Chapter 3:

Program Integrity in Medicaid Managed Care

Program Integrity in Medicaid Managed Care

Key Points

- Program integrity consists of initiatives to detect and deter fraud, waste, and abuse as well as routine oversight to ensure compliance with state and federal law. These activities are meant to ensure that taxpayer dollars are spent appropriately on delivering accessible, high-quality, and necessary care.
- Comprehensive managed care is now the primary Medicaid delivery system, accounting for nearly half of federal and state spending on Medicaid and about 60 percent of beneficiaries in 2015. However, managed care program integrity issues have not traditionally received the same focus as those in fee for service.
- States require that Medicaid managed care organizations (MCOs) proactively minimize fraud, waste, and abuse. Risk-based payments also create financial incentives for MCOs to minimize improper payments.
- There is considerable variation among states in program integrity requirements for Medicaid MCOs, state oversight of MCO program integrity activities, and the extent to which states and MCOs work together to reduce fraud, waste, and abuse.
- While many program integrity practices are perceived to be effective, there are few mechanisms for measuring return on investment or for sharing best practices. In addition, there is a need for greater coordination among state staff assigned to managed care and program integrity functions as well as better data on managed care encounters.
- Federal regulations for Medicaid managed care were updated in 2016, including more detailed provisions relating to program oversight and program integrity. Many stakeholders believe the changes will strengthen managed care program integrity and lead to greater consistency across states. However, the Centers for Medicare & Medicaid Services is still in the process of developing guidance and implementing major portions of the rule, so it is too early to assess the complete effects of the new rule.
- Looking ahead, the Commission may examine other areas of program integrity in managed care, such as:
  - how states validate their encounter data for future rate setting;
  - incentives for MCOs to make investments in prepayment auditing;
  - mechanisms for sharing provider screening data among states and programs; and
  - how to measure the effectiveness and impact of program-related activities and best practices.
- The Commission may also consider how well current program integrity rules apply to new value-based purchasing models, particularly the use of accountable care organizations and managed long-term services and supports plans.

CHAPTER 3: Program Integrity in Medicaid Managed Care

From its earliest reports, MACPAC has focused repeatedly on program integrity in Medicaid and the State Children's Health Insurance Program (CHIP).[1] As described in previous Commission reports, program integrity activities are meant to ensure that taxpayer dollars are spent appropriately on delivering accessible, high-quality, and necessary care and preventing fraud, waste, and abuse (Box 3-1). The Commission also previously identified challenges associated with the implementation of an effective and efficient Medicaid program integrity strategy (MACPAC 2013, 2012). These challenges include insufficient collaboration and information sharing among various oversight entities and few federal program integrity resources for delivery models other than fee for service (FFS).

BOX 3-1. Fraud, Waste, Abuse, and Managed Care Oversight

Program integrity consists of initiatives to detect and deter fraud, waste, and abuse as well as routine program oversight to ensure compliance with state and federal regulations. These activities are meant to ensure that taxpayer dollars are spent appropriately on delivering accessible, high-quality, and necessary care.

Medicaid regulations define fraud and abuse in the same way for fee for service and managed care (42 CFR 455.2).

Fraud is an intentional act of deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing the act or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Abuse comprises provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program or in payment for services that are not medically necessary or that fail to meet professionally recognized standards for health care. For example, a dentist might recommend a root canal and crown when standards of dental practice would indicate that a filling is appropriate. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Medicaid regulations do not define **waste**, but it is generally understood to include the misuse of resources (not caused by criminally negligent actions) that directly or indirectly results in unnecessary costs to the Medicaid program, such as requesting duplicate laboratory tests or imaging.

Managed care oversight consists of minimum contracting standards and oversight responsibilities placed on states that contract with managed care plans to provide Medicaid services on a per member per month basis (42 CFR 438). States are responsible for exercising general oversight over their plans' compliance with their contracts and adherence to federal and state laws, regulations, and policies, including when fraud or abuse is suspected. States establish additional oversight and monitoring of quality, access, and timeliness of care for managed care enrollees. Managed care oversight also focuses on administration and management, appeal and grievance systems, claims management, customer service, finance, information systems, marketing, medical management, provider networks, and quality improvement.

Traditionally, Medicaid program integrity activities were designed with the assumption that states would enroll and pay providers directly for individual services—for example, that states would check national databases to ensure that a provider excluded from participation in Medicare was also excluded from Medicaid—and that they would implement prepayment edits and audits in the claims adjudication process to help identify and suspend potentially improper payments. But over time the program's structure has changed dramatically, and now managed care is 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).[2] This shift has important consequences for strategies to ensure program integrity.

While both the federal and state agencies that oversee Medicaid remain statutorily responsible for ensuring program integrity, the nature of their efforts change when Medicaid services are provided through a managed care delivery system instead of FFS. In FFS, the state is responsible for contracting with providers, processing claims, managing utilization, and paying providers and is therefore best positioned to monitor for provider fraud, waste, and abuse. In managed care, these responsibilities are contracted to a managed care organization (MCO), which assumes responsibility for monitoring for false or improper claims submission by providers and other types of fraud and abuse.

It is important to note, however, that although MCOs are given primary responsibility for oversight of their providers and claim payments, states cannot delegate their federally mandated responsibility to ensure appropriate payment, access, and quality. Thus, states must assume broader program oversight responsibility—ensuring that capitation payments are appropriate, validating that MCOs have adequate provider networks, and providing oversight of MCO administrative requirements. Correspondingly, the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the Medicaid program, must ensure that states provide appropriate oversight of contracted managed care plans and comply with federal requirements.

Earlier MACPAC reports on program integrity focused on state and federal initiatives to detect provider fraud and eligibility errors, the two areas of concern that have been most frequently addressed in legislation and rulemaking (MACPAC 2013, 2012). In those early reports, noting that states were increasingly enrolling beneficiaries into MCOs, MACPAC highlighted the importance of identifying the program integrity challenges and opportunities relating to managed care. In May 2016, CMS published updated federal regulations for Medicaid managed care, which included more detailed provisions relating to program oversight and program integrity.[3] This update provided the impetus for the Commission to move ahead with an examination of managed care program integrity, focusing on initiatives to detect and deter fraud, waste, and abuse. The broader program oversight aspects of managed care program integrity activities may be the subject of future Commission work.

Over the past year, the Commission undertook an in-depth examination of state, federal, and MCO program integrity activities to assess the scope of current activities, their perceived effectiveness, and the anticipated effects of regulatory changes, including the degree to which the new rule addresses the Commission's earlier concerns. This examination included an environmental scan of managed care program integrity policies and interviews between July and October 2016 with 10 states, 3 MCOs, and several federal agencies, including the Center for Medicaid and CHIP Services (CMCS), the Center for Program Integrity (CPI), and the Center for Medicare (all within CMS) as well as the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS). The Commission also heard from a panel of federal and state experts at its December 2016 public meeting.

This study found the following:

- While the prevalence of managed care has grown over the last 15 years, making it a major Medicaid delivery system today, only recently have managed care program integrity issues received the same amount of focus at the state and federal level as program integrity in FFS.
- There is considerable variation among states in program integrity requirements for Medicaid MCOs, state oversight of MCO program integrity activities, and the extent to which states and MCOs work together to reduce fraud, waste, and abuse.
- Many program integrity practices are perceived by states and MCOs to be effective, but states have few mechanisms for measuring the return on investment of program integrity activities or for sharing best practices.
- Most states and plans interviewed for this study commented that the updated regulations, which incorporate many prior recommendations made by federal oversight agencies and adapt practices from leading states, are likely to strengthen managed care program integrity (Appendix 3A).
- States indicated they are already operating largely in compliance with some provisions in the new rule, while other provisions will require them to make substantial operational changes.
- CMS is still in the process of developing subregulatory guidance to assist states and MCOs in complying with the updated program integrity provisions, and states are still in the process of assessing the new rule, implementing changes where necessary while awaiting additional guidance from CMS. It is too early to assess the complete effect of the new rule.

We begin this chapter with a description of the program integrity issues in managed care and how these are similar to or different from those in FFS Medicaid, which we follow with summaries of the program integrity responsibilities of CMS, states, and MCOs. We then report the findings of our research, particularly regarding the strengths and weaknesses associated with existing program integrity measures, whether there are additional or alternative steps the federal government could take to ensure program integrity in Medicaid managed care, and the degree to which the new managed care rule is likely to strengthen state and federal oversight. We conclude the chapter with a brief discussion of issues that the Commission may examine in the future.

Program Integrity in Managed Care

Comprehensive managed care is now the primary Medicaid delivery system in 29 states, accounting for nearly half of federal and state spending on Medicaid and about 60 percent of beneficiaries in 2015 (MACPAC 2016a, 2016b). States vary in how they have designed and implemented Medicaid managed care programs, including the populations enrolled, the roles and responsibilities assigned to MCOs, the level of oversight and management retained at the state level, and the maturity of their programs. In a comprehensive managed care program, states contract with MCOs to deliver all or most Medicaid-covered services for plan enrollees. MCOs are paid a capitation rate—a fixed dollar amount per member per month—to cover a defined set of services for each enrolled member, and they must contract with a network of providers to deliver these services. The capitation rates must be developed in accordance with generally accepted actuarial principles and practices, they must be appropriate for the enrolled population and the services covered in the contract between the state and MCO, and they must be certified by qualified actuaries. MCOs are at financial risk if spending

on benefits and administration exceeds payments; conversely, they are permitted to retain any portion of payments not expended for covered services and other contractually required activities.

The primary differences between FFS and managed care delivery systems—in particular the payment and contracting arrangements—create new or different kinds of program integrity risks that require program-specific safeguards (Table 3-1). For example, under a managed care contract, the state delegates provider contracting, utilization management, and claims processing to an MCO. This means that the MCO, not the state, is primarily responsible for making sure that payments are accurate and that sufficient data are collected for oversight. State responsibilities must adapt to include oversight of and payment to plans; for example, to make sure capitation payments are appropriate and that encounter and enrollment data are accurate and valid.

TABLE 3-1. Characteristics of Fee-for-Service and Managed Care Delivery Systems and Program Integrity Risks Specific to Managed Care

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 fraudulent 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

Note: MCO is managed care organization.

Source: MACPAC, 2017, review of Title XIX of the Social Security Act and 42 CFR 435–460.

MCOs carry the financial risk associated with capitated payment arrangements, meaning that they are at risk for any losses if the costs associated with covering Medicaid enrollees exceed the capitation payments received from the state. Therefore, the traditional assumption has been that MCOs have an incentive to proactively reduce fraud, waste, and abuse to minimize avoidable losses. But the various approaches MCOs use to avoid or recover improper claim payments (e.g., purchasing claims-editing software and hiring investigators) have costs, and there is little information on which program integrity efforts consistently generate positive returns.

Moreover, other financial considerations can influence MCO decisions about the amount and type of investments they make in ensuring program integrity. For example, although recoveries of fraudulent payments can be easily quantified, the amounts potentially saved through cost avoidance activities are harder to estimate. If a state's contract with a Medicaid MCO links incentives or penalties to recoveries but not to cost avoidance, then the MCO might invest more resources in postpayment fraud detection activities and less in upfront fraud prevention. Medicaid MCOs are also required to report annually their medical loss ratio (the proportion of the Medicaid capitation spent on claims and activities that improve health care quality) and are expected to achieve a medical loss ratio of at least 85 percent.[4] Expenses for fraud reduction activities are not counted toward the medical loss and are considered administrative costs, along with other MCO administrative expenses and financial margins, which might cause MCOs to limit the amounts they spend on program integrity activities.

Although states may not delegate their federally mandated responsibilities to MCOs, they may delegate day-to-day responsibility for oversight of network providers. Prior to 2016, there were few federal rules that specifically addressed managed care program integrity and there was substantial variation among states in their requirements for MCOs and their oversight activities. For example, before 2016, federal regulations on program integrity for Medicaid managed care required MCOs to certify the accuracy of data submitted to the state, including encounter data submitted by network providers, and prohibited health plans from contracting with providers who had been debarred by federal agencies, including the Medicare program. Federal rules also required Medicaid health plans to have a written fraud and abuse plan that included, at minimum, a description of compliance oversight, training, and education for MCO staff as well as communication standards, disciplinary guidelines, internal monitoring, and corrective action plans.

As the proportion of Medicaid spending that flows through managed care contracts has increased, states and the federal government have sought to strengthen the oversight of managed care plans and to ensure that MCOs are conducting a full range of program integrity activities. In 2016, CMS updated the federal rule, thereby expanding the federal oversight role, standardizing the expectations for states across all managed care authorities, and updating program standards to reflect the current scope of Medicaid managed care programs (42 CFR 438). Subpart H of the new rule focuses specifically on program integrity: it adapts provisions from FFS, addresses vulnerabilities identified by oversight agencies including the U.S. Government Accountability Office (GAO) and the OIG, and implements best practices used by leading managed care states. Other subparts of the rule support program integrity through stronger program oversight, such as requirements to improve the reporting and quality of encounter data (Subparts D and E) and by requiring MCO contract provisions to flow down to subcontractors (Subpart D). States and MCOs may conduct additional program integrity activities beyond those required. Below we summarize Medicaid managed care program activities conducted by federal agencies, states, and MCOs.

Federal program integrity activities

The CMS CPI is responsible for the Medicaid Integrity Program, a comprehensive federal strategy to reduce Medicaid provider fraud, waste, and abuse. Managed care is a component of many of its initiatives, including periodic reviews of state program integrity operations, training, and technical assistance for states (CMS 2015). CPI publishes information on noteworthy state practices to address fraud and abuse in Medicaid managed care and provides training for state staff on managed care program integrity. CPI has also developed a managed care plan compliance toolkit with guidance to assist Medicaid managed care plans in preventing, detecting, and reporting Medicaid fraud, waste, and abuse (CMS 2015).

As noted earlier, managed care program integrity also involves broader program oversight, which, at the federal level, is the responsibility of various entities within CMS. CMCS reviews state documents (e.g., waivers and MCO contracts) to ensure that managed care programs comply with federal statutes and regulations. For example, CMCS annually reviews and approves each MCO contract and any contract amendments to ensure they include all required provisions, including those relating to program integrity.

Many federal efforts have focused on oversight and accountability for the accuracy of the payments made by states to MCOs. For managed care payments, the fundamental payment principle is that capitation rates be actuarially sound (42 CFR 438.4). States are required to submit for federal review the capitation rates that correspond to the populations and services covered in the managed care program, actuarial certifications for those rates, and data and documentation to support these certifications. CMCS reviews the capitation rates for each Medicaid managed care program to determine whether the payments are actuarially sound and support the necessary contract terms to deliver high-value, high-quality services to enrollees.

CMCS also collects managed care encounter data (information relating to the receipt of any items or services by an enrollee under an MCO contract) from the states, which are required to collect these data from the MCOs. CMCS uses these data to measure state and plan performance, monitor compliance with federal rules, and support program integrity efforts. The federal government has statutory authority to disallow Medicaid matching payments if states fail to submit complete and accurate data, although to date it has not exercised this authority (§§ 1903(i)(25) and 1903(m)(2)(A)(xi) of the Social Security Act).

Other offices within CMS also have responsibilities relating to Medicaid managed care program integrity. For example, as required by federal law, the Office of Financial Management measures the rate of improper payments for all CMS programs. This includes a review of a random sample of capitation payments made by state Medicaid programs to MCOs to determine whether they were made in accordance with the relevant contracts and capitation rate schedules (CMS 2017). The improper payment rate does not include an estimate of erroneous payments made by Medicaid MCOs to their plan providers.

Lastly, while not within CMS, the OIG is responsible for overseeing the integrity of all HHS programs, including Medicaid. The OIG conducts audits and investigations of both state Medicaid programs and CMS, and evaluates aspects of the Medicaid program to make recommendations focused on improving efficiency and reducing fraud, waste, and abuse. The OIG also oversees the state-based Medicaid Fraud Control Units (MFCUs).

State program integrity activities

All state Medicaid programs, regardless of delivery system design, must comply with federal Medicaid program integrity requirements. For example, states must have mechanisms to identify, investigate, and refer suspected fraud and

abuse cases to appropriate state and federal law enforcement agencies and cooperate with federal program integrity initiatives including the Medicaid Integrity Program and the Payment Error Rate Measurement (PERM) program (42 CFR 455).[5] In addition, all states have an MFCU, which operates independently from the Medicaid program, to investigate and prosecute Medicaid provider fraud, including fraud committed by providers under contract to Medicaid managed care plans.[6]

States with managed care programs have two additional program integrity responsibilities: conducting program integrity activities for the managed care program and making sure MCOs maintain effective program integrity programs of their own. For example, states must:

- periodically, but no less than every three years, conduct or contract for an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by or on behalf of each MCO;
- directly enroll and conduct all applicable screening and disclosure reviews and database checks for all MCO network providers (beginning in January 2018);
- investigate information received from whistleblowers relating to the integrity of the MCO, subcontractors, or network providers; and
- ensure that MCOs disclose certain information, such as personal and financial conflicts of interest, for each person with at least a 5 percent ownership or controlling interest in the entity and ensure that MCOs agree to provide information related to business transactions upon request.

States are required by federal rules to put specific program integrity requirements in their contracts with Medicaid health plans. For example, each contract must require MCOs to:

- implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse;
- ensure that all network providers are enrolled with the state as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements; and
- provide written disclosure of any prohibited affiliation and information on ownership and control.

The contract also must specify the retention policies for the treatment of recoveries of all overpayments from the MCO to a provider, including, specifically, retention policies for treatment of overpayment recoveries due to fraud, waste, or abuse.

State Medicaid managed care programs are also required to comply with a number of other federal requirements relating to transparency and accountability; these program oversight activities strengthen program integrity (Table 3-2). For example, the state must validate that MCOs have adequate provider networks and review encounter data to guard against underutilization. States must provide oversight of MCO administrative requirements, such as marketing and enrollment rules. States also must develop mechanisms for appropriate payments, for example, mechanisms for ensuring that capitation rates are correct and actuarially sound, that MCOs are not paid for non-enrolled individuals, and that the FFS program does not pay claims for services that are the responsibility of the MCOs.

States also may choose to conduct additional program integrity activities beyond those required by federal law, including encounter data analyses and joint program integrity investigations with MCOs. Many states periodically convene staff from the state managed care unit, program integrity unit, MCO program integrity department, and MFCU to discuss information about potential fraud, waste, and abuse. These opportunities for staff

of different state entities to share information on program integrity practices can also help strengthen state knowledge and oversight of MCO operations.

MCO program integrity activities

Medicaid MCOs conduct a variety of program integrity activities, including those required by federal rule, those required as a condition of contracting with a state, and those initiated by the health plan itself to minimize improper provider payments.

As noted above, federal rules require Medicaid managed care plans to comply with many specific requirements relating to program integrity, which are enforced through contracts with the states. For example, as part of its contractually required policies and procedures to detect and prevent fraud, waste, and abuse, each Medicaid MCO must have the following:

- a formal compliance program with written policies, procedures, and standards of conduct;

TABLE 3-2. State Requirements for Addressing Medicaid Managed Care Program Integrity Risks

Managed care program integrity risk	Regulatory requirements for states
• Incorrect or inappropriate rate setting	• Use detailed data for capitation rate development, certification, and federal review • Report medical loss ratio (MLR) and use MLR in capitation rate development • Conduct an independent audit of the encounter and financial data submitted by managed care plans
• Inaccurate encounter or claims data • Incomplete or inaccurate information on contract performance • Lack of access to subcontractor information or falsification of information	• Establish clear contractual language regarding required MCO reporting • Monitor MCO compliance with program integrity provisions • Post MCO data on state website • Require that all subcontractors be held to same provisions as MCO
• Underutilization in subcontracted or capitated providers • Inappropriate physician incentive plans	• Screen and enroll managed care plan network providers • Review ownership, control, and exclusion status for MCOs and subcontractors
• Payment to MCOs for non-enrolled individuals • Marketing or enrollment fraud	• Establish clear contractual language regarding acceptable marketing • Monitor MCO marketing activities

Note: MCO is managed care organization.

Source: MACPAC analysis of 42 CFR 438.

- a designated compliance officer and regulatory compliance committee;
- a program integrity training program to educate MCO staff;
- disciplinary guidelines that enforce compliance program policies;
- a system for routine internal monitoring and auditing of compliance risks and for responding to compliance issues as they are raised or for investigating and correcting potential compliance problems when identified in the course of self-evaluation and audits; and
- a method to periodically verify whether billed services were received by enrollees.

MCOs must cooperate with state and law enforcement agencies on program integrity activities. For example, MCOs must promptly report all overpayments identified or recovered to the state, specifying the overpayments due to potential fraud, and they must promptly refer any potential fraud, waste, or abuse to the state Medicaid program integrity unit or directly to the state MFCU, as applicable. MCOs must notify the Medicaid agency if they receive information regarding changes to enrollee or provider eligibility. They must also suspend payments to a network provider if the state has determined that there is a credible allegation of fraud against that provider.

Medicaid MCOs must comply with other state and federal requirements that support program integrity and ensure that taxpayer dollars are spent appropriately (Table 3-3). For example, MCOs must provide audited financial reports, complete and accurate encounter data for all services provided to enrolled members, and documentation demonstrating compliance with network adequacy requirements.

Medicaid MCOs may also engage in a variety of program integrity activities beyond those required by federal rule or specified in contracts with the state. For example, MCOs may implement additional prepayment and postpayment reviews of provider claims to detect patterns of fraud or conduct data matching with other insurers to identify unreported third-party liability.

Assessment of Managed Care Program Integrity Activities

Over the past year, the Commission conducted a comprehensive assessment of the scope of current Medicaid managed care program integrity activities, the perceived effectiveness of these activities, and the anticipated effects of regulatory changes. This examination included an environmental scan of managed care program integrity policies and interviews between July and October 2016 with 10 states, 3 MCOs, and several federal agencies, including the Center for Medicaid and CHIP Services (CMCS), the Center for Program Integrity (CPI), and the Center for Medicare (all within CMS) as well as the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS). The Commission also heard from a panel of federal and state experts at its December 2016 public meeting. Through this review, MACPAC identified several key findings:

- State managed care oversight and traditional FFS program integrity activities, which have largely operated in separate spheres, are increasingly coordinated by rule and by practice as state managed care staff take more oversight responsibility for MCO program integrity activities and as state program integrity staff expand fraud detection activities to encompass managed care providers. However, initiatives to ensure program integrity in managed care still lack the sophistication of those for FFS, and in many states program integrity in managed care is not a primary area of focus.
- State Medicaid personnel we interviewed indicated that additional guidance, training, and tools to support information sharing

would further strengthen managed care program integrity efforts. Interviewees identified many practices perceived to be effective but noted that there are few mechanisms for measuring the return on investment of program integrity activities or for sharing best practices. In the absence of clear guidance, states have developed their own policies and procedures, resulting in variation among states in what they require of Medicaid MCOs, state oversight of MCO program integrity activities, and how states and MCOs work together to reduce fraud, waste, and abuse.

- Personnel from state Medicaid programs, MCOs, and federal agencies also assert that the updated federal regulations, which incorporate many prior recommendations made by federal oversight agencies and adapt practices from leading states, are likely to strengthen managed care program integrity. However, most states are still in the process of assessing the new rule and implementing changes where necessary, and some provisions in the final rule have not yet gone into effect. The full effect of the new rule will not be known for several years.

TABLE 3-3. MCO Requirements for Ensuring Medicaid Managed Care Program Integrity

Managed care program integrity risk	Regulatory requirements for MCOs
• Incorrect or inappropriate rate setting	• Report medical loss ratio • Submit annual report on overpayment recoveries • Submit audited financial reports
• Inaccurate encounter or claims data (from providers and subcontractors) • Failure to coordinate with investigations and prosecutions of fraudulent claims • Incomplete or inaccurate information on contract requirements • Lack of access to subcontractor information or falsification of information • Inappropriate physician incentive plans	• Submit encounter data per specific requirements • Comply with contractual reporting and recovery requirements • Validate that billed services were received by enrollees • Promptly refer potential waste, fraud, and abuse to appropriate entity • Suspend payments to network providers if there is a credible allegation of fraud
• Payment to MCOs for non-enrolled individuals • Marketing or enrollment fraud	• Notify state about changes in enrollee eligibility status
• Lack of adequate provider network or underutilization	• Credential and recredential all network providers • Provide data demonstrating compliance with provider network requirements

Note: MCO is managed care organization.

Source: MACPAC analysis of 42 CFR 438.

In the Commission's view, these findings indicate that recent changes in federal guidance have the potential to help strengthen Medicaid managed care program integrity. However, the federal government has not issued complete guidance on all aspects of the new rule and states and MCOs have not yet developed all of the necessary infrastructure to support the additional requirements. While the Commission has not identified the need for specific statutory or regulatory changes at this time, based on our findings, the program integrity recommendations MACPAC made in March 2012 remain relevant for managed care and FFS delivery models. That is, CMS should enhance states' abilities to detect and deter fraud and abuse by developing methods for better quantifying the effectiveness of program integrity activities, by improving dissemination of best practices in program integrity, and by enhancing program integrity training programs (MACPAC 2012).

MACPAC findings

We discuss our specific findings below.

State emphasis on managed care program integrity varies widely. States use a variety of approaches to develop program integrity contract and reporting requirements, with some using only the federally required contractual provisions and others creating additional requirements. Many states have included provisions allowing penalties or liquidated damages for failure to comply with contractual requirements (e.g., not conducting required fraud and abuse oversight activities); however, only a few states actively levy fines or liquidated damages against MCOs. The number and type of state staff focused on managed care program integrity also varies considerably, with some states hiring no dedicated managed care program integrity staff and others hiring large teams focused solely on reviewing health plan reports and conducting on-site health plan audits. Finally, the level of review and validation of MCO reporting, particularly on the medical loss ratio (MLR) and performance reports, also varies widely.

This variation stems in part from a lack of consistent federal guidance as well as limited opportunities for states to share best practices. Other researchers have reached the same conclusion: a recent GAO review of CMS oversight and support of state Medicaid program integrity efforts found that CMS lacked a systematic approach to collecting and sharing state best practices for program integrity activities across states (GAO 2017). MCOs operating in multiple states are frustrated by the requirement to comply with multiple sets of rules and reporting formats relating to similar program expectations. States that have more recently implemented Medicaid managed care programs have been able to adapt policies and procedures from states with more mature programs that have identified which practices are likely to work. New and more explicit federal rules may lead to greater consistency in the future, but the full effects are unknown at this time.

State managed care oversight and program integrity initiatives have traditionally operated separately, but may work together more closely in the future. Traditionally, many states have separate departments for managed care program staff, who oversee not only program integrity but all aspects of MCO contracts, and program integrity staff, who generally focus on oversight of individual providers as opposed to MCO contracts. (MFCUs, by law, are organizationally separate from the Medicaid agency.) These operational separations mirror those at the federal level: managed care oversight is the responsibility of CMCS, responsibility for program integrity is at CPI, and MFCUs are overseen by the OIG.

However, as managed care delivery systems take on increasing importance within Medicaid, it is clear that there is overlap between managed care oversight and program integrity that requires coordination among the staff assigned to these separate functions. Similarly, the growing volume of Medicaid services provided through managed

care increases the need for Medicaid program integrity staff to be able to examine services and providers across delivery systems to identify potential problems.

At the federal level, CPI and CMCS staff worked together on the development of the new rule to ensure that program integrity requirements for managed care were appropriate. At the time of our interviews, most states had not yet developed new contract provisions in response to the new rule but several interviewees indicated that they would be interested in bringing program integrity and managed care oversight staff together to respond to new program integrity requirements. Some parts of the rule will also require greater integration between managed care and FFS staff. For example, the CMS final rule and the 21st Century Cures Act (P.L. 114-255) establish a new requirement for states to screen and enroll all new managed care providers (that is, those who are not already enrolled) in their FFS program (CMS 2016).[7]

States identified the need for greater collaboration among the state program integrity unit and managed care program unit, MFCU, and MCOs. Program integrity experts reported that the most common sources of fraud, waste, and abuse were the same in managed care and FFS: providers found to have engaged in suspect practices in one MCO were likely also doing so in other MCOs, other states, and in other federal programs such as Medicare. However, MFCUs and state program integrity staff interviewed noted that managed care plans typically refer fewer cases of potential fraud than the FFS program. Therefore, efforts to promote information sharing about fraud, waste, and abuse cases, suspect providers, or emerging fraudulent schemes could help prevent additional improper payments, reduce duplication of efforts, and support the development of stronger investigative cases when complex fraudulent activities occur.

Some states have attempted to increase coordination by implementing regular meetings across program integrity, managed care, and MFCU staff and, less frequently, by co-locating program integrity and managed care program management staff. Some states cited challenges in improving collaboration, including state administrative capacity limitations and MCO hesitation to share information with other plans due to proprietary concerns. As noted before, there are multiple offices at the federal level working with states on these issues (e.g., CPI organizes the state Fraud and Abuse Technical Advisory Group for state program integrity staff and CMCS runs the state Managed Care Technical Advisory Group for managed care staff) and these siloed approaches may also hamper efforts to improve collaboration at all levels.

Differences between the approaches taken by MCOs and states to ensure program integrity create challenges for oversight agencies. State Medicaid agencies and managed care plans both use similar claims-editing processes to screen for potentially improper claims and conduct retrospective reviews to examine claims for patterns of fraud, which can be investigated and recovered as appropriate. However, MCOs generally have greater flexibility than states to implement provider oversight and utilization management tools to reduce the risk of fraud, waste, and abuse by providers with unusual service delivery patterns. This flexibility helps MCOs maintain access and compliance with network adequacy rules while potential program integrity issues are investigated and resolved.

The differences between the approaches available to states and MCOs create two challenges for oversight agencies. First, recoveries are a significant focus of program integrity activities: by law, state and federal overpayments must be identified and returned to the government, and, for managed care, factored into the rate-setting process. While MCOs report on overpayment recoveries made during the year, typical reporting requirements do not capture the dollars saved through activities focused on avoiding overpayment, potentially undervaluing successful program integrity efforts conducted by MCOs in

comparison to traditional pay-and-chase efforts performed under FFS.

Second, while MCOs are concerned primarily with the integrity of their own providers, state and federal officials are concerned with providers that participate in any Medicaid MCO or FFS program. Without clear guidance regarding required referrals to state investigators, MCOs may terminate providers without notifying the state about suspected fraud, waste, or abuse. Moreover, when MCOs do notify the state, they may not need to provide a reason, given that "without cause" termination clauses are typically included in provider contracts. State personnel, particularly staff of MFCUs, expressed concern that limiting the cases sent for investigation affects their ability to exclude fraudulent providers from the system, thereby posing a risk to Medicaid beneficiaries enrolled in other MCOs or receiving services through FFS.

Data quality is important for program integrity but continues to be a concern. State and federal entities reported continuing challenges to obtaining accurate, complete, and timely encounter data from MCOs. Such data are needed for predictive modeling, data analytic strategies, and investigation of potential fraud, waste, and abuse across MCOs and between managed care and FFS. Most states have processes for verifying the accuracy of encounter data submitted by MCOs, such as system edits and staff reviews. Most states also contract with an external quality review organization (EQRO) or other vendor to validate additional data. The new rule requires all states to have mechanisms to review encounter data and to develop quality assurance protocols to ensure that encounter data are complete and accurate. States are now also required to conduct an external audit of encounter data at least every three years.

Knowledgeable staff from some states noted that guidance on technical matters like data quality benchmarks and encounter data validation protocols could help them develop their capacity to oversee MCO compliance with stricter encounter data submission requirements. These benchmarks and protocols could be obtained from other states or from other programs, such as Medicare. Personnel from other states requested that CMS provide states with specific examples of enforceable contract language (e.g., liquidated damages if encounter data are not received).

States use different incentives to encourage MCOs to rigorously pursue program integrity, but there is no clear information favoring one approach over others. As noted earlier, MCOs are at risk for any losses if the costs associated with covering Medicaid enrollees exceed the capitation payments received from the state, including any costs resulting from fraud, waste, or abuse. Thus, in addition to their contractual responsibilities to prevent improper payments, MCOs have a financial incentive to monitor for fraudulent provider activity. However, there are financial and non-financial costs associated with program integrity activities. Financial costs include staffing expenses for claims examiners and case investigators as well as other supports, such as staff training, sophisticated fraud detection software, and third-party liability matching services. Non-financial costs include provider frustration with delayed payments and the challenge of maintaining adequate provider networks while proactively addressing provider fraud by suspending or removing providers as appropriate. States want to ensure that MCOs make sufficient investments in program integrity and do not waste taxpayer money. MCOs must also manage program integrity expenses within the overall administrative allocation they are expected to maintain under Medicaid MLR rules.

Procedures for accounting for program integrity expenses and recoveries in the rate-setting process vary from state to state. States may make different assumptions about the underlying level of improper payments in the base data and corresponding adjustments to the baseline. Some states require MCOs to return any overpayments recovered through MCO audits and investigations to the state and others allow MCOs to keep recovered overpayments but require that they

report the amounts to the state periodically. These approaches reflect state preferences regarding MCO contracting and risk sharing and affect subsequent rate setting. However, it is not clear whether certain rate-setting approaches are more effective than others in providing incentives for MCOs to invest in program integrity and to pursue recoveries when improper payments are discovered.

It is still too early to gauge the full impact of the Medicaid managed care final rule. The 2016 rule incorporates many provisions that directly and indirectly support program integrity, but because few provisions have gone into effect at this time, it is difficult to know what the ultimate impact of the rule will be. As well, the current administration is contemplating changes that will likely delay implementation of the final rule, and it is not known to what extent these changes and the possible delay will directly or indirectly affect program integrity provisions. Some states are already in compliance with some requirements, and those we spoke with are preparing to respond to remaining provisions. Most of those we interviewed agreed that the new rule will likely strengthen program integrity, but also will require staff and information technology resources to implement (e.g., provider screening capabilities). We anticipate that the added requirements will present challenges given administrative capacity constraints in many states and the diffusion of operational responsibilities among different agencies and departments. Knowledgeable state and MCO staff said they would like implementation support, additional guidance, and greater clarity around federal policy in the following areas:

- **Encounter data:** Accurate, complete, and timely encounter data from MCOs are needed to allow all partners in program integrity identify fraud, waste, and abuse. Additional guidance, tools, and best practice guidelines that states can use (e.g., specific and enforceable MCO contract language) that result in the MCO submitting complete, accurate, and timely data would help states improve encounter data collection.
- **Cross-agency collaboration:** State, federal, and MCO officials face challenges in coordinating their managed care program integrity activities, but they agree that collaboration is important. Additional guidance from CMS on ways in which collaboration has worked across MFCUs, state and federal entities, and MCOs could prove valuable.
- **Oversight tools:** Because states have different levels of experience with managed care and take different approaches toward managed care program integrity, many would like more and better opportunities to learn from each other and to share documents, information, and tools, including but not limited to specific MCO contract language, MCO reporting layouts, and encounter data validation methods. Many states agree that the Medicaid Integrity Institute, which is operated in coordination with the U.S. Department of Justice, is an effective mechanism for training state Medicaid staff and that it also facilitates the sharing of best practices and ideas across states.
- **Payment and recoveries:** Federal rules on how states pay MCOs on a capitated basis can create conflicting financial incentives for MCOs when deciding how to invest in program integrity. States also seek best practices on how other states have handled recoveries. States cited a need for additional guidance from CMS in the areas of implementation and enforcement of MCO contracts to best align payments with program integrity incentives.

Issues for the Future

Looking ahead, the Commission's review suggests that the discussion of program integrity would benefit from additional research into the impact of specific provisions of the new federal managed

care rule. Issues of interest include how states validate their encounter data for future rate setting; best practices across states that provide incentives for MCOs to make investments in prepayment auditing as well as postpayment reviews; how to improve mechanisms for sharing provider screening data among states and programs; and how to measure the effectiveness and impact of program-related activities and best practices.

The adoption of value-based purchasing models in states, particularly the use of accountable care organizations (ACOs), may affect how states and MCOs approach program integrity. ACOs rely in part on the reporting of quality measures to improve outcomes that have the potential to save costs. However, it is unclear how provider-led organizations such as ACOs would approach program integrity in cases of potential fraud. In addition, many states are turning to MCOs to coordinate the delivery of long-term services and supports (LTSS), an area that has been identified by the OIG as being vulnerable to fraud and abuse in FFS (OIG 2017). It will be important to determine whether current rules, as implemented by managed LTSS plans, can effectively protect enrollees and state Medicaid programs against fraud and abuse or if additional standards are needed.

Only after the final rule is fully implemented and enforced will we know what works best for all players in managed care program integrity. States, MCOs, and federal entities that oversee program integrity will play key roles in demonstrating how effectively the provisions of the rule may be applied. The new administration will determine how (or whether) to implement and enforce the various provisions of the final rule and we look forward to additional guidance being issued on provisions scheduled to take effect in 2017 and 2018. MACPAC is prepared to assess the specific requirements as they are carried out.

Endnotes

[1] CHIP-funded expansions of Medicaid are subject to the same administrative requirements as Medicaid, including program integrity requirements. Many states operate CHIP programs as stand-alone programs, but in practice use the same staff and systems that support Medicaid such that the two programs are administratively integrated (e.g., they process claims on the same system, use the same providers, and have the same program integrity processes). Some states operate CHIP as a fully separate program that is typically smaller in size and subject to different federal administrative requirements. For these reasons, the administrative capacity issues unique to separate CHIP programs are generally excluded from this chapter.

[2] Total Medicaid benefit spending across all states and territories in 2015 was $526.1 billion. Spending on all forms of managed care in 2015, including comprehensive managed care and premium assistance, was $230.2 billion (MACPAC 2016a).

[3] The rule was finalized in May 2016 and constituted the first update of the federal regulations on Medicaid managed care since the initial rulemaking in 2002 (CMS 2016).

[4] This requirement applies no later than the rating period for MCO contracts starting on or after July 1, 2019. Fraud reduction activities are also included in the numerator if they are included in the numerator of the MLR calculation for the commercial market, as defined in 42 CFR Part 158. As of May 2017, CMS has not changed its definition of fraud reduction activities in the numerator of the MLR calculation for the commercial market.

[5] For a detailed description, see MACPAC's June 2013 report to Congress (MACPAC 2013).

[6] MFCUs, for which the OIG has oversight responsibility, investigate and prosecute Medicaid provider fraud as well as patient abuse and neglect in health care facilities and board and care facilities in 49 states and the District of Columbia (only North Dakota does not have an MFCU).

[7] Databases specified in the final rule include the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the System for

Award Management (SAM), and any other databases the state or the Secretary of the U.S. Department of Health and Human Services may prescribe. There is some overlap between the screening and credentialing processes. The screening process involves verifying a provider's licensure for enrollment in the Medicaid program, while credentialing involves the state or the MCO verifying a provider's education, training, liability record, and practice history prior to execution of a network agreement (CMS 2016).

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APPENDIX 3A: Summary of Medicaid Managed Care Program Integrity Regulatory Requirements

TABLE 3A-1. Regulatory Requirements for Oversight and Integrity of Medicaid Managed Care Programs

Section of CFR, Title 42	Requirement
State managed care program integrity requirements	
438.66(a)–(c)	Have a monitoring system for all managed care programs that addresses all aspects of the program
438.602(a)	Monitor managed care plan compliance with program integrity provisions
438.602(b)	Screen and enroll managed care plan network providers
438.602(c), (d)	Review ownership, control, and exclusion status for managed care plans and subcontractors
438.602(e)	Conduct an independent audit of the encounter and financial data submitted by managed care plans
438.602(f)	Receive and investigate information from whistleblowers about the integrity of managed care plans, subcontractors, and network providers
438.602(g); 438.604	Collect data and publish information from managed care plans on the state's managed care website, including managed care contracts, compliance with access and availability of services requirements, results of audits of encounter and financial data submissions
438.608(d)	Contractually specify overpayment recovery procedures, including retention policies, reporting procedures, and procedures for repayment to the state
State general managed care requirements and statutory definitions	
438.66(e)	Implement an annual managed care program report
438.68	Develop and enforce network adequacy standards
438.104	Monitor managed care organization marketing activities
438.332	Require and monitor accreditation status of managed care plans
438.334	Establish a Medicaid managed care quality rating system
438.340	Establish quality measures and performance outcomes in the state quality strategy, review and evaluate the effectiveness of the state quality strategy
438.364	Develop an annual external quality review technical report
438.2	Definitions: "rating period," "overpayment," "network provider," among others
438.3(c), (e)	Describes the services for inclusion in rate development
438.4	Actuarial soundness definitions and requirements
438.5	Establish rate development standards

TABLE 3A-1. (continued)

Section of CFR, Title 42	Requirement
438.6	Special contract provisions related to payment
438.7	Rate certification submission
438.8; 438.74	Medical loss ratio (MLR) and state oversight of MLR requirements
438.60	Prohibition of additional payments for services covered under managed care contracts
Managed care organization (MCO) program integrity requirements	
438.3(m)	Submit audited financial reports specific to the Medicaid contract
438.242; 438.604(a)(1)	Maintain a health information system; submit encounter data
438.604(a)(2)	Submit data for capitation rate development and certification
438.8(k); 438.604(a)(3)	Submit data used to calculate and monitor compliance with the MLR
438.604(a)(4)	Submit data to determine compliance with solvency requirements
438.207(a), (b); 438.604(a)(5)	Submit documentation demonstrating compliance with the availability, accessibility, and timeliness of services and network adequacy
438.604(a)(6); 438.608(c)	Submit information on ownership, control, and disclosure of any prohibited affiliation of managed care plans and subcontractors
438.604(a)(7); 438.608(d)	Submit annual report of overpayment recoveries
438.608(a)(1)	Maintain written program integrity policies and procedures; designate a compliance officer; establish a regulatory compliance committee; provide employee training and education; establish disciplinary guidelines; and designate staff to audit and respond to compliance issues
438.608(a)(2)	Promptly report overpayments, specifying overpayments due to potential fraud
438.608(a)(3)	Promptly notify the state about changes in an enrollee's circumstances that may affect an enrollee's eligibility
438.608(a)(4)	Notify the state about a change in a network provider's circumstances that affects the provider's eligibility to participate in the program
438.608(a)(5)	Establish a method to verify that services represented as delivered by network providers were received by enrollees
438.608(a)(6)	Provide written policies to all employees, contractors, and agents that provide detailed information about the false claims act
438.608(a)(7)	Promptly refer any potential fraud, waste, or abuse identified to the state Medicaid program integrity unit or to the state Medicaid Fraud Control Unit
438.608(a)(8)	Suspend payments to a network provider when the state determines a credible allegation of fraud

Notes: CFR is *Code of Federal Regulations*. All citations are included in Title 42 of the CFR.

Source: MACPAC, 2017, analysis of 42 CFR.