Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-15

Request Titles

R-15 Managed Care Organization Audits

Dept. Approval By: Josh Block

OSPB Approval By:

___	**Supplemental FY 2014-15**
X	**Change Request FY 2015-16**
___	**Base Reduction FY 2015-16**
___	**Budget Amendment FY 2015-16**

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16 FY 2015-16	FY 2016-17 Continuation
Total of All Line Items	**Total**	**$2,463,406**	**$0**	**$2,463,406**	**$300,000**	**$300,000**
	FTE	-	-	-	-	-
	GF	$969,283	$0	$969,283	$150,000	$150,000
	CF	$262,420	$0	$262,420	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$1,231,703	$0	$1,231,703	$150,000	$150,000

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16 FY 2015-16	FY 2016-17 Continuation
01. Executive Director's Office - Professional Audit Contracts	**Total**	**$2,463,406**	**$0**	**$2,463,406**	**$300,000**	**$300,000**
	CF	$262,420	$0	$262,420	$0	$0
	FF	$1,231,703	$0	$1,231,703	$150,000	$150,000
	GF	$969,283	$0	$969,283	$150,000	$150,000

Letternote Text Revision Required? Yes ___ No X ___

If Yes, describe the Letternote Text Revision:

Cash or Federal Fund Name and CORE Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name: N/A

Approval by OIT? Yes ___ No ___ **Not Required:** X

Schedule 13s from Affected Departments: N/A

Other Information: N/A

Cost and FTE

- The Department requests ongoing funding of $300,000 total funds, including $150,000 General fund to hire an auditing firm to perform audits on financial reports and encounter data from physical and behavioral health managed care organizations that contract with the Department. This request would not require any additional FTE.

Current Program

- The Department contracts with behavioral and physical health managed care organizations to provider or arrange for services for Medicaid clients enrolled with one of these organizations.
- In FY 2013-14 the Department spent over $700,000,000 on behavioral health and physical health managed care contracts.

Problem or Opportunity

- Currently, the Department does not audit the financial or encounter data beyond assessing the reasonableness of payment at a high level of aggregation based on summary statistics.
- Similarly, the Department is currently evaluating applying medical loss ratios (MLRs) across all managed care plans as an effective way to ensure that health plans are adequately funding the provision of medical services. The Department would benefit from assistance in the form of experience and guidance in incorporation MLRs across all managed care plans.
- Furthermore, the Department requires assistance to ensure that contract language provides for adequate and enforceable oversight of managed care plans.

Consequences of Problem

- Without an in depth audit to ensure that reported charges are both reasonable and allowable, the Department risks over payment for services provided to Medicaid clients under managed care contracts.
- Without assistance in instituting MLRs across all managed care plans, the Department would lose valuable out-of-state experience and background to ensure proper implementation and enforceability in contract language.

Proposed Solution

- The Department requests to hire an auditor to conduct a thorough review of current managed care contract language and provide experience and guidance in implementing MLRs across all managed care plans.
- The auditor would use selected algorithms to analyze claims data from one managed care plan to identify outlier populations that could be at risk of overpayment. Further analysis of these outlier populations would ensure compliance with regulations for allowable medical expenses.

Department Priority: R-15
Request Detail: Managed Care Organization Audits

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
Managed Care Organization Audits	$300,000	$150,000

Problem or Opportunity:

The Department utilizes a combination of financial reports, encounter data, and claims data to establish capitation rates for physical health and behavioral health service managed care contracts. Currently, the Department does not audit the financial or encounter data beyond assessing the reasonableness of payment at a high level of aggregation based on summary statistics; managed care contractors attest that the information is accurate. The Department does not have the internal resources to perform in depth analyses to ensure proper payment, which is essential to demonstrating sound stewardship of financial resources as part of the Department's mission. In FY 2013-14 the Department spent over $700,000,000 on behavioral health and physical health managed care contracts. Furthermore, a recent report by the U.S. Government Accountability Office strongly recommended that states conduct audits of payments to and by managed care organizations within Medicaid[1]. Without an in depth audit to ensure that reported charges are both reasonable and allowable, the Department risks over payment for services provided to Medicaid clients under managed care contracts.

Furthermore, the Department is currently evaluating applying medical loss ratios (MLRs) across all managed care plans, as MLRs are an effective way to ensure health plans are adequately funding the provision of medical services. In recent communication with the Department, CMS has indicated that they are adding additional MLR requirements to the expansion rate approval process. It is also likely that CMS will require Medicaid health plans to implement MLRs in the near future, and the federal Office of Inspector General (OIG) has stated that MLRs will be a focus of their 2014 work plan[2]. To this end, the Department would benefit from assistance in incorporating MLRs across all managed care plans. Implementation assistance would entail contract language recommendations, guidance in defining administrative expenses, designing a financial reporting template, and guidance in developing a rate setting timeline. The Department would draw on the auditors experience implementing MLRs in other states to guide a successful implementation that meets federal requirements.

[1] <http://www.gao.gov/products/GAO-14-341>
[2] <http://oig.hhs.gov/reports-and-publications/archives/workplan/2014/Work-Plan-2014.pdf>

Proposed Solution:

The Department requests $300,000 total funds, including $150,000 General Fund, in FY 2015-16 and future years to contract with an auditing firm to analyze financial reporting and claims submitted by health plans to ensure that submissions are both allowable and reasonable, in order to ensure proper payment for services provided by physical and behavioral health plans. Specifically, the auditor would perform the following tasks:

- Conducting a thorough review of current managed care contract language to identify weaknesses and recommend appropriate changes and specific language.
- Providing experience and guidance to the Department with implementing MLRs across all managed care plans.
- Using selected algorithms on claims data of one or more managed care plans to identify outlier populations that could be at risk of overpayment.
- Further testing identified outlier populations to ensure compliance with regulations for allowable medical expenses.
- Tying financial reports to supporting information to ensure reporting accuracy in accordance with standards established by the American Institute of Certified Public Accountants.
- Auditing of administrative expenses to ensure reported expenses are allowable and accurate.

Stronger contract language would ensure the Department has proper and enforceable oversight of managed care plans. The Department would ensure proper submission of financial and encounter data, assist with recoupment, and protect Department rights in future years. By running algorithms on claims data, the auditor may identify outlier payments and verify if the Department overpaid in these instances. Implementing MLRs across all managed care plans would meet federal requirements for administrative spending, ensure appropriate funding of medical services, and drive quality outcomes for clients.

Anticipated Outcomes:

As a result of the auditor's analysis, the Department would be able to: assess if overpayment has already occurred and potentially recoup those funds; mitigate future overpayments by correcting errors in the reporting process; strengthen the enforceability of contract provisions and requirements; and implement MLRs across all Medicaid managed care plans.

Though the Department cannot guarantee savings will result from audit findings, savings can result from both a recoupment of inappropriate payments and avoidance of future overpayments. In FY 2013-14 the Department spent roughly $190,000 on audits of nearly $400,000,000 in outpatient hospital expenditures. This led to approximately $25,000,000 in recoupments and $28,000,000 in avoided future overpayments.

Ensuring proper payment for services aligns with the Departments performance plan by ensuring sound stewardship of financial resources. Implementation of MLRs align with the Department performance plan by striving to improve health outcomes, client experience, and lower per capita costs.

Assumptions and Calculations:

Based on estimates submitted by an auditing firm, the Department is requesting $300,000 total funds, including $150,000 General Fund, to hire an auditor to complete the work described. This request would not require any additional FTE. A full breakdown of estimated charges and services provided is provided in table

2. Costs for contract reviews are based on estimates of 25 hours per contract for the 14 contracted managed care plans as detailed in table 2 at a cost of $200 per hour. Other costs are estimated using the upper limit of a proposal from an auditing firm. As the Department spent over $700,000,000 on managed care plans in FY 2013-14, it is reasonable to assume that the upper limit will be required to audit abnormalities that may arise in the data. As seen in table 2, the Department would utilize additional funds to audit managed care plans on a rotating basis. Audits would vary based on scope and size of the managed care plans in a given year. For example in FY 2016-17 the Department would need further contract review, so funds would be used for additional audits of managed care plans or analysis of outlier populations.

Potential for savings due to recoupment or avoided overpayments are not included in the calculations as the Department does not have evidence that overpayments have occurred. The Department would use the regular budget process to account for any savings achieved as a result of the audit findings.

Table 1.1 - Managed Care Organization Audits FY 2015-16								
Item	**FTE**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**	**Source**
(1) Executive Director's Office, (F) Professional Audit Contract								
Managed Care Audits	0.0	$300,000	$150,000	$0	$0	$150,000	50.00%	Table 2 Row G
Total	**0.0**	**$300,000**	**$150,000**	**$0**	**$0**	**$150,000**		

Table 1.2 - Managed Care Organization Audits FY 2016-17								
Item	**FTE**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**	**Source**
(1) Executive Director's Office, (F) Professional Audit Contract								
Managed Care Audits	0.0	$300,000	$150,000	$0	$0	$150,000	50.00%	Table 2 Row G
Total	**0.0**	**$300,000**	**$150,000**	**$0**	**$0**	**$150,000**		

Table 1.2 - Managed Care Organization Audits FY 2017-18								
Item	**FTE**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**	**Source**
(1) Executive Director's Office, (F) Professional Audit Contract								
Managed Care Audits	0.0	$300,000	$150,000	$0	$0	$150,000	50.00%	Table 2 Row G
Total	**0.0**	**$300,000**	**$150,000**	**$0**	**$0**	**$150,000**		

Table 2 - Breakdown of Audit Costs					
Row	**Item**	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**	**Comments/Calculation**
A	MCO and BHO Contract Review	$70,000	$45,000	$45,000	25 Hours Per Contract *14 Contracts * $200 Hourly Rate
B	Algorithmic Review of MCO Claims Data	$75,000	$75,000	$75,000	Price to identify outlier populations in **one** MCO claims data
C	Testing of Outlier Populations	$30,000	$30,000	$30,000	Cost to audit outlier populations identified with algorithms
D	Tying of Financial Reports to Supporting Information	$50,000	$50,000	$50,000	In accordance with the American Institute of CPAs
E	Administrative Expense Audits	$50,000	$50,000	$50,000	Cost per MCO
F	Additional Review of Claims Data or Administrative Expense Audits	$25,000	$50,000	$50,000	This may change in each FY based on rotation cycle as the Department will audit one or more managed care plans per year
G	**Total**	**$300,000**	**$300,000**	**$300,000**	Row (A + B + C + D + E + F)

Table 3 - HCPF Payments to BHOs and MCOs FY 2013-14			
Row	**Item**	**Paid Amount**	**Calculation/Comment**
	CHP MCOs		
A	Kaiser	$15,598,137	Historical Data
B	Denver Health	$9,475,106	Historical Data
C	CO Access HMO	$72,679,232	Historical Data
D	Colorado Choice	$2,862,640	Historical Data
E	Delta Dental	$11,268,968	Historical Data
F	CO Access SMCN	$32,053,728	Historical Data
G	Rocky Mountain Health	$16,930,036	Historical Data
H	Subtotal CHP+ MCOs	$160,867,847	Row (A + B + C + D + E + F + G)
	Medicaid MCOs		
I	Denver Health	$118,574,749	Historical Data
J	Rocky Mountain HMO	$7,329,446	Historical Data
K	Subtotal Medicaid MCOs	$125,904,195	Row (I + J)
	Mental Health BHOs		
L	Colorado Access Behavioral Care	$74,077,413	Historical Data
M	Behavioral Health Care Inc.	$96,803,924	Historical Data
N	Colorado Health Partnerships	$137,226,809	Historical Data
O	Foothills Behavioral Health Partners	$62,539,714	Historical Data
P	Northeast Behavioral Health Partners	$46,264,217	Historical Data
Q	Subtotal Mental Health BHOs	$416,912,077	Row (L + M + N + O + P)
R	**Total**	**$703,684,119**	Row (H + K + Q)