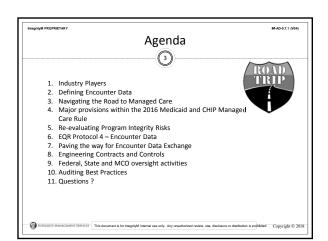
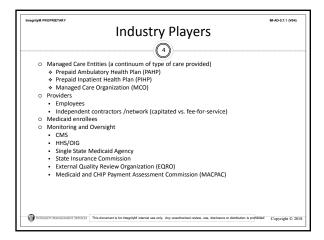
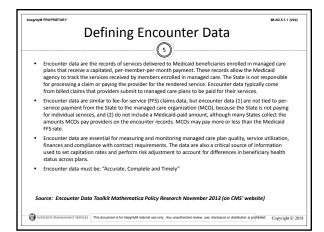


Headquartered in Alexandria, Virginia, Integrity Management Services (IntegrityM) is a certified women-owned small business, CMMI Level 3 appraised, ISO 9001:2015 and FISMA compliant organization. IntegrityM was created to support the program integrity efforts of Federal and State government programs, as well as private sector organizations. IntegrityM provides experience and expertise to government programs and private businesses supporting government programs. Results are achieved through analysis and support services, such as statistical and data analysis, compliance audits, investigations, medical review, outreach and education, and software solutions.

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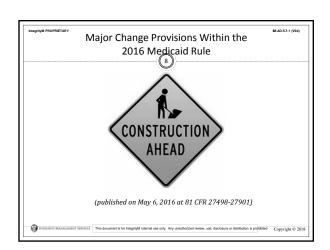






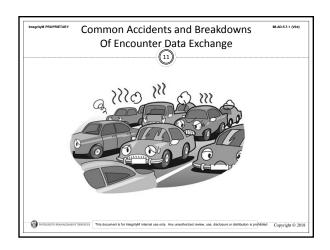


Navigating the Road to Managed Care Navigating the Road to Managed Care Managed care is now the primary Medicaid delivery system in 29 States. Nearly half of Federal and State spending on Medicaid in 2015—over \$230 billion—was on managed care, and the proportion continues to grow each year (MACPAC 2016a). The industry is continuing to develop best of practice approaches to address the complexities of the new (2016) Medicaid Managed Care Regulation CMS is in the process of developing sub regulatory guidance (e.g. specific and enforceable encounter data contract language) This shift has resulted in emerging awareness and heightened the importance of Program Integrity within both state and managed care organizations, increasing variation in program integrity outlooks and activities Too early to judge effectiveness of new regulation

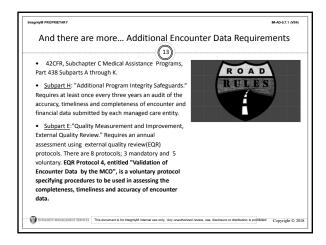


| IntegrityM PROPRIETARY | Major Change Provisions Within the | | | | |
|------------------------|--|--|--|--|--|
| | 2016 Medicaid Rule | | | | |
| | 2010 Wedicald Rule | | | | |
| | (9) | | | | |
| | On April 21, 2016, the Centers for Medicare & Medicaid Services (CMS) issued final regulations that revise and significantly strengthen existing Medicaid managed care rules | | | | |
| regulations tha | | | | | |
| | sed Federal expectations of fundamental aspects of State Medicaid Managed | | | | |
| Care Progra | | | | | |
| | changes include; | | | | |
| | er disbursement of program integrity responsibilities across CMS, States, and | | | | |
| MCOs | | | | | |
| | gthen payment provisions through the assurance of complete, accurate and | | | | |
| | encounter data | | | | |
| | Medicaid and CHIP managed care requirements with other major health | | | | |
| | age programs (MA, Marketplaces) | | | | |
| | ce the beneficiary experience of care and strengthen beneficiary protections | | | | |
| ☐ Promo | te quality of care | | | | |
| | ff.org/medicaid/issue-brief/cmss-final-rule-on-medicaid-managed-care-a- | | | | |
| summary-of-ma | ajor-provisions/ | | | | |
| | | | | | |
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| INTEGRITY MANAGEMENT S | This document is for IntegrityM internal use only. Any unauthorized review, use, disclosure or distribution is prohibited Copyright © 2018 | | | | |

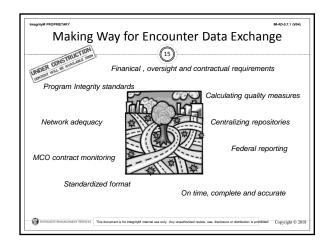
Adjusting to the "Shift" The Medicaid Program covers more than 20% of the US and accounts for more than 16% of US healthcare spending. For many years Medicaid - like other medical programs - was administered on a FFS basis by States that built their own independent claim payment systems (MMIS). States had access to all of their claims data In 2017, 73% of Medicaid beneficiaries were in Managed Care plans Recently, states have been shifting to MCOs in an attempt to improve access and quality of care, more stable funding streams, program cost reduction This change reduces state access to the data which is now housed by the MCOs The shift presents many new challenges across the industry

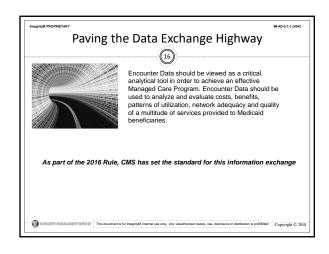


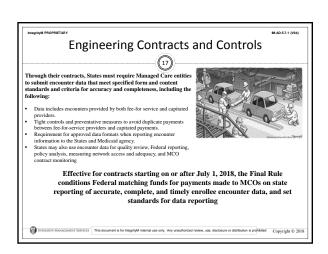
| to | Program Integrit Managed Care v | ty Risks Specific ws. Fee-for-Service |
|--|--|---|
| Fee-for-service characteristics | Managed care characteristics | Program Integrity risks specific to managed care delivery systems |
| State pays providers for services | State pays MCO a capitated payment | Incorrect or inappropriate capitation rate setting for MCO payments Underutilization of services by MCO enrollees |
| State processes claims | MCO processes claims | Inaccurate encounter (claims) data submitted by MCO Failure of MCO staff to cooperate with State investigations and prosecutions of frauduent claims Focus on cost avoidance, not recoupment of State dollars |
| State oversees individual providers and contracts | State oversees MCO contract; MCO can subcontract | MCO submits incomplete or inaccurate information on contract performance Lack of access to subcontractor information on contract performance or falsification of information |
| State pays providers on a fee-for- service basis | MCO can subcapitate providers or use other incentives | Underutilization by MCO enrollees Inappropriate physician incentive plans |
| State covers all Medicaid beneficiaries | MCO covers only assigned or enrolled beneficiaries | Payment to MCOs for non-enrolled individuals Marketing or enrollment fraud by MCO |
| State contracts with all qualified providers | MCO contracts with a select provider network | Lack of adequate MCO provider network MCO must choose between removing risky providers and maintaining network adequacy Lack of communication results in a disqualified provider terminated from one MCO being hired by another MCO |
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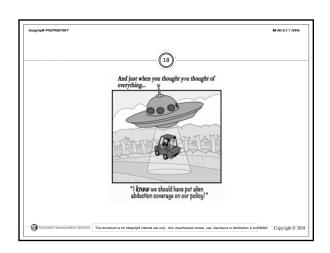


| | Sub Part E (EQR) | Sub Part H (Audit) |
|-----------------|--------------------|-----------------------------------|
| Frequency | Annual | Every 3 Years |
| Objectives | Complete, Accurate | Accurate, Complete, and Timely |
| Report Type | Assessment Report | Audit Report |
| Requirement | Voluntary | Mandatory |
| Review Guidance | Parameters | GAGAS |









Program Integrity Oversight

Federal Program Integrity Oversight

19

Federal Program Integrity Oversight:

• CMCS (Center for Medicaid and CHIP Services); reviews state contract documents and collects managed care encounter data to measure performance, monitor compliance with Federal rules, and support program integrity efforts across states and MCOs

• OFM (Office of Financial Management); measures the rate of improper payments for all CMS programs

State Program Integrity Oversight:

• State based activities, while also contractually binding MCOs to implement program integrity policies and procedures of their own

• Periodically, but no less than every three years, conduct or contract for an independent audit of the accuracy, timeliness, and completeness of the encounter and financial data submitted by or on behalf of each MCO

Medicaid MCO Program Integrity Oversight:

• Implementing activities required by Federal rule, as a condition of contracting with a State, and those initiated by the health plan itself to minimize improper provider payments

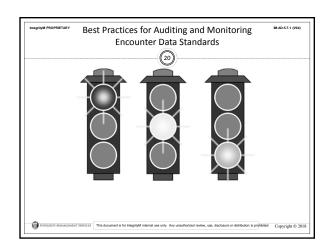
• Policies and procedures to detect and prevent fraud, waste, and abuse

https://www.macpac.gov/publication/june-2017-report-to-congress-on-medicaid-and-chip/

MUMINITY STRINGES

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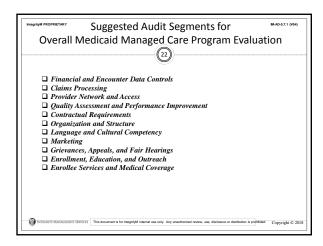
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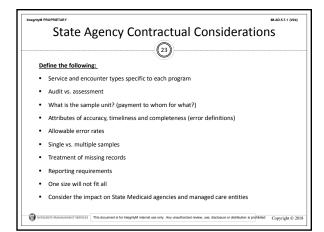


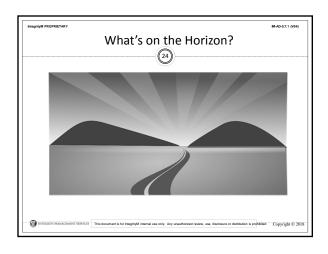
Each audit should proceed logically and systematically to use audit resources efficiently and effectively. Audit work should be broken down into 7 phases, each of which has a bearing on how and to what extent the audit is conducted. The phases are defined as follows:

Phase 1 - Selection of Auditee and Scope of Review
Phase 2 - State Agency Background Information
Phase 3 - Initial Risk Evaluation
Phase 4 - MCO Documentation
Phase 5 - Risk Re-evaluation
Phase 6 - Detailed Audit Procedures/Data Verification Using Applicable Segments
For each segment, the auditor must first determine contractual requirements and determine if the MCO has developed and implemented written policies to address the elements of each segment
Phase 7 - Reporting

Adhering to GAGAS standards is an important tool in reducing audit risk







IM-AD-5.7.1 (V04) Best of Practice Guidance (25) Best of practice methods on how States validate encounter data for rate setting, how they can
encourage managed care organizations to invest in prepayment auditing, and how States and plans
can better share provider screening data and measure the effectiveness of specific program
integrity practices Additional guidance, training, tools and education from regulatory oversight agencies Developing best of practice encounter data protocols are big left up to the State's to define. The majority are being built around the re-alignment of Agency resources and patient/service type When determining the need for internal or external consulting resources to support agency efforts with encounter data audit and program evaluation, it is critical that each Managed Care Program within both the State Agency and MCO Entity, take the following into consideration for encounter data evaluation:

Analyzing data output

Standardized audit and investigation protocols Statistical and quality data analysis
 Definition and generation of performance metrics based on the above NT SURVICES This document is for IntegrityM internal use only. Any unauthorized review, use, disclosure or distribution is prohibited Copyright © 201 IM-AD-5.7.1 (V04) Thank you! (26) Thank you for attending today's presentation. We'll be happy to answer questions! For more information, or to contact Jennifer or John please contact info@integritym.com or (703) 683-9600. @_IntegrityM_ www.linkedin.com/company/integrity-management-services-inc INTEGRITY MANAGEMENT SERVICES This document is for IntegrityM internal use only. Any unauthorized review, use, disclosure or distribution is prohibited Copyright © 2018