraud. Federal and state false claims cases have resulted in the recovery of billions of dollars to state Medicaid programs. MFCUs often partner with US Attorneys’ offices, HHS-OIG and other federal agencies which have authority to pursue such cases under the federal false claims statute. With its knowledge of the Medicaid program, a state agency can be an important contributing partner in these criminal and civil investigations, leading to significant recoveries.

Do your agency and the MFCU possess all the knowledge and tools necessary to support these investigations and obtain maximum recoveries?

False claims cases can involve complex issues requiring specialized knowledge, including:

- Specialized claims analyses.
- Clinical reviews by qualified staff who possess both medical credentials and coding certifications (few, if any, MFCUs are able to employ staff physicians).
- Expert advice and opinions in such areas as hospital, nursing home and pharmacy pricing.
- Programs governed by complex rules, such as the physician UPL program, disproportionate share hospital funding and the pharmacy 340B and rebate programs, to name a few.

As the use of managed care and APMs continue to grow in state Medicaid programs, the MFCUs and their enforcement partners must adapt their investigations to identify fraud in these programs or even fraud committed by MCOs themselves. MFCUs are required to comply with federal Performance Standards, including Performance Standard 6 “Case Mix,” requiring that the MFCUs develop a commensurate number of managed care cases. However, managed care cases can present challenges for MFCUs which
lack experience with encounter data or managed care policies and contracts.

**Have you established an effective relationship with your MFCU?**
There are risks associated with not having a good relationship with your MFCU or not having the requisite expertise to support the investigations:

- The MFCU may not identify all the issues presented by the case or potential recoveries.
- More complex elements to the case may not be developed or presented through the lack of expertise or witnesses.
- A federal investigation initially involving Medicare issues may not be expanded to consider whether the Medicaid program has also been defrauded or the Medicaid component of the case may not be fully developed.

With our knowledge and experience with State Medicaid programs and our extensive work involving fraud, waste and abuse, Myers and Stauffer is an ideal partner for MFCUs which need expert, technical or other assistance with their fraud cases.

Myers and Stauffer can assist your state MFCU with their criminal and civil fraud cases by:

- Using data analytics tools which might not be available to MFCU staff.
- Providing qualified clinical staff, including physician medical directors, nurses and certified coders, who can assist with chart reviews involving clinical and coding issues.
- Providing expert advice and opinions in complex areas, such as hospital and nursing home reimbursement, and pharmacy pricing.
- Assisting MFCUs which seek to pursue fraud investigations involving managed care providers. With our extensive experience with managed care, including validation of encounter data, we can assist MFCUs with respect to claims data, contracts and other managed care issues.

8. **Responding to external stakeholder reviews**

**CMS State Program Integrity Reviews**
The state program integrity review process plays a critical role in how CMS provides effective support and assistance to States in their efforts to combat provider fraud and abuse. The reviews are comprehensive, including examinations of provider enrollment, provider disclosures, program integrity, managed care, the state's relationship with the MFCU, and other areas.

Through these reviews, CMS assesses the effectiveness of a state's program integrity efforts, including its compliance with federal statutory and regulatory requirements. The reviews also assist in identifying effective state program integrity activities which are considered to be noteworthy and should be shared with other states.

CMS also conducts focused program integrity reviews on an as-needed basis. Focused reviews examine specific areas of program integrity concern in one or more states. Some of these focused reviews include:

- Managed care program review.
- Provider enrollment.
- Non-emergency transportation.

Each federal fiscal year the Medicaid Integrity Group publishes a “Program Integrity Review Annual Summary” to provide support and assistance to states. These summary reports include a compendium of data collected from...
comprehensive integrity reviews for which final reports were issued and, in addition, information about effective practices and areas of vulnerability and non-compliance.

**HHS/OIG Audits**

HHS/OIG has the responsibility to protect the integrity of HHS programs, including Medicaid, by identifying FWA, identifying opportunities to improve efficiencies, and holding accountable those who do not meet program requirements. HHS/OIG’s annual Work Plan summarizes new and ongoing OIG reviews of categories of service for which vulnerabilities have been identified and, in addition, identifies reviews to ensure state compliance with federal laws and regulations governing the Medicaid program and specifically state Medicaid program integrity programs. This focus on state compliance includes areas of critical importance for state Medicaid agencies, such as:

- The accuracy of state Medicaid eligibility determinations.
- The accuracy of expenditures, collections and monetary drawdowns reported by states on the Quarterly Medicaid Statement of Expenditures (Form CMS-64).
- States’ uses of payment suspensions resulting from credible allegations of fraud.
- Whether states correctly apply enhanced Federal medical assistance percentage (FMAP) payments authorized by the ACA.
- Whether states are completing Transformed Medicaid Statistical Information System (T-MSIS) data (designed to be a detailed national database of Medicaid and CHIP information).
- The performance of credit balance audits.

The 2016 OIG Work Plan also includes various reviews focused on managed care, including, among others:

- Whether MCOs are identifying FWA and how states are overseeing the MCOs’ efforts in this area.
- States’ methodologies for assigning MCO payments to different Medicaid FMAPs.
- Whether Medicaid managed care plans are appropriately and correctly reimbursed for services provided, including MLR calculations.
- Whether states’ reimbursements to managed long-term-care (MLTC) plans comply with federal and state requirements.

These areas of review can have significant, negative financial impacts on your state’s Medicaid program. Whether you are responding to a State Program Integrity Review, a focused review, an OIG Work Plan Review, or other federal or state reviews, Myers and Stauffer’s seasoned PI experts can help you provide answers to CMS, HHS-OIG and other external stakeholders.

9. Developing and maintaining an effective case management system

An effective case tracking system is essential to enable your staff to work efficiently and effectively while being capable of responding to requests for information from external stakeholders. An antiquated manual tracking system can result in a significant loss of staff time due to inefficiencies and duplication of efforts. Many of our subject matter experts have experienced the difficulty of finding a system that is designed to handle the complex government health care environment while at the same time supporting PI functions.

Considerations for choosing or developing your case tracking system include the following:

- Are you able to establish business rules to facilitate workflow?
- Do you have the ability to perform ad hoc analyses or generate status reports?
- Is your system able to produce reports based on various time frames (e.g. daily, monthly or quarterly or other)?
- Is there consistency in the use of data elements for reporting purposes?
- Can you ensure the integrity of your cases by tracking all changes?
- Do you have the ability to sort, filter, or search on designated criteria or data elements?
- Are you able to efficiently store all documents related to a case?
• Is your system able to support fraud and abuse investigations?

We understand how frustrating it is to find out you have been submitting inaccurate or inconsistent results or have been unable to verify key figures due to limitations of your current case tracking system. Myers and Stauffer can assist you in designing or adopting an effective case tracking system that will address these issues.

10. Adapting to alternative payment models and the future

During recent years both public health care programs and private plans have developed a strong interest in transitioning from the fee-for-service model to the development of alternative health care delivery and payment models which take into account quality of care. In 2010, the Affordable Care Act established tools such as the Medicare Shared Savings Program and the Center for Medicare and Medicaid Innovation (CMMI) for the purpose of transitioning from fee-for-service to APMs.

In 2013 the CMMI began the State Innovation Model (SIM) initiative to provide federal funding for states to test innovative health care delivery and payment models. Since that time, 32 states have received SIM grants. As a result of the SIM Initiative and other programs such as Delivery System Reform Incentive Payments (DSRIP), the Federal government is spending billions of dollars to incentivize states to transition from the fee-for-service model to alternative payment models which focus on quality measures and “value-based” and eventually “population based” outcomes.

Subsequently, in 2015 the Health Care Payment Learning and Action Network (LAN) was established as a collaborative network of public and private stakeholders to reform the nation’s health care system to incentivize the quality of health care outcomes. LAN aims to have 30 percent of US health care payments in APMs by the year 2016 and 50 percent by 2018. In March 2016, CMS announced that it had met early its goal of tying 30 percent of Medicare reimbursements to APMs tied to quality of care. It is possible that CMS will establish similar goals for state Medicaid programs.

These alternative payment model reforms fall into two general categories: delivery system models, such as MCOs, accountable care organizations (ACOs) and patient-centered medical homes (PCMH); and payment models, including capitation, pay for performance (P4P), shared savings, global bundling, and DSRIP.

APMs are clearly the wave of the future and present new challenges for state Medicaid programs.

Is your program prepared to adapt to this transition from fee-for-service to alternative payment models?

As part of this transition, CMS is developing “national quality measures” for incorporation into the APMs. As a result, it will become critical that State programs understand such measures, and adapt their program integrity protocols to review and oversee the use of such measures in their reimbursement system. States will need to address such questions as:

• How are the national quality measures defined?
• Do the quality measures meet the needs of your state?
• How are the measures reported? What are the data sources for these measures? Are providers, for example, self-reporting the measures? How will you ensure that such self-reporting is complete and accurate?
• How and where are the measures documented? Are the measures documented in patient charts or in Electronic Health

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With this transition, CMS is developing “national quality measures” for APMs. It will be critical that state programs understand such measures and adapt their PI protocols to review and oversee these measures in their reimbursement system.
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Records (EHR)? How can EHR systems be leveraged to enhance quality reporting?
• How are the quality measures and reporting of those measures verified?

In the early stages, funding for the development of quality measures tends to be used for such start up items as infrastructure and the establishment of reporting systems. Since this work may be developed and documented in a variety of ways requiring verification or attestation, programs will need to develop new oversight and review protocols that are tailored to their APMs.

Similarly, states will need to adapt to other payment methodologies. With respect to the increasing use of bundled payments, for example, issues will arise such as:
• Was a bundled service medically necessary and does it accurately reflect the service which was actually rendered?
• Are there instances of stinting, inappropriate patient selection, and cost shifting?
• If a payment was made to one of a number of providers who actually contributed to the bundled service, was the payment appropriately passed through to all providers?

Many government health care programs have well-established audit procedures to review claims in the fee-for-service world. These include comparing the number of units billed to the number of services rendered, or comparing the level of service billed to the level of service rendered. However, different vulnerabilities will arise for APMs based on clinical measures, and new approaches to fraud, waste and abuse will need to be considered and developed.

By assisting with such programs as SIM, PCMH and DSRIP, Myers and Stauffer has become a national leader in the transition to APMs and understands the new challenges that these methodologies present to state PI programs. We can help you to: understand these new methodologies, develop and implement new delivery and payment models and create new compliance and oversight strategies for this rapidly changing health care environment.

Need more information?
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Why Myers and Stauffer?

For nearly 40 years, Myers and Stauffer has provided professional accounting, consulting, data management and analysis services to state and federal agencies managing government-sponsored health care programs. Since the early 2000’s, Myers and Stauffer has supported states with audit and consulting services specifically focused on program integrity. In advising on program integrity issues, Myers and Stauffer draws on its work in various engagements such as PERM eligibility reviews, claims testing, electronic health records incentive payment audits, provider cost report audits, managed care audits and other compliance initiatives.

Myers and Stauffer’s staff includes a breadth of knowledge and disciplines: Certified Public Accountants, Certified Fraud Examiners, Medical Director, Registered and Licensed Practical Nurses, Pharmacists, certified coders, IT and data analysts, statisticians, attorneys and others. Our staff’s backgrounds include work for CMS and other federal agencies, state Medicaid and audit agencies (including former state PI leaders), Medicaid Fraud Control Units, fiscal agents, hospitals, pharmacies, insurance and others.