Audit Overview:
Preventing and Detecting Medicaid Fraud, Waste, and Abuse in Managed Care
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Why the audit is being conducted

Audits of Medicaid managed care programs in other states have determined that these programs are at a high risk for fraud, abuse, and improper payments. Managed care programs are different than traditional fee-for-service programs because the state pays a fixed amount per member per month, based on historical medical claims data and administrative expenses. If improper payments are made but go undetected, the state may be paying too much for the program.

During fiscal year 2011, the Health Care Authority spent $1.5 billion for Medicaid managed care programs. During this period, Healthy Options, which is the largest of the managed care programs and the focus of this audit, provided care to more than 670,000 people at a cost of $1.3 billion. This audit will evaluate potential improper payments on Medicaid claims in the rapidly growing Healthy Options program.

Overpayments could result in an unwarranted increase of monthly premium payments which could increase the state's long-term health care costs.

Our analysis identified potential improper payments

During our preliminary analysis of claims data, we identified areas with the highest potential risk for overpayments, including the following examples:

- Providers with higher-than-usual rates of procedures with complications that could indicate over-billing.
- Brief hospital stays of less than a day that should have been billed as outpatient services instead of more expensive inpatient services.
- Patients with many prescriptions, or prescriptions taken over a long period of time, that may indicate abuse of prescription drugs.

Next steps

We will drill down in the above areas and test a sample of claims for overpayments. If improper payments occurred, we will review what caused them and estimate the extent to which they increased the state's costs.

We will also evaluate managed care organizations' reporting of administrative costs, recoveries from other insurance programs, and prescription rebates.

The results of our audit will be released in late 2013.

Medicaid managed care in Washington state

Medicaid is a joint federal-state program that provides health coverage to families with children and pregnant women, medically needy individuals, the elderly, and people with disabilities who meet state and federal income and other guidelines. The program provides coverage for approximately 1.2 million Washington state residents at an annual cost of about $8 billion.

Medicaid managed care is a significant component of Washington's Medicaid program, representing 57 percent of all Washington Medicaid members during fiscal year 2011. The state Health Care Authority runs this program.

The Authority contracts with managed care organizations to provide coverage for each member and pays the organization a monthly amount per member. In 2011, managed care organizations received more than $1.3 billion from Washington state and the federal government to provide medical care for about 670,000 people.

Healthy Options Managed Care Organizations: Total paid and program enrollment

Managed Care	Fiscal Year 2009	Fiscal Year 2010	Fiscal Year 2011
Total paid	$1.30 billion	$1.31 billion	$1.34 billion
Number of members enrolled	576,761	658,333	672,963

Risks of fraud, abuse, and improper payments

The challenges inherent in overseeing a program of Medicaid's size and diversity make the program vulnerable to improper payments. For fiscal year 2011, the federal Department of Health and Human Services estimated an improper payment rate of 8.1 percent for Medicaid nationwide.

Audits of Medicaid managed care programs in other states have found errors and irregularities, including:

- Providers overstating medical claims.
- Managed care organizations inaccurately reporting claims.
- Overstated administrative expenses or payments to managed care organization affiliates.
- Underreported rebates and recoveries from other insurance plans.

These types of errors and irregularities can increase the amount that states pay for managed care.

Scope of the audit

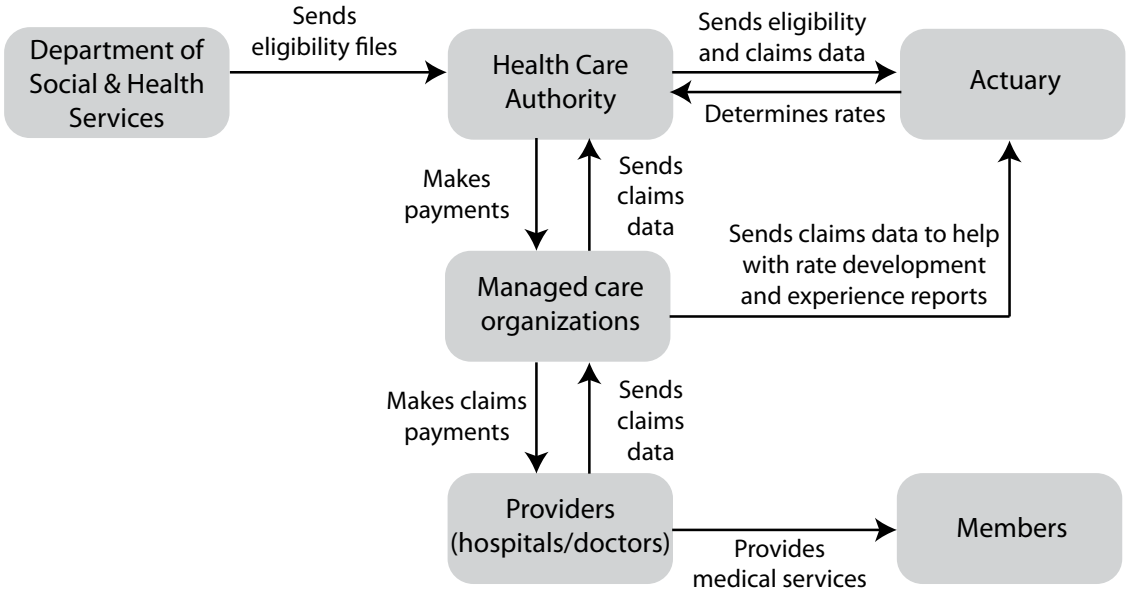
In connection with a competitive bidding process for the period starting July 1, 2012, the Health Care Authority selected five managed care organizations to provide services under the new contracts. Our audit covers 2010 health care claims processed by the two largest Medicaid managed care organizations in Washington. Together, they provided services to more than 80 percent of Washington's managed care members and received more than $1 billion in payments.

How Medicaid managed care works

Who is involved in the delivery of Medicaid managed care?

- The Health Care Authority administers the program, oversees managed care organizations, and pays the organizations a monthly amount to provide services to members.
- The Department of Social and Health Services determines member eligibility.
- Managed care organizations contract with providers for services, pay providers when services are rendered, and receive monthly payments from the Health Care Authority.
- Providers are the health care facilities and doctors providing services to members and billing managed care organizations.
- The actuary determines rates for future premium payments based on managed care organizations' claims and cost data.
- Members are patients receiving services from providers.

Washington's Medicaid managed care structure



Washington expects Medicaid enrollment to grow by 26 percent in 2014

The federal Affordable Care Act allows states to expand eligibility to people in households earning up to 138 percent of the federal poverty level. The Health Care Authority has said it expects this expansion could add 325,000 people to the Medicaid rolls in 2014. If this occurs, the Authority expects that managed care participation could rise proportionately. This would mean about 185,000 more enrollees – an increase of more than 26 percent on current participation.

This potential expansion makes it even more important to ensure the program is properly monitored. Even a slight decrease in the rate paid to the managed care organizations for each member enrolled in the program could result in substantial cost savings.

Medicaid Programs: How does managed care compare to fee-for-service?

In a fee-for-service program, providers bill the state directly for services to members. In a managed care program, the state pays the managed care organization a monthly premium, also known as a capitation rate, for each member and the managed care organization pays providers for their services. The premium payment is determined by an actuarial analysis of the historical costs of the program.

As a result, the managed care organization, rather than the state, bears the risk that the payments will be insufficient to cover the cost of care, or benefits if the cost of care is less than the premiums received. The benefits of managed care to the state are two-fold:

- It shifts the short-term risk of increased medical costs to the managed care organizations
- Costs are more predictable in the short term, since capitation rates are more stable.