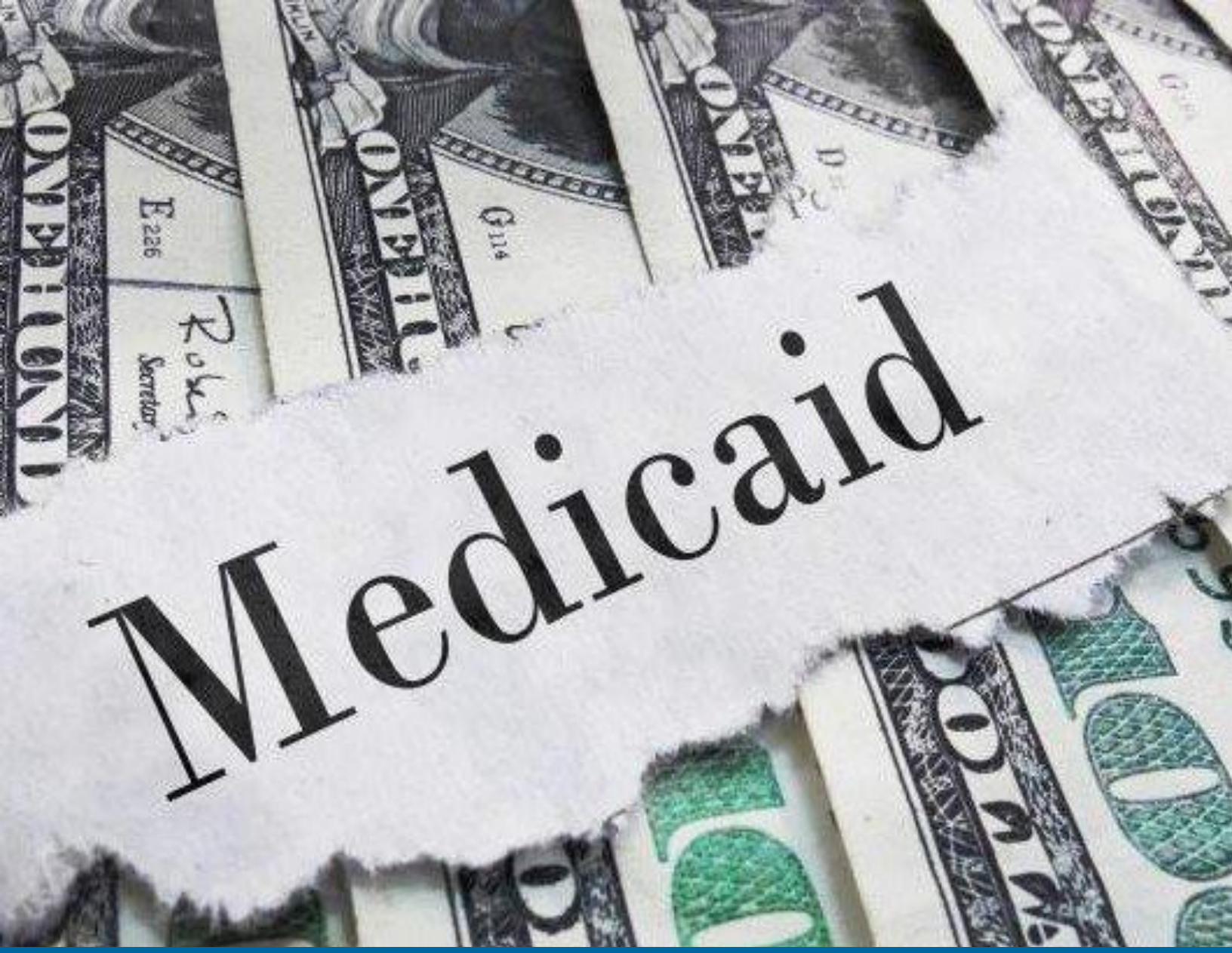

FOLLOW-UP REVIEW • REPORT NUMBER 22-06 • SEPTEMBER 2022

Medicaid/PeachCare Managed Care Program Integrity

Actions have been taken to address audit findings

Greg S. Griffin | State Auditor
Lisa Kieffer | Director

DOAA
Georgia Department of Audits & Accounts

Follow-Up Review Report No. 22-06

September 2022

Performance Audit Division
Greg S. Griffin, State Auditor
Lisa Kieffer, Director

Why we did this review

The follow-up review was conducted to determine the extent to which the Georgia Department of Community Health (DCH) addressed recommendations from our July 2020 performance audit (Report #18-05).

This performance audit evaluated the extent to which DCH included adequate program integrity provisions in its contracts with managed care organizations (CMOs); DCH utilized data to detect potential acts of fraud, abuse, or overpayments; DCH coordinated activities and actions of all payment providers; DCH ensured CMOs adequately monitor subcontractors' performance in completing program integrity responsibilities; and the Medicaid Fraud Control Unit referral process maximized the identification and recovery of overpayments.

About Program Integrity

The federal Centers for Medicare & Medicaid Services (CMS) requires Georgia to have a program dedicated to preventing, detecting, and reviewing suspected fraud and abuse cases. DCH's managed care contracts require CMOs—which establish their own health care networks—to identify, investigate, and address potential fraud and abuse. By monitoring CMO program integrity efforts, DCH can limit the amount of improper payments.

Medicaid/PeachCare Managed Care Program Integrity

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What we found

Following the original audit, DCH designated its Program Integrity Unit as the single party responsible for Medicaid program integrity, furthering an enterprise approach recommended in the original audit report. This—along with changes to the CMO contract—has improved DCH's monitoring efforts and communication with the CMOs. As noted in our original report, action taken should help reduce Medicaid overpayments and the state's managed care premium costs.

Data Analysis

The original report noted that DCH had not analyzed Medicaid payments to identify questionable claim patterns that may indicate fraud and abuse. Additionally, DCH had not ensured that the CMOs analyze their claims data for providers that another payer had determined to be a risk.

DCH has developed a process for analyzing claims data across all Medicaid payers, as recommended in the original report. Staff stated they conduct quarterly reviews to identify questionable claims that may indicate fraud or abuse, which are then shared with the Fee-For-Service division and the CMOs. DCH is currently contracting to develop an artificial intelligence data analysis tool that will further assist in its analyses of both Fee-For-Service and CMO claims data.

DCH's revised contract with the CMOs includes language requiring CMOs to have a Program Integrity Program designed to detect and prevent fraud, waste, and abuse. The contract requires CMOs to analyze their providers' payment trends to identify questionable patterns, as well as claims data of providers who have been investigated by other payers or identified as a risk for improper billing. CMOs must also now implement prepayment and post-payment reviews (i.e., reviewing documentation for certain providers before or after paying the claim to ensure Medicaid requirements were met).

Performance Monitoring

The original report noted that DCH had not defined performance goals related to the CMOs' program integrity activity levels (which varied across the CMOs), timeliness of investigations, and overpayment recoveries. In particular, we found that DCH did not monitor CMO cases to ensure actions were taken within the statutory time limits necessary to recover improper payments.

DCH has established timeliness standards for CMO fraud referrals and investigations since the original audit. These include the expected number of days for CMOs to request and review records and for DCH to approve overpayments or refer cases to the Medicaid Fraud Control Unit (MFCU). DCH has also begun tracking the status of CMO cases and referrals to identify cases at risk of losing eligibility for overpayment recovery. It should be noted that the General Assembly has not changed the statutory time limits for the CMOs to conduct post-payment audits and recover associated overpayments.

DCH has not yet included in its contract broader goals and expected performance measures related to program integrity. According to staff, future analysis of CMO activity will identify trends, such as the percentage of overpayments collected and the percentage of assigned cases that have been closed. Staff noted DCH is in the process of developing performance measures that will be included as a future contract amendment.

Communication

The original report noted that DCH had not ensured sufficient communication occurred with and among the CMOs. For example, DCH did not notify CMOs when it identified a provider at risk of submitting questionable claims, and CMOs did not report instances of provider terminations. Additionally, DCH did not ensure the status of CMO program integrity investigations or fraud referrals were accurate, complete, or timely.

Communication among DCH and the CMOs has increased significantly since the original audit. For example, DCH notifies all CMOs when it identifies providers with questionable Fee-For-Service claims or determines a provider must be suspended or terminated. CMOs are then expected to take similar action. DCH also notifies CMOs of MFCU fraud referral case status and when the MFCU concludes its investigations.

DCH has also improved the mechanisms by which CMOs communicate their activities. In particular, DCH simplified CMOs' quarterly reports into a standardized format that staff stated can be easily analyzed. The report now requires information such as the number of new cases initiated, total amounts recovered, and referrals to the MFCU. Additionally, the revised contract requires that the CMOs report all overpayment recoveries within 60 days, as well as monthly, quarterly, and annually.

DCH's Response: DCH agreed with the current status as presented in the following table.

The following table summarizes the findings and recommendations in our 2020 report and actions taken to address them. A copy of the 2020 performance audit report (#18-05) may be accessed at Medicaid/PeachCare Managed Care Performance Audit Report.

Medicaid/PeachCare Managed Care Program Integrity Follow-Up Review, September 2022

Original Findings/Recommendations	Current Status
Finding 1: Program integrity efforts are fragmented and uncoordinated among various DCH units and its CMOs, which increases the risk of undetected and unrecovered improper payments. We recommended that DCH assess and address risk of questionable payments in the Medicaid program utilizing an enterprise perspective that encompasses all organizational units, including Fee-For-Service and the four CMOs. We recommended that DCH assign responsibility for program integrity to a single party. This assignment was expected to provide the discipline and structure necessary for DCH to coordinate and guide program integrity efforts.	**Fully Addressed –** Since the original audit, DCH has begun utilizing an enterprise perspective that involves both Fee-For-Service and the four CMOs. DCH staff reported that the agency's Office of the Inspector General's Program Integrity Unit became the single party responsible for program integrity efforts in July 2020. The Program Integrity Unit, which already monitored Fee-For-Service, began auditing CMOs and reviewing providers across the enterprise. DCH also now coordinates program integrity activities with the CMOs. When investigating providers, DCH notifies the CMOs to ensure they also evaluate the provider. Additionally, DCH included language in its new contract with CMOs to ensure CMOs understand their responsibility for investigating referrals and notifying other entities of ongoing investigations.
Finding 2: DCH does not analyze payment trends for providers across all Medicaid payers once questionable claims patterns indicative of fraud or abuse are identified. We recommended that DCH analyze payment trends for providers across all Medicaid payers when a pattern of questionable claims is identified, which would allow DCH to identify whether corrective actions should be taken.	**Fully Addressed –** DCH reported that the Program Integrity Unit has developed a process for analyzing claims data for the CMOs and Fee-For-Service Medicaid programs. The quarterly reviews are intended to identify questionable claims patterns indicative of potential fraud or abuse. If questionable payment trends are identified by either Fee-For-Service or a CMO, DCH shares this information between the programs. DCH also plans to use an artificial intelligence data analysis tool to identify questionable patterns in both Fee-For-Service and CMO claims data. DHS staff anticipate that a third party contractor will implement the tool by the end of calendar year 2022.

Medicaid/PeachCare Managed Care Program Integrity Follow-Up Review, September 2022

Original Findings/Recommendations	Current Status
Finding 3: DCH does not notify CMOs of providers DCH has identified as a potential risk for submission of questionable claims. We recommended that DCH inform CMOs of the providers it identifies with questionable claims practices to enable CMOs to implement timely detective and preventive controls.	**Fully Addressed –** DCH has increased its communication with CMOs and directs CMOs to investigate providers with questionable practices that are identified through Fee-For-Service claims. In July 2020, DCH expanded the Program Integrity Unit's responsibilities to notify all payers, including the CMOs, of providers identified with questionable claims. Program Integrity Unit staff reported it has increased its communication with CMOs from quarterly to monthly to discuss concerns about providers and coordinate efforts to investigate claims. DCH also directs CMOs to investigate providers that have been identified with questionable Fee-For-Service claims.
Finding 4: DCH does not ensure that all payers analyze claims data for providers placed on prepayment reviews by one payer to determine if the other payers should take similar actions. We recommended that DCH revise its CMO contract to allow DCH to direct CMOs to conduct improper billing risk assessments for providers who have been identified as risks by other payers and placed on prepayment reviews to determine whether they should take similar action.	**Fully Addressed –** DCH has revised its CMO contract to ensure CMOs assess whether actions should be taken against providers placed on prepayment reviews by other payers. DCH also created a uniform prepayment policy applicable to both Fee-For-Service and CMOs. DCH has revised its CMO contract to ensure all payers analyze claims data to determine whether they should take actions against certain providers. Upon notice from DCH, CMOs must conduct an improper billing risk assessment of identified providers who have been investigated by other payers or identified as a risk for improper billing patterns. The contract requires CMOs to use the results of the assessment to determine whether further actions such as prepayment review, post-payment review, suspension, or termination should be taken for these providers. The contract also requires CMOs to implement prepayment and post-payment reviews based on DCH's policies and procedures, which were updated in April 2021 to include a uniform prepayment policy for Fee-For-Service and CMOs.

Medicaid/PeachCare Managed Care Program Integrity Follow-Up Review, September 2022

Original Findings/Recommendations	Current Status
Finding 5: DCH does not ensure that Fee-For-Service and CMOs review claims data for providers investigated by other payers to determine if they should also investigate. We recommended that DCH revise its CMO contract to require that CMOs assess the risk of improper billing practices for providers who have been investigated by other CMOs or the Fee-For-Service program to determine whether they should open an investigation.	**Fully Addressed –** According to DCH, the Program Integrity Unit began conducting risk assessments in July 2020 to identify providers under investigation by CMOs or the Fee-For-Service program. The Program Integrity Unit then requests that CMOs and the Fee-For-Service program investigate these providers. DCH formalized this process in the new CMO contract, which requires CMOs to conduct risk assessments of providers who have been investigated by DCH or another CMO. The CMO contract also requires CMOs to provide DCH a report summarizing the results of investigations of fraud, waste, abuse, or overpayment identified by their fraud investigative unit.
Finding 6: DCH does not ensure CMOs consistently report the termination of provider contracts due to concerns of program abuse or non-compliance. We recommended that DCH revise its CMO contract to clearly define when and how the CMOs should report terminations related to fraud, integrity, and quality issues to DCH. We recommended that DCH develop a framework that allows for the informal communication of provider terminations made as a result of program integrity concerns, but not categorized as such by the CMOs. In the original report we noted that CMOs may have found credible allegations of fraud but terminated the provider contract for business reasons (rather than "for cause"), which resulted in underreporting to DCH. As such, DCH was not alerted to assess its risk associated with these providers.	**Partially Addressed –** DCH revised its contract to require CMOs to report provider terminations; however, the contract's limited scope could continue to result in underreporting. DCH also established a process for reporting the termination or suspension of provider contracts across the enterprise. DCH's revised contract requires CMOs to report terminations that "involve issues related to fraud, waste, abuse, quality, or other program integrity concerns." However, because the language is limited to program integrity concerns, there is currently no contractual requirement that ensures CMOs have not underreported terminations that are vaguely categorized (as noted in the original report). DCH staff indicated they will issue a directive to the CMOs to report all terminations and modify contract language in a future amendment. According to DCH, the agency has worked with the CMOs to develop a standard process of reporting the termination of provider contracts. When DCH becomes aware that a CMO has taken action against a provider due to fraud, it notifies other CMOs through the Medicaid information system, as well as a letter informing them of the provider's termination or suspension. The letter directs the CMO to also take the necessary action and confirm to DCH when the termination or suspension has occurred.

Medicaid/PeachCare Managed Care Program Integrity Follow-Up Review, September 2022

Original Findings/Recommendations	Current Status
Finding 7: DCH has not defined acceptable levels of CMO program integrity activity or developed objectives for determining whether CMOs' activities are effective in identifying and preventing improper payments. We recommended that DCH clearly define standards or goals related to each CMO's program integrity activity levels. These goals should be included in the CMO contracts to provide the necessary foundation for assessing CMO performance and for enforcing the adherence to established standards. We recommended that DCH staff analyze CMO activity reports to identify trends in CMO program integrity activity levels and outcomes. We recommended that DCH establish performance standards related to the timeliness of investigation completion to ensure that associated overpayments remain eligible for recovery. Finally, we recommended that DCH track overpayment recoveries resulting from program integrity actions. DCH was expected to analyze the case reports to identify baseline investigation outcome measures and develop performance goals related to CMO overpayment recovery.	**Partially Addressed –** DCH has established timeliness standards for CMO fraud referrals and investigations, though broader goals related to program integrity have not yet been incorporated into the CMO contract. DCH is also working to establish a mechanism to collect CMO reports, which will facilitate detailed analysis. According to DCH staff, in March 2021 CMOs agreed to adhere to the timelines that DCH established for CMO fraud referrals and investigations. These timelines include the expected number of days for CMOs to request and review records and for the Program Integrity Unit to approve overpayments or send fraud referrals to the Medicaid Fraud Control Unit (MFCU). The goal of the timelines and their associated performance standards is to ensure CMOs complete investigations in time to meet statutory requirements related to overpayments. DCH reported that it has begun analyzing CMO activity reports, which are now submitted in a simplified standard format to identify trends. DCH staff stated the Program Integrity Unit collaborated with CMOs to establish a secure site that will enable CMOs to upload case tracking information for further analysis. Quarterly, DCH verifies identified overpayments and amounts recouped in the quarter and to date. Additionally, staff stated they monitor CMOs' activity levels and plan to share results with CMOs during their monthly meetings. Staff stated future analyses will identify trends by provider type, number of days to notify a provider of overpayment, the percentage of overpayments collected, and the percentage of assigned cases that have been closed. DCH has not yet included performance standards and goals related to program integrity in the CMO contract. DCH staff stated it is in the process of developing performance measures that will be included as an amendment to the recently revised contract. As stated in the original audit, any performance measures should address activity levels such as the number of cases closed (which varied by CMO) along with the length of investigations.

Medicaid/PeachCare Managed Care Program Integrity Follow-Up Review, September 2022

Original Findings/Recommendations	Current Status
Finding 8: DCH does not ensure that information reported by CMOs regarding the number and status of CMO program integrity investigations is accurate or complete. We recommended that DCH consider eliminating the duplicate quarterly reports required of the CMOs and allow CMOs to report case information on one standard quarterly report. If it continued with two reports, we recommended that DCH review and compare quarterly fraud reports and quarterly meeting reports to identify potential discrepancies, gaps, and errors. We recommended that DCH require CMOs to report potential and actual overpayment recoveries. We also recommended that DCH include this information as a separate field in the quarterly fraud reports and quarterly meeting reports. We recommended that DCH develop an information system that would enable Program Integrity staff to track each CMO's caseload.	**Fully Addressed –** DCH eliminated its second quarterly report and created a standardized template for the CMOs. DCH's revised contract requires each CMO to regularly report the results of its fraud investigative unit's work and overpayments recovered. In December 2020, DCH's Program Integrity Unit simplified CMOs' quarterly reports into one standardized format, which can be sent across the enterprise through SharePoint. The report requires information such as the number of new cases initiated, total amount of payments recovered, providers placed on prepayment review, and MFCU referrals. The MFCU also completes a report that tracks active cases from the CMOs. DCH staff stated the Program Integrity Unit tracks the number of opened and closed cases via a monthly report. DCH revised its contract to require CMOs to submit monthly, quarterly, and annually the results of investigations of fraud, waste, abuse, or overpayment that were conducted by the CMO fraud investigative unit. CMOs must also report all overpayment recoveries within 60 days, as well as monthly, quarterly, and annually. CMOs currently use a SharePoint site to document case status, closed date, referral status, and case determination. Staff reported that the data analysis tool previously discussed will further augment the efforts to track each CMO's caseload.

Medicaid/PeachCare Managed Care Program Integrity Follow-Up Review, September 2022

Original Findings/Recommendations	Current Status
Finding 9: DCH does not ensure that it receives or communicates accurate and timely information regarding CMO fraud referrals or the status of CMO fraud investigations, resulting in inadequate oversight of these cases. We recommended that DCH develop an information system that would enable Program Integrity staff to track cases referred to the MFCU. We also recommended that DCH eliminate email as the primary means to track case status. We recommended that DCH issue notices to CMOs when MFCU investigations have concluded, which would enable the CMOs to resume investigations and recover any associated overpayments.	**Fully Addressed –** DCH has begun tracking cases referred to the MFCU and notifying CMOs of the status of investigations. DCH reported that the data analysis tool it is developing will allow staff to track cases referred to the MFCU. Program Integrity staff use SharePoint to track these cases in the interim. Staff can document information such as the case referral date, whether the MFCU opened an investigation, the case determination, and current status of these referrals. While email has not been replaced entirely, it is no longer the primary means to track case status. DCH now documents decisions about MFCU fraud cases and notifies CMOs when investigations have concluded. DCH uploads a notification letter and the investigation's results to the CMOs' drop box on SharePoint (physical copies of the official notification letter and results are also mailed).

Medicaid/PeachCare Managed Care Program Integrity Follow-Up Review, September 2022

Original Findings/Recommendations	Current Status
Finding 10: DCH does not monitor CMO cases to ensure that actions, including fraud referrals, are made within the statutory time limits for administrative recovery of improper provider payments, resulting in the forfeiture of approximately $1.4 million in estimated recoverable funds. We recommended that the General Assembly consider exempting the CMOs' operations from O.C.G.A. § 33-20A-62, which restricts the amount of time health plans may audit claims and recover overpayments in the managed care environment. This would allow CMOs more time to conduct post-payment audits and recover associated overpayments. As in other states, DCH could facilitate Medicaid managed care audits and recoveries according to its Fee-For-Service time frame (i.e., three years). We also recommended that DCH implement procedures to monitor the status of CMO cases to ensure that all actions, including claims audits and fraud referrals, occur within the time frame allowed by state law for administrative recovery of overpayments. We recommended that DCH implement procedures to track the status of MFCU investigations to identify any CMO cases at risk of aging out of eligibility for administrative recovery and to request that the MFCU expedite their prosecution decision.	**Partially Addressed –** The General Assembly has not revised O.C.G.A. § 33-20A-62. DCH has established a SharePoint site for the CMOs to document and track case details such as status, closed date, and whether the case is at risk of becoming ineligible for overpayment recovery. The General Assembly has not passed legislation to exempt CMOs' operations from statutory time limits for conducting post-payment audits and recovering associated overpayments. Consequently, CMOs are still generally limited to 18 to 24 months from the date of service to recover overpayments using administrative actions. This can indirectly reduce recovery of Medicaid overpayments. DCH staff stated that the timeliness standards created for CMO fraud referrals and investigations are designed to help ensure that CMOs meet the statutory time limits for administrative recoveries. Additionally, DCH has developed a business process that outlines the protocol for CMO fraud referrals, which includes a process for notifying CMOs of MFCU investigation results. Finally, DCH indicated it updated its memorandum of understanding to state that the MFCU will either accept or reject CMO fraud referrals within 30 days of receipt to enable CMOs to recover administrative overpayments if the referral is rejected. However, CMOs' ability to recover overpayments is reduced if the MFCU accepts the referral due to the related business and legal processes. DCH currently uses SharePoint to track case status, closed date, MFCU referral status, and the date the case will no longer be eligible for payment recovery. The CMOs' quarterly fraud reports also provide information for DCH to monitor the status of fraud referrals, and the MFCU provides CMOs updates at quarterly meetings. DCH staff stated they plan to replace SharePoint with an artificial intelligence data analysis tool. At that time, DCH will monitor case opening and closing dates to ensure CMOs adhere to statutory requirements.

Medicaid/PeachCare Managed Care Program Integrity Follow-Up Review, September 2022	
Original Findings/Recommendations	**Current Status**
Finding 11: DCH does not ensure that CMOs monitor their subcontractors' performance in preventing, detecting, and recovering improper Medicaid payments. We recommended that DCH implement procedures to ensure that the contract documents contain necessary program integrity activity and reporting requirements. We recommended that DCH implement procedures to review program integrity activity information reported by CMOs for indicators confirming CMOs' subcontractors are conducting a satisfactory level of program integrity activities.	**Partially Addressed –** DCH has updated its contract to include general subcontractor language related to program integrity. DCH will contract with a third party to review, monitor, and evaluate the CMO subcontractors' program integrity activities, which will inform future contract language. DCH's revised contract states that CMOs must ensure their contractors have "internal controls designed to prevent, reduce, detect, investigate, correct, and report known or suspected fraud, abuse, and waste activities." The contract does not include specific language related to specific program integrity activity or reporting; however, DCH staff stated this will be added as an amendment based on a third-party review. DCH is developing a contract aimed to determine whether CMOs effectively monitor their subcontractors' performance in preventing, detecting, and recovering improper payments. This includes confirming the CMOs' contracts outline program integrity responsibilities; reviewing subcontractors' policies and procedures related to fraud, waste, and abuse; and determining whether the subcontractors have a system to monitor and report program integrity cases.
11 Findings	**7 Fully Addressed** **4 Partially Addressed** **0 Not Addressed** **0 No Recommendations**

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