Managed Care Organization

AUDIT GUIDE

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An elevated approach to program analysis.

Managed Care Organization Audit Guide

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5911 Kingstowne Village Parkway, Suite 210
Alexandria, VA 22315

Visit our website at www.integritym.com

Contact our team at info@integritym.com

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MANAGED CARE ORGANIZATION AUDIT GUIDE

Purpose

This Audit Guide is for use in developing comprehensive or limited scope audits of Managed Care Organizations (MCO) under the Medicaid program. The Audit Guide is intended to present a general approach for the review of various audit areas tailored to the depth or degree of coverage as the auditor and other interested parties determine. The guide serves as a tool in assisting the auditor to assure the review of various aspects of the MCO and its operations complies with governing regulations, program rules, and generally accepted auditing standards.

Background

Federal regulations require that all audit work performed by Federal or federally contracted auditors is accomplished in accordance with Generally Accepted Government Auditing Standards (GAGAS), which are promulgated by the Government Accountability Office (GAO). GAGAS are contained in the GAO publication commonly known as the Yellow Book. All audit work should be performed and documented in accordance with these standards. The use of this Audit Guide will assist an auditor to plan and implement review steps in accordance with those standards.

In the past, the Centers for Medicare & Medicaid Services (CMS) used contractors to audit providers participating in the Medicaid program. The reviews cover numerous aspects, including program integrity and economy and efficiency. The audits were full field audits or desk reviews and could be limited in scope. The audits included not only providers receiving payment on a fee-for-service basis, but also organizations having in-house or contracted provider networks that provide services under a managed care capitation arrangement. The vast majority of these contracted audits involved fee-for-service providers.

Currently, a majority of Medicaid program beneficiaries are enrolled in a managed care environment, and managed care expenditures are growing at a faster rate than fee-for-service payments. The size and diversity of the Medicaid managed care program make it particularly vulnerable to misinterpretation or circumvention of the governing regulations, resulting in unwarranted cost-cutting, questionable service delivery, and improper payments.

Scope

The scope of this Audit Guide is to make a determination as to whether the MCO complied with Federal and State requirements in the performance of its risk-based Medicaid contract. It contains relevant Federal criteria and reviewed standards as established by other professional sources, such as industry groups.

Methodology

This Audit Guide is intended to cover the major facets of a managed care operation and includes a section outlining the logical implementation of the review by phases. The latter part of the Audit Guide contains 15 segments, each addressing an identifiable functional area or operation. A comprehensive audit would make use of all 15 segments. A limited scope audit would contain one or more segments. Each segment can be accessed and completed independently to suit the scope of review as the auditors and other interested parties determine.

The segments included in this Audit Guide are for the auditor's guidance and are not intended to replace professional judgment. Additional or modified audit segments may be needed in some cases. Material changes to the audit approach should be approved by audit management before proceeding.

Criteria

In performing a specific audit, the auditor will need to obtain the specific State Medicaid agency's criteria for managed care organizations as well as the specific MCO contract for the MCO to be audited. The terms of the specific MCO contract should be consistent with Federal criteria because the contract is required to be reviewed and approved by CMS prior to the State Medicaid agency signing it. For these reasons, the specific MCO contract is excellent criteria for use by the auditor in conducting the review because it should conform to all applicable Federal and State criteria. By signing the contract, the MCO agrees to all of its terms.

In developing this Audit Guide, we researched and used various criteria, such as:

- 42 Code of Federal Regulations (CFR) Part 438
- 42 CFR Section 1396
- CMS Policy Guidance
- CMS Checklist for Managed Care Contract Approval - February 14, 2014
- 42 CFR 482.24(c)(1)

- recent regulatory requirements and guidance published on May 6, 2016 at 81FR 27498-27901

Medical Records

Various segments of this guide suggest using medical records as an important source of information when conducting the audit. The use of medical records generates the question of what exactly should be included in a medical record. The type of provider is a factor to be considered. For example, necessary documentation in the medical record maintained by a durable medical equipment supplier is different from the necessary documentation in the medical record maintained by the patient's primary care physician. Auditors need to review the specificity of medical record requirements in the MCO contract with the State Medicaid agency and the MCO contracts with network providers and internal medical staff guidance.

Sampling

Many of the segments of this guide may require the auditor to draw a sample. We have not prescribed what type of sample to take (i.e., random, stratified, or judgmental/purposeful). The decision should be based on the audit objectives. Depending on the specific audit, many of the populations could be quite small, thereby reducing the value of random samples. Therefore, the types of sample and the number of sample items are left to the auditor's discretion based on the audit scope and CMS guidance.

The decision to use a random, stratified, or judgmental sample should be based on auditor judgment. Often, a small judgmental sample will suffice, such as when the sampling objective is to verify that internal controls are functioning as intended, or to perform a "walk-through" of systems to see how they work. When a sample is needed to determine the amount or rate of unallowable claims, generally a random or stratified random sample is needed to extrapolate the results. Depending on the segments being used in any particular audit, it is possible that a single sample of claim lines, claims, recipient date of services, or other sample units can be used to meet multiple objectives.

Documenting Audit Results

Each of the segments should be referenced to applicable working papers showing what and how the work was accomplished and what conclusion the auditor has arrived at based upon the work. This documentation is consistent with GAGAS requirements. In addition, if a finding or potential finding exists, the auditor should document the GAGAS elements of a finding (criteria, condition, cause, effect, and recommendation).

Review Implementation

The audit should proceed logically and systematically to use audit resources efficiently and effectively. The audit work is broken down into 7 phases, each of which has a bearing on how and to what extent the audit is conducted. The phases are defined as follows:

- Phase 1 - Selection of Auditee and Scope of Review
- Phase 2 - State Agency Background Information
- Phase 3 - Initial Risk Evaluation
- Phase 4 - MCO Documentation
- Phase 5 - Risk Re-evaluation
- Phase 6 - Detailed Audit Procedures/Data Verification Using Applicable Segments
- Phase 7 – Reporting

PHASE 1 - Selection of Auditee and Scope of Review

The auditor needs to identify clearly the entity to be audited and what exactly is to be audited. A comprehensive audit requires the use of all 15 segments. If that is not feasible, the scope of review needs to define exactly what segment(s) constitute the scope of the audit.

PHASE 2 - State Agency Background Information

The auditor should obtain and review relevant Federal and State agency criteria. Important Federal regulatory criteria are found at 42 CFR 438. The Medicaid single State agency can supply relevant State criteria. The auditor should obtain a complete copy of the contract (including documents included by reference and all appendices) and note requirements, including deliverables. The auditor should obtain, if possible, the State Medicaid agency's opinion on MCO compliance with the MCO contract and the basis for its opinion (this includes compliance with contract deliverables). Any past reviews of the MCO by various other entities (such as the State Insurance Commissioner) in the State agency's possession should be obtained and evaluated.

PHASE 3 - Initial Risk Evaluation

This Audit Guide was developed based on recognizing risks. In planning the audit of an MCO, the auditor needs to give careful consideration to two types of risk - audit risk and MCO program risk.

Audit risk is the possibility that the auditor's findings, conclusions, recommendations, or assurance may be improper or incomplete due to factors, which can be controllable or uncontrollable.. The assessment of audit risk involves quantitative and qualitative considerations. Audit risk includes

the risk that auditors will not detect mistakes, inconsistencies, significant errors, or fraud in the evidence supporting the audit. Adhering to GAGAS standards is an important tool in reducing audit risk.

MCO program risk deals with the provision of medically necessary care to MCO enrollees. State Medicaid Agencies make capitated payments to the MCO with the MCO assuming the responsibility for providing all necessary medical care. The HMS Federal auditor needs to be aware that there could be factors, which interfere with the MCO providing necessary medical care. Merely auditing MCO payments to providers does not necessarily give assurance that all medically necessary care was provided. The financial incentives in an MCO environment are not the same as those in a fee-for-service environment.

The auditor uses the information gathered in Phases 1 and 2 in determining the specific risk in the segments included in the audit. This determination may affect/modify the scope determined in Phase 1. Any change in scope needs to be communicated, authorized, and documented by all relevant parties.

PHASE 4 - MCO Documentation

The auditor should conduct an entrance conference with the MCO and explain the audit objectives and accompanying timeframe. The auditor should request a complete and up-to-date copy of the MCO's written policies and procedures (to include internal controls) along with a list and an explanation of schedules, metrics, and other relevant reports. The auditor should request the MCO to produce copies of reviews (e.g., internal audit reports, external audit reports, consultant reports, Insurance Commissioner reports) and MCO corrective actions in response to those reviews.

PHASE 5 - Risk Re-Evaluation

The auditor should evaluate all of the information gathered at this point and re-determine risk. The amount of and the relative importance of risk along with monetary and timing constraints will determine the audit scope as well as the detailed audit procedures needed to satisfy the scope of review. One of the more important risks to be addressed is whether a capitated MCO is providing all medically necessary services to enrollees. This risk needs to be addressed through appropriate medical review of comprehensive enrollee medical records, and analysis of enrollees who received few or no medical services.

PHASE 6 - Detailed Audit Procedures/Data Verification Using Applicable Segments

The applicable review segments are the foundation for Phase 6. This phase would include the performance of detailed audit steps addressing the

requirements contained in the specific MCO's contract. All audit work should be documented in accordance with GAGAS. Applicable professional standards should be used; if they are not followed, a written determination for their exclusion should be included in supporting working papers. Conclusions should be documented in the working papers. Any findings should contain the proper elements of a finding as contained in the Yellow Book (criteria, condition, cause, effect, and recommendation).

PHASE 7 - Reporting

Audit results are usually reported by issuing a draft audit report and subsequently, a final audit report. Reports should comply with the GAGAS reporting standards for performance audits. The MCO should be given the opportunity to formally respond to possible findings in the draft report. The final report should, at a minimum, summarize the MCO's opinion of findings.

A condensed description of the 15 Segments begins on the next page.

Segment Descriptions

For each segment, the auditor must first determine contractual requirements and determine if the MCO has developed and implemented written policies to address the elements of the segment.

MCO Segment 1 - Contract Award and Reporting Requirements

Objective: The purpose of this segment is to assure that contractual deliverables are accurate and timely. The entire MCO contract must be made available to the auditor for review. The State Medicaid agency may need to be consulted when confirming its receipt of deliverables.

MCO Segment 2 - Organization and Structure

Objective: The purpose of this segment is to assure that the MCO's organizational structure meets various legal requirements; can provide all required medical services; and that MCO executives possess the required knowledge, skills, and abilities to perform their duties. The auditor may need access to the personnel files of all MCO executives to perform this segment.

MCO Segment 3 - Language and Cultural Competency

Objective: The purpose of this segment is to assure that the MCO recognizes and addresses the cultural and linguistic diversity of enrollees and the needs of disabled enrollees.

MCO Segment 4 - Marketing

Objective: The purpose of this segment is to assure that marketing actions and materials are truthful and understandable and, if needed, received prior approval from the State Medicaid agency.

MCO Segment 5 - Enrollment, Education, and Outreach

Objective: The purpose of this segment is to assure that enrollees are provided with sufficient information (including an enrollee information handbook and provider directory) to obtain medically necessary care. The auditor will need to determine if the documents contain accurate information and are periodically updated.

MCO Segment 6 - Enrollee Services

Objective: The purpose of this segment is to assure that an enrollee services group is available to personally assist enrollees in obtaining care. The auditor will need to determine the qualifications of members of the group and their access to information.

MCO Segment 7 - Enrollee Medical Coverage

Objective: The purpose of this segment is to assure that enrollees receive all medically necessary care, including emergency care. In performing this segment, the auditor will need complete access to enrollees' medical records to assure that all identified needs were addressed.

MCO Segment 8 - Provider Network and Access

Objective: The purpose of this segment is to assure that qualified providers are available to provide necessary care services. As such, auditors will need access to provider membership records. In performing work in this segment, the auditor may want to consider reviewing and assessing the applicability of the findings contained in a recent HHS/OIG report entitled "Access to Care: Provider Availability in Medicaid Managed Care" (OEI-02-13-00670). The report can be accessed here.

MCO Segment 9 - Utilization Management, Care Coordination, and Case Management

Objective: The purpose of this segment is to assure that care provided to a specific enrollee by various providers is coordinated and case management services are provided when necessary.

MCO Segment 10 - General Financial Controls

Objective: The purpose of this segment is to assure that assets are safeguarded; required financial information is readily available, accurate, and timely; regulatory financial requirements are met; and year-end financial statements are independently audited.

MCO Segment 11 - Management Information System (MIS)

Objective: The purpose of this segment is to assure that the management information system (MIS) is documented and provides accurate and timely data to all users.

MCO Segment 12 - Quality Assessment and Performance Improvement

Objective: The purpose of this segment is to assure that the provision and quality of care is actively monitored on an ongoing basis and that the results are used to improve performance. In performing this segment, the auditor will examine to extent to which the MCO monitors the quality of network providers.

MCO Segment 13 - Grievances, Appeals, and Fair Hearings

Objective: The purpose of this segment is to assure that Grievances, Appeals, and Fair Hearings are completed properly.

MCO Segment 14 - Claims Processing

Objective: The purpose of this segment is to assure that requests for payment for services rendered are monitored and adjudicated in a timely manner.

MCO Segment 15 - Compliance Activities

Objective: The purpose of this segment is to assure that corporate compliance activities are comprehensive, utilize a code of conduct, and require the training of all staff. In performing this segment, the auditor will examine the role of the MCO Compliance Officer.