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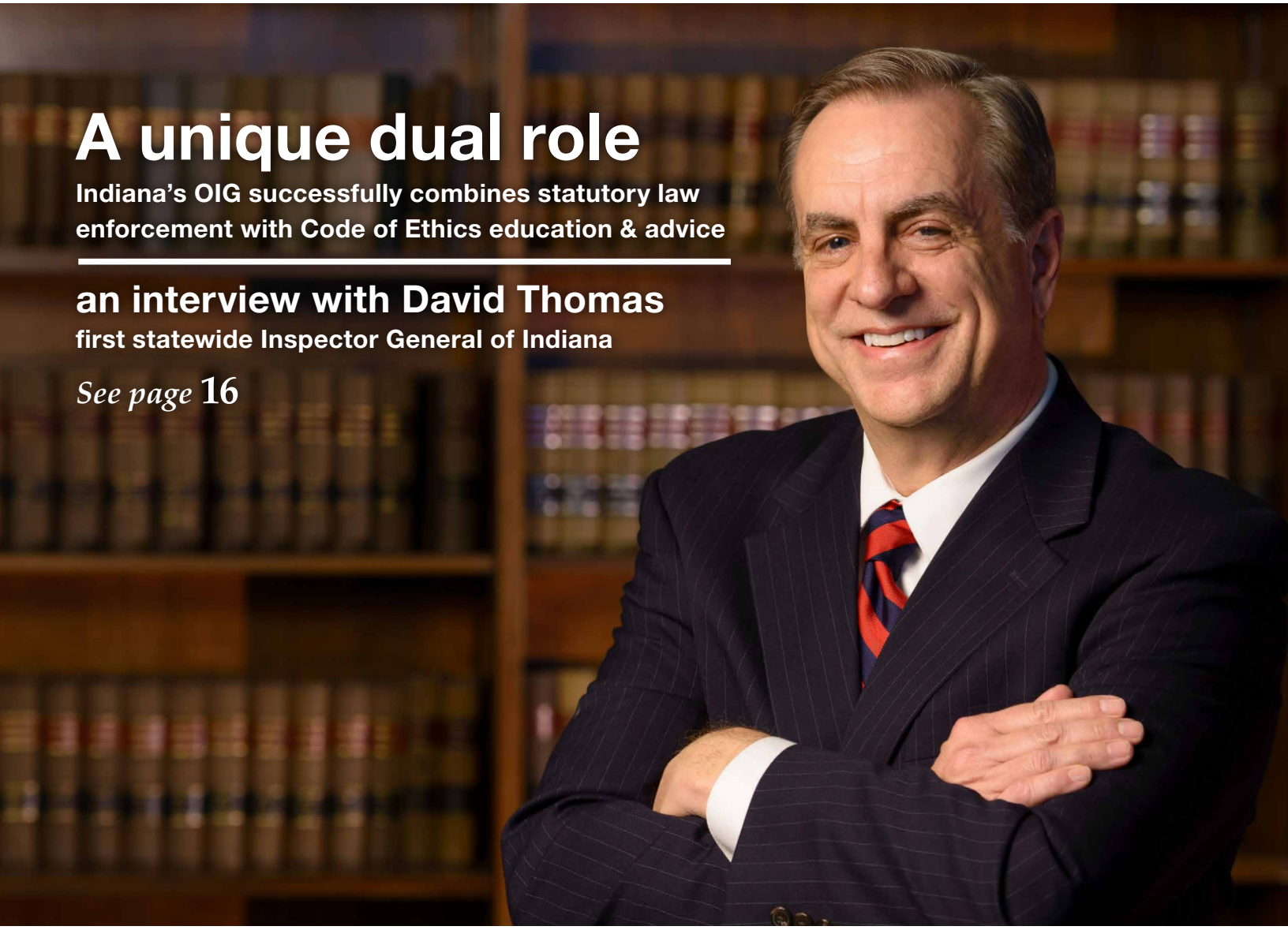

A unique dual role

Indiana's OIG successfully combines statutory law enforcement with Code of Ethics education & advice

an interview with David Thomas

first statewide Inspector General of Indiana

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by Tonya Teschendorf

How state Medicaid plans can prepare for increased federal oversight

» Understand the current problems facing state Medicaid programs.
» Know what increased CMS oversight of state Medicaid plans would achieve.
» Understand CMS's oversight and compliance requirements for Medicare.
» Understand how direct oversight could work at a state Medicaid level.
» Learn how Medicaid plans can prepare for new compliance rules.

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In recent years, both the private sector and the government—including the General Accounting Office, Department of Health and Human Services Office of the Inspector General's (OIG), and the U.S. Government Accountability Office (GAO)—have critically analyzed federal government oversight of state Medicaid programs.

Teschendorf

The criticism has been aimed at (among other issues) a lack of oversight of payments to private insurers, quality standards, contract requirements, data collection and comparative data, beneficiary care, and provider networks. As a result, we are now starting to see oversight action from the Centers for Medicare & Medicaid Services (CMS) aimed at both the states and the healthcare plans.

Compliance with requirements under the Affordable Care Act has generated significant challenges for government-sponsored health plans. Specifically, problems generated by the large numbers of members enrolling and disenrolling in the state exchanges are just beginning to surface as members are now accessing benefits. State Medicaid plans are also struggling with the pain of increased membership and care management issues.

As CMS becomes more involved at the state level, Medicaid plans must be prepared to comply with more stringent CMS rules and regulations. Compliance with both state and federal regulatory requirements requires sophisticated systems and workflow solutions to administer plan and data management.

It is important to understand some of the major issues surrounding state Medicaid plan programs, what CMS is currently doing to move toward greater oversight of Medicaid plan management, and what Medicaid plans need to do to better manage certain everyday compliance challenges.

Why state Medicaid plans would benefit from better oversight

Recent reports and studies have cited numerous problems and complaints involving state Medicaid plans throughout the country. Recognizing and understanding these issues are key to predicting increased CMS oversight

in the near future. Some of the specific problems surrounding state Medicaid plans include the following.

Lack of uniform standards among states
Even though the federal government requires states to establish quality standards for Medicaid programs and monitor quality and reporting compliance, there is practically no uniformity in these standards across the states. Shortfalls in contract requirements and data collection make it difficult to compare state-to-state data and assess whether beneficiary health has actually improved throughout the country.

Staff cuts raise questions of accountability
Some states have cut back on staffing of their Medicaid offices. This not only raises concerns about the states' ability to hold health plans accountable, but also has resulted in the federal government being criticized for failing to ensure the states properly oversee their plans.

Inconsistencies in practices
States are required to set rates, monitor contracts and enrollment practices, and oversee operational functions and compliance programs of their Medicaid plans—but *how* each state complies differs. This, unfortunately, leads to operational and reporting inconsistencies and makes sharing and comparing best practices, data, and other important information difficult. It also creates an additional level of complexity for health plans that operate in multiple states and have to adhere to varying compliance guidelines.

Current lack of CMS state oversight
Each state is required to audit health plans that provide Medicaid services. CMS monitors that state oversight; however, CMS has been accused of having problems with such oversight, according to reports from the OIG and GAO.

Increased CMS oversight of state Medicaid programs and health plans

To alleviate various challenges noted above, CMS is moving to exert more *direct* control and oversight of these programs, and the federal government will most likely tie federal dollars to state controls. As with its oversight and control of Medicare plans already in force, it stands to reason that CMS will continue to develop Medicaid regulatory guidance to establish standards and monitor compliance across all states. The onus will be on the health plans to better self-regulate.

In addition, increased oversight by CMS will likely require investing in much-needed resources at the state level to provide the required auditing of programs and compliance. States will likely require federal funds to do so. Any fines assessed to plans and paid to the state would help expand the oversight program.

An example of an area where CMS is currently flexing its oversight muscle at the plan level is found in the agency's recent actions affecting Medicaid Special Needs Plans (SNP). In the CMS proposed rule[1] released on January 6, 2014, CMS put forth its intention to add authority that will require plan sponsors to hire an independent auditor to perform full/partial program audits, validate corrections to deficiencies found during an audit, and conduct verification of corrections in cases where the plan self-discloses deficiencies to CMS. In effect, CMS is outsourcing its own audit function to the plans.

SNP plans are included in this proposal because CMS currently audits SNP Model of Care Implementation under Medicare Parts C and D. It is important to note that the agency's proposal to require health plan sponsors to hire independent auditors is very similar to the current validation reviewer (contractor) requirements under the Medicare Data Validation of Part C and D Annual Reporting requirements.

Hence, the connection between current Medicare oversight and proposed oversight that would affect certain Medicaid plans.

Other CMS activity points to increased agency oversight, as well. CMS recently released an updated version of Chapter 16b Special Needs Plans in the *Medicare Managed Care Manual*. And, at the state level, CMS is currently revising and updating the *State Medicaid Manual* and is developing a *Medicaid State Children's' Health Insurance Program Manual*. All of this activity around revised and new guidance certainly comes on the heels of well-intended critical analysis of the current and future state of Medicaid plan regulatory oversight.

How Medicaid plans can prepare for increased CMS oversight

When CMS establishes greater control and oversight of Medicaid at the state level, government-sponsored health plans will have a new set of issues to work through in order to comply with the new regulatory guidance. The good news is these new regulations will most certainly mirror those already in effect for Medicare. Therefore, mirroring best practices in Medicare compliance today will better position health plans in the future.

Based on Medicare compliance programs, Medicaid plans can expect CMS to require increased operational reporting and increased compliance within the risk management function. To best prepare for rigorous compliance changes, Medicaid plans should implement the following.

Streamline process workflow

Conformity with CMS compliance guidance requires highly efficient communication and effective collaboration between a number of operative departments throughout a health plan. Marketing communications, Compliance, IT, Operations, and medical management will need to coordinate their functional activities and reporting in order to comply with CMS standards. An effective process workflow that keeps everything running smoothly, on-time, and in compliance is critical.

Enhance project management

Health plan member communications directors have the tough job of guiding collateral through a creation cycle that includes tracking multiple versions, pushing through numerous bottlenecks, dealing with multiple subject matter experts, ensuring regulatory compliance, and setting up printing and delivery. An effective project management tool specifically designed for health plans can make things infinitely simpler and ensure materials are in compliance with CMS. This will also enable easier reporting when CMS audits are required.

Improve risk management

A robust risk management function will be essential for Medicaid plans required to detect, mitigate, and alleviate risk throughout an organization. An organization's risk management tool is key to compliance management as federal and state guidance evolves at a brisk pace.

The writing is on the wall

Well-documented issues of a lack of uniformity and accountability surround state Medicaid programs. Understanding CMS's history of recognizing problems and acting to find solutions, it stands to reason the agency will, in the future, establish compliance programs for state Medicaid plans that mirror those of Medicare. Improving process workflow, project management, and risk management will enable Medicaid plans to make a smooth transition when that day comes.

1. Federal Register: CMS: Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, proposed rule. Available at http://1.usa.gov/1lnV5ms