

## **Underutilization and Compliance in a Managed Care Setting**

The focus of regulatory and enforcement efforts by both the federal and state governments continues to shift to the delivery of health care by Managed Care Organizations (MCOs).

Managed care arrangements involve different economic incentives that present new and different opportunities for non-compliance and fraud and abuse. This has not escaped the attention of regulators and enforcement officials. For example, the press release that accompanied the release of the Office of Inspector General Final Compliance Guidance for Medicare+Choice Organizations (M+C Compliance Guidance) commented that: "Unlike traditional fee-for-service Medicare, where the financial incentives can prompt the delivery of unneeded care, the financial incentives for Medicare+Choice Organizations are just the opposite."

Put in somewhat less delicate terms, when an MCO is paid a fixed monthly amount for each member's care regardless of the level of services provided (referred to as capitation), the less treatment provided, the more profit made. Because MCO's often compensate their primary care physicians (PCPs) on a capitated basis, there is also an economic incentive for an unscrupulous provider to curtail services or to engage in other activities to lower the cost of services provided. MCOs also commonly employ other techniques and protocols to control costs, such as requiring PCP referrals to specialists and preauthorization for some procedures. These techniques, if applied improperly, can also result in denial of needed services. Given this as a backdrop, it is not surprising that "underutilization" is considered a red flag that requires further inquiry. In fact, the M+C Compliance Guidance identifies underutilization, defined as the "inappropriate withholding or delay of services," as one of the six "compliance risk areas" that should receive special attention in an effective compliance program.

Underutilization by itself should not be a pejorative term. It may result from a variety of factors that are not caused by the MCO or provider and often are largely beyond their control. The individual patient may simply not wish to be seen at all or may decline a needed test or treatment, for example, or there may be cultural biases at work that limit acceptance of treatment. Nevertheless, in the current atmosphere, MCOs must carefully scrutinize any indication of underutilization to ensure it is not being caused by the organization's policies and procedures or by inappropriate actions of its providers.

### *Direct Detection of Underutilization*

A discussion of the specific statistical and analytical methods for detecting and assessing underutilization is beyond the scope of this column. There are a number of generally accepted methodologies to compare the delivery of services among providers who have similar panels or to compare a particular provider's utilization to established utilization norms for similar patients. Statistical analysis alone is often not sufficient, however, and medical record review and other techniques must also be employed. It is critical to ensure such processes exist in your organization and they are functioning effectively.

### *Other Indicators*

Direct evidence of underutilization is often difficult to find and subject to differing interpretation. Therefore it is prudent to look for indirect evidence or “flags”. The existence of one or more of these flags does not indicate underutilization is present, and certainly not that there is intentional fraud or abuse; they do, however, indicate a need for further inquiry.

**Physician Incentive Plans** – if used, must be reviewed to ensure they do not provide incentives for denial of service and they comply with all applicable regulations.

**Frequent delay beyond mandated periods in first contact with member or in assignment or change of PCP** – can result in receipt of the capitation payments by the plan or provider with no services provided to the member.

**Lack of sufficient provider network (either in number or location)** – can result in unavailability of services generally or lack of needed specialized services.

**High incidence of complaints/grievances and appeals** – by patients, physicians or other providers may indicate denial or delay of services.

**Unreasonable pre-certification requirements and/or delays in approvals** -- could indicate intentional denial or delay or just inefficiency; either is a compliance concern.

**Provider is not accessible because of office hours or inconvenient location** – may be a way of discouraging patients and thereby limiting services.

**Unreasonable delays in scheduling appointments, waiting time to see providers or obtaining referrals from PCPs** - could indicate intentional denial or services or just inefficiency; either is a compliance concern.

**Non-Physicians providing services requiring a doctor or misrepresentation of credentials** – may be a method of reducing the costs of treatment and also constitutes fraud and/or abuse.

Of course, these flags are only useful to the compliance officer if they are recognized and reported. These indicators will first become apparent to the MCO personnel who regularly deal with member and provider complaints and issues and those who regularly monitor quality assurance and utilization. Specialized training for these employees in the risks and indicators of underutilization as well as regular audits of these areas are key components in detecting and addressing the problem.