PUBLIC TESTIMONY SUMMARY

I-900 STATE AUDITOR'S PERFORMANCE AUDIT:

Health Care Authority's Oversight of the Medicaid Managed Care Program (April 14, 2014)

As Heard by the Joint Legislative Audit & Review Sub-Committee on I-900 Performance Audits on April 23, 2014

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Title: Health Care Authority's Oversight of the Medicaid Managed Care Program

Audit Scope and Objectives:

SAO reports that the audit asked the following questions:

1. Are managed care organizations overpaying for medical expenses? If they are, why did overpayments go undetected, and how do the overpayments affect premium rates?
2. Are policies and procedures in place to ensure costs reported by managed care organizations to the third-part actuary:
   - Offset recoveries, rebates and refunds against medical costs;
   - Include only allowable administrative expenses and allocate costs on a reasonable basis; and
   - Report costs related to subcontractors properly?

SAO used a sample of claims from Calendar Year 2010 for its analysis.

SAO Findings:

SAO summarized the audit issues as follows:

- Inadequate oversight and data analysis led to overpayments;
- Undetected overpayments in 2010 resulted in potential higher premium costs in 2013;
- Data used to set 2013 premium rates was not verified and retained;
- Inconsistent reporting of administrative costs, recoveries and rebates.

SAO Recommendations:

SAO summarized its recommendations as follows:

The Health Care Authority (HCA) should improve its oversight of managed care organizations to ensure appropriate controls are in place to detect and prevent medical and administrative cost overpayments, and also provide guidance on the reporting of medical cost recoveries and administrative costs. By examining and updating its contract language with the managed care organizations as appropriate, the HCA should be able to address our recommendations and allow the state to recover any future overpayments identified in state and other audits.

SAO recommendations to HCA include these key elements:

1. Review and improve the controls used to prevent overpayments by requiring the managed care organizations to review their system edit checks and post-payment procedures to ensure claims are reviewed in sufficient detail to identify miscoding and other causes of overpayments.
2. Update contract language with the managed care organizations to allow the HCA to recover overpayments identified in state and other audits where appropriate.
3. Require the organizations to report detailed claims and administrative cost data to the HCA in a prescribed format on a periodic basis.
4. Create and implement a comprehensive revenue, cost reporting and monitoring system to enhance accountability for the managed care organizations' compliance with contract provisions.
5. Provide better guidance and criteria for defining medical and administrative expenses and recoveries, including what are allowable expenses and when rebates and recoveries should be reported.

Agency Responses in Audit Report?	Yes, beginning on page 44
Legislative Action Requested?	No

Agencies Testifying:

The Office of Financial Management (Tracy Guerin, Deputy Director)

Health Care Authority (Mary Anne Lindeblad, Medicaid Director)

Summary of Testimony from Audited Agencies:

We found the audit helpful for our stewardship of the Medicaid Managed Care Program. The Health Care Authority (HCA) has begun implementing some of the same steps that were recommended in the audit. The agency also has a robust action plan to make further improvements.

HCA has stepped up to improve oversight of the Medicaid Managed Care Program. Many things have changed since the SAO audit's 2010 data extraction. In the Fall of 2013, we established a special quality control unit to increase the accuracy and timeliness of the data we receive from the managed care plans. We also changed the way we get the data from the plans. It now comes

directly to the HCA, giving us the opportunity to review it for quality and completeness. We have also put in place a one percent withhold on the plans' premiums if they do not submit timely and accurate encounter data, so there is an incentive for them to get us the correct data. In the Spring of 2012, we began an initiative to refocus and step up our Managed Care Program integrity and accountability. This now includes a closer look at other things outside the rates, such as subscriber grievances and care coordination.

We do have some disagreement on the sampling methodology used in the audit as explained in the written response. Our focus moving ahead will be to continue to ensure that our managed care plans are in compliance with our processes, that those processes reflect best practices, and that the oversight ensures that the plans pay their providers correctly.

Other Parties Testifying:

(No other parties signed in to testify.)

Summary of Testimony from Other Parties:

(No other parties signed in to testify.)