Health Committee
Pennsylvania House of Representatives
Expansion of Health Choices
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Chairman Baker, Chairman Myers, and members of the Health Committee, I thank you for the privilege of appearing before you on behalf of the Coalition of Medical Assistance Managed Care Organizations regarding the proposal to expand the Health Choices program. The Coalition consists of:

- AmeriHealth Mercy Health Plan
- Gateway Health Plan
- HealthAmerica Pennsylvania, Inc.
- HealthPartners
- Keystone Mercy Health Plan
- UnitedHealthcare of Pennsylvania, Inc.
- UPMC for You, Inc.

I would like to present a brief background, followed by a discussion of access, quality, special needs, and the cost effectiveness of the HealthChoices program.

Historically, this Legislature has had major concerns regarding the cost, quality and access to healthcare for our citizens unable to afford that care – primarily, the aged, the disabled, and children. The Medical Assistance Program was created by Congress and implemented at the State level to assure citizens were not deprived of necessary healthcare services in order to sustain and enhance their lives. The late Governor Bob Casey, with the support of the General Assembly, designed the Health Choices managed care program. Former Governor Tom Ridge began the phased implementation of this program. The program of capitated

managed care has consistently received the support of each of the four Legislative caucuses, even during the past 8 years, when the executive created challenges for this delivery system. The mandatory Managed Care Program by zones (the HealthChoices program) started in the southeast in 1997 and has been successfully phased into the southwest and the Lehigh/Capital zones. The question before you is should the program be expanded to additional zones and statewide?

Although it is tempting to make the argument for statewide Managed Care exclusively based on the extraordinary cost savings this program had provided to the Commonwealth, I prefer to brief you on a couple different reasons that are also compelling for the expansion of the HealthChoices program.

First, impoverished citizens in need of health services have had extraordinary challenges in gaining access to the healthcare system. Some providers, due to low payments and delayed payments, have made access to care in some areas very difficult. Managed Care organizations provide fully staffed provider relation departments and provide training and education to both providers and recipients. This is an on-going process, not a once and done! In many instances, we pay higher rates than the fee for service system and we always make timely payments. We assist recipients locate providers, and ease the access of gaining appointments when necessary. Where barriers due to cultural, language, or for whatever reason exist, we assure that adequate healthcare services are provided. Our emphasis often changes the incentives in the healthcare system to promote preventive primary care leading to healthier lifestyles, early intervention, and screenings.

In addition to access, our plans uniformly adhere to high quality standards. We use extensive quality measurements to gain feedback and to implement health improvement strategies. Our plans are among the highest ranked by the National Committee of

Quality Assurance whose standards include onsite reviews of clinical and administrative processes for accreditation, HEDIS (Healthcare Effectiveness Data Information Set) measurements of performance including, but not limited to, immunization and mammography screening rates. Comprehensive surveys of recipients are undertaken to assure consumer satisfaction. Each of our Managed Care organizations have quality improvement plans and invest in areas such as enhanced pediatric care, women's health, diabetes, asthma, HIV, COPD (Chronic Obstructive Pulmonary Disease), as well as congestive heart failure programs.

While talking about access and quality, it is especially important that we spend a moment focusing on those citizens with special needs. Case Managers are available to our clients. Our plans invest in identification and screening for these individuals to assure appropriate services are provided. We analyze pharmaceutical and other claims data so that we might coordinate care through our integrated service structure and through case management. In the most difficult circumstances, we assure the provision of services as needed for special needs populations.

Finally, I must talk about the cost effectiveness of the Managed Care system. As you know, we have competition within each of our regions which require that we provide quality, accountability, access, and cost containment. The Managed Care organization bears the full risk thereby protecting the Commonwealth and her taxpayers. The predicable funding provided by Managed Care has made the difficult task of balancing our state budget considerably easier. As many of the more senior members might recall, huge deficiencies in the medical assistance budget used to be the norm when the program lacked stability and predictability. Now, the MCO bears the risk, not the taxpayer. Supplemental appropriations are solely the result of eligibility increases, not the volume of services needed or the cost of services provided.

The Lewin Group a nationally recognized health research organization, found that taxpayers have saved over $5B as a result of managed care in the last 11 years. These savings will grow by an additional $2.9B over the next 5 years according to their projections.

In state dollars, the Lewin Group estimated that the expansion to statewide managed care would save Pennsylvania taxpayers an additional $375M over the next 4 years.

These savings include the fraud, waste, and abuse avoided as a result of the state-of-the-art detection and prevention programs used by the managed care organizations. According to CMS in a recent audit, the error rate in the fee for service system is 4%. The error rate for Managed Care is .19%. I am not justifying any fraud, waste, or abuse, however, you can see that for every dollar wasted in the Managed Care system, $20 is wasted in the fee for service system. This difference converts to tens of millions of taxpayer dollars lost without benefit to your constituents, our subscribers.

In summary, as you know, the National healthcare reforms are estimated to increase our existing 2.2M medical assistance caseload to between 500,000 and 700,000 additional participants. For our existing caseload and for this expansion, Pennsylvania needs the most accessible high quality healthcare system possible for those whose healthcare needs are to be paid for by taxpayers. We respectfully believe that the healthcare system that protects taxpayers while assuring accessible high quality care is the Managed Care system called HealthChoices in Pennsylvania.

Mr. Chairman, I again want to thank you and the Committee for your willingness to allow me to testify on behalf of the MCOs and with your permission, I will attempt to respond to whatever questions you or the committee have for me.

HealthChoices Medicaid Managed Care: Protecting the Commonwealth from Fraud, Abuse and Waste

In today's challenging fiscal environment, it is more important than ever that Commonwealth funds are spent wisely, and that all appropriated dollars are used for their intended purpose. In Pennsylvania, Medicaid Managed Care Organizations (MCOs) have developed effective programs to protect the Department of Public Welfare (DPW) from illegal activities of both providers and consumers. Because MCOs are "at-risk" for the cost of services, and every dollar lost negatively affects the ability of MCOs to operate a cost-effective program, detecting and deterring fraud, abuse and waste is a critical priority. The ability of the MCOs to protect the program and adopt innovative private-sector solutions is an important benefit of the Medicaid managed care program and delivery model.

General Overview - MCO Fraud and Abuse Detection Activities -

- MCOs have established Special Investigation Units (SIUs) responsible for protecting the program from provider and consumer fraud, abuse and waste.
- MCOs conduct provider reviews, investigate complaints, recover overpayments and report suspected fraud to DPW's Bureau of Program Integrity (BPI).
- MCOs review provider preclusions from other state and federal health care programs on a monthly basis and terminate these providers from their networks.
- MCOs also perform other core functions that serve to reduce provider and consumer fraud, abuse and waste, including the extensive use of pre-authorization guidelines, provider credentialing, clinical editing and sophisticated utilization review activities.
- SIUs also develop and implement multi-year strategic plans to guide their efforts.

Consumer Fraud and Abuse Detection Activities -

- MCOs monitor utilization to identify individuals engaged in drug-seeking behavior.
- Consumers suspected of fraudulent activity are referred to BPI and the Office of Inspector General for criminal investigation, and are enrolled in the Recipient "Lock-in" Program. This program requires consumers to seek services from a single doctor, pharmacy, hospital or other Medicaid provider to minimize the possibility of future abuse.
- MCOs are proactive in ensuring that information that may impact an existing member's Medicaid eligibility is transmitted to DPW for action. For example, MCOs alert DPW when they learn that a member is at a different address, deceased, or in a facility.

"Up-front" Claims Processing and Fraud Detection Technology -

- MCOs utilize advanced data-mining software and best practices to identify inappropriate payments before they are made and to target instances of potential overbilling for further investigation and record reviews.
- "Up-front" claims processing and clinical editing software identifies and precludes payment for instances of upcoding, unbundling and incorrect coding. Providers submitting suspicious claims are often put on "pre-payment review," where claims are reviewed manually before payments are made.
- MCOs have implemented sophisticated fraud and abuse detection software to identify suspicious billing patterns and "medically improbable" events for further review. This

specialized data-mining software utilizes proprietary algorithms that are continually updated to capture emerging fraud schemes.

Provider Retrospective Audit and Recovery Activities -

- In addition to cases identified through data mining, SIUs perform audits based on complaints, trends identified by law enforcement, and information from coding seminars.
- SIUs perform random claim audits, frequently reviewing 1% - 5% of claims.
- Sophisticated audit protocols have been developed to prioritize case referrals. One plan uses weighted "red flags" to identify audit targets (e.g. misspelled audit terminology, white-outs or multiple erasures on claims, inconsistency between specialty and treatment, and constant submittal of photocopied claims).
- When overpayments are identified, MCOs are aggressive in recovering every dollar overspent. Most MCOs typically recover all of the dollars owed to them.
- MCOs utilize highly skilled business partners to enhance their in-house efforts. These include MedAssurant and MedReview (to conduct DRG validation audits), Ingenix (to provide end-to-end detection and prevention services) and HMS (to provide third party liability recovery and identification).

Special Investigation Unit Expertise, Training and Flexibility -

- SIUs are well-staffed, and staff turnover is low. Many staff members have professional credentials in forensic accounting, fraud examination, and clinical fields, and often have law enforcement backgrounds.
- SIUs have the ability to draw upon other audit staff as needed to assist with investigation activities. This flexibility helps to address fluctuating case loads.
- MCOs hire specialized contractors to assist them in their review and recovery efforts.
- MCOs require continuous training for their SIUs and belong to industry trade groups to keep current with emerging fraud trends and technologies.
- MCOs hold regularly scheduled "information sharing" meetings with other plans and BPI to share best practices and identify opportunities for program improvement.

Provider and Consumer Outreach, Training and Reporting -

- MCOs perform outreach activity to providers and recipients to make them aware of the potential for fraud and abuse, and to provide instructions on what to do if it is identified.
- MCOs have anonymous ways for members and providers to report fraud and abuse.
- MCOs educate their network providers on DPW's "Provider Self-audit Protocol," which encourages providers to conduct self-audits and report program overpayments.
- MCOs also use consumer complaints and grievances to identify potentially fraudulent provider activities.

Program Outcomes -

- Based on the most recent information available, the MCOs recouped and cost-avoided over $65 million as a result of provider review activities and up-front processing edits.
- During the most recent quarter, over 1,144 providers were under review for potential fraud and abuse.
- The MCO recipient "Lock-in" Program cost–avoided nearly $29 million during the same period, and restricted over 600 new consumers who were abusing the program.
- In total, over 1,000 MCO consumers are currently enrolled in the "Lock-in" Program.