Medicaid Program Integrity for Managed Care Entities (MCE)

Medicaid Program Integrity Overview

FISCAL AND OPERATIONS DIVISION
Office of Program Integrity

PRESENTATION

This training is intended to assist Oregon Managed Care Entities (MCE) to responsibly carry out their fraud, waste and abuse prevention, and compliance and oversight obligations under the applicable contract with OHA and federal and state Medicaid laws.

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Although every reasonable effort has been made to ensure the accuracy of the information within these training materials, the ultimate responsibility for complying with the federal and state fraud and abuse laws and Medicaid program requirements lies with the provider of services.

What we will cover

- Medicaid
- Program integrity
- Oversight of Managed Care Entities (MCE) and Oregon Health Authority (OHA) responsibilities
- Office of Program Integrity (OPI) responsibilities
- MCE responsibilities

Medicaid

Overview

Two government programs help people pay for healthcare:

Medicare – health insurance program for the aged and disabled under Title XVIII of the Act.

- Care of people who are older (65+), disables or chronically ill
- 100% administered and funded by federal government
- No financial tests to qualify
- Coverage of hospitals, outpatient, nursing homes and prescription drugs

Medicaid – medical assistance provided under a State plan approved under Title XIX of the Act.

- Care of people with limited income and resources
- Administered by states
- For individuals who meet certain minimum financial eligibility standards Income and asset tests vary by state
- Cover certain medical services, such as physician, hospital, and nursing home care
- No two states' Medicaid program or eligibility requirements are the same

Medicaid and CHIP

- **Medicaid**
  - Established under Title XIX of the Social Security Act.
  - Provides medical assistance for millions of low-income, disabled, and elderly Americans.
- **Children's Health Insurance Program (CHIP)**
  - Established by Title XXI of the Social Security Act.
  - Provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid.

Medicaid and CHIP

- Together, Medicaid and CHIP cover more than 1 in every 3 children, and more than half of all low-income children.
- Medicaid and CHIP are joint federal-state funded health programs.
  - The federal government establishes minimum program requirements.
  - States design, implement, administer, and oversee their own programs.
  - States also have many flexibilities they can use to increase the services offered or number of people covered by Medicaid.
  - The federal government reimburses states by matching qualified expenditures based on the Federal Medical Assistance Percentage, which cannot be lower than 50%.

Medicaid in Oregon

- Oregon operates its Medicaid and CHIP programs as the Oregon Health Plan. The Oregon Health Plan started under a Section 1115 Demonstration Waiver in 1994.
- Over the years the waiver has allowed Oregon many flexibilities, including:
  - Coverage according to the Prioritized List of Health Services
  - Using the same benefits and service delivery model for both Medicaid and CHIP programs
  - The coordinated care model
- As of October 1, 2023, 1.5 million people have Oregon Health Plan coverage.

OHP Service Delivery

Managed Care Entity (MCE)

- State enters into risk-based contracts with MCEs (private insurance companies or non-profits), who are in turn responsible for processing claims and payments.
- State pays the MCE a capitated rate.
- CCOs serve 90% of OHP members.

Fee-For-Service (FFS)

- State contracts with providers who serve FFS members. The state processes the claims and pays the provider directly.
- Fewer than 10% of OHP members are FFS members.

OHP Service Delivery

- Managed care is the main delivery model.
- OHA currently contracts with one MCE type:
  - 16 coordinated care organizations (CCOs) for medical, dental, behavioral health and prescription care.

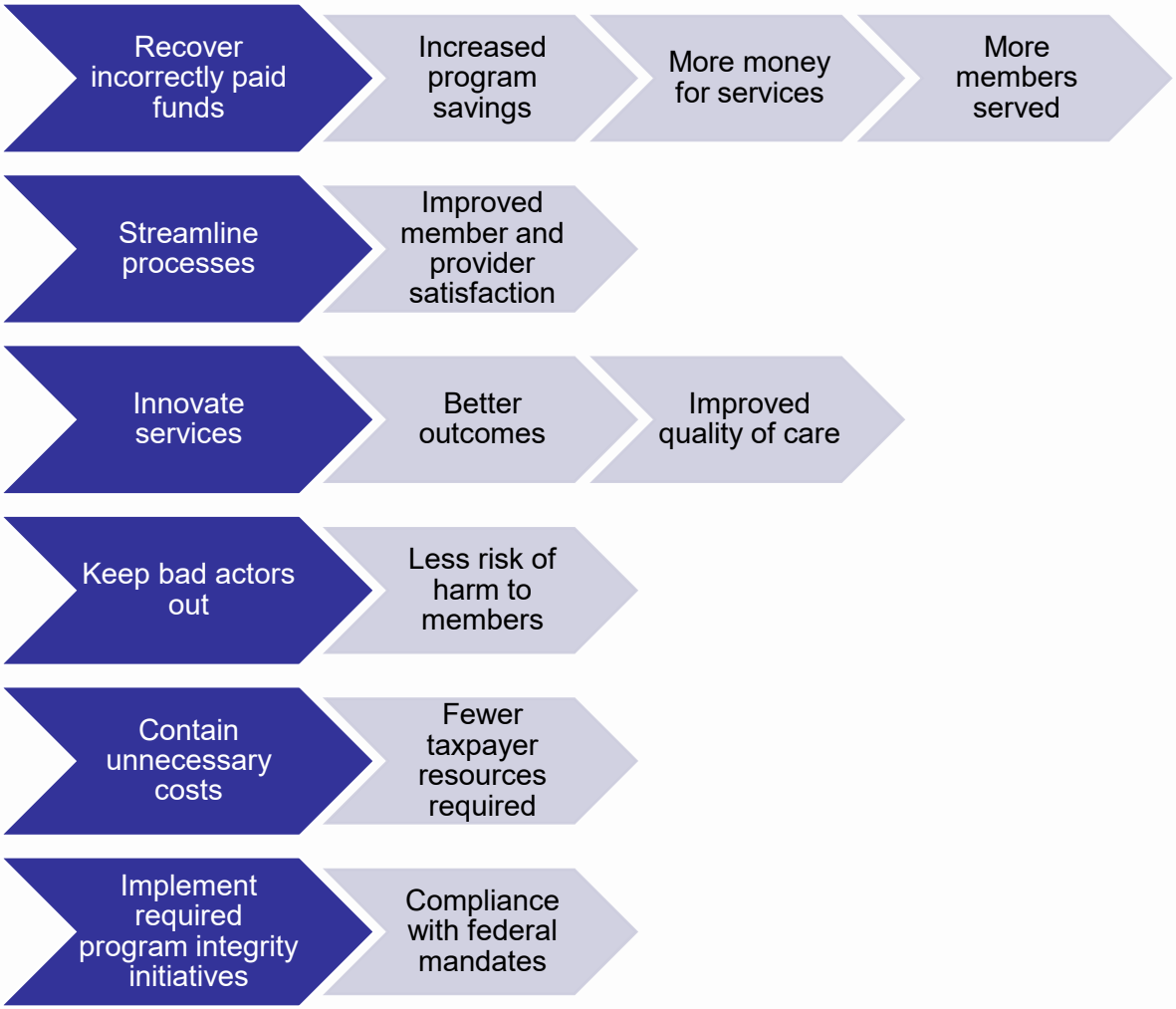
Program integrity

What is program integrity?

- Program integrity means ensuring that state and federal tax dollars are:
  - Used to deliver covered and appropriate services to eligible people and
  - Not diverted due to fraud, waste, and abuse (FWA).

- State Medicaid Agencies (SMA) use program integrity actions to achieve many program outcomes

Program integrity actions and outcomes



What is program integrity?

- Centers for Medicare and Medicaid Services (CMS) and the State Medicaid Agencies (SMAs) are responsible for ensuring payment integrity safeguards are within all Medicaid program policies and operations.

- As shown on the next slide, program integrity is woven throughout the Medicaid program.


Program integrity
Complaints
Training and education
Member eligibility
Encounter data
Audits
Provider enrollment and contracting
Authorization and denial of claims
Financials
Investigations
Verification of services
Provider credentialing and screening
Surveys
Compliance reviews

Why program integrity?

- Fraud, waste and abuse (FWA) affects everyone by:
  - Draining critical resources from our health care system and
  - Contributing to the rising cost of health care for all.
- Taxpayer dollars lost to FWA harm multiple parties, particularly some of our most vulnerable citizens.

Federal regulations

- State Medicaid programs must comply with requirements set in Title 42 of the Code of Federal Regulations (CFR).
- These are some of the requirements that pertain to state and MCE program integrity.

42 CFR § 433.304 and § 455.2)

- Fraud and abuse definitions

42 CFR § 455.12 – §455.23

- State Medicaid Agency Fraud Detection and Investigation Program Requirements

42 CFR § 457.915

- CHIP fraud detection and investigation program requirements are similarly outlined in federal regulations

42 CFR § 438.608

- MCE Program Integrity Requirements

Foundational health care fraud laws

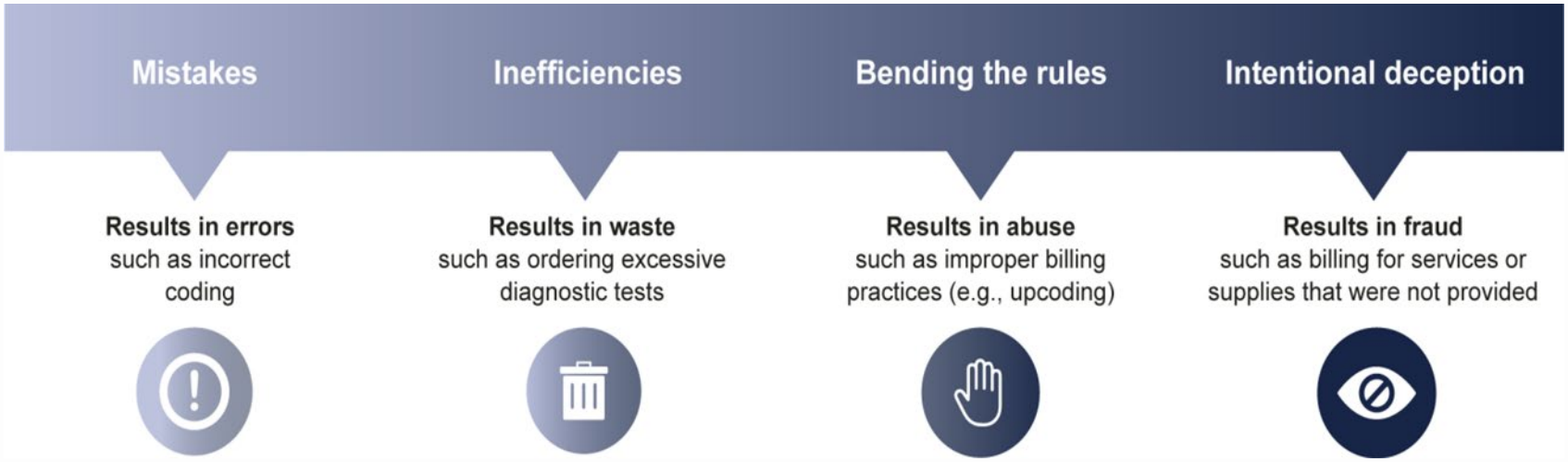
- In addition to the CFRs about fraud in Medicaid and CHIP programs, health programs must also follow foundational US health care fraud laws.
- It is critical that you read any law you work with, even if you are not a lawyer or have never really read any before.

Foundational health care fraud laws

Anti-kickback Statute • 42 USC 1320a-7b	Stark Anti-Referral Statute • 42 USC 1395nn	Civil False Claims Act • 31 USCC 3729-3733	Civil Monetary Penalties Statute • 42 USC 1320a-7a	Health Care Fraud Statute • 18 USC 1347
Health Care Benefit Program - False Statements Statute • 18 USC 1035	Mail Fraud • 18 USC 1341	Wire Fraud • 18 USC 1343	Criminal False Statements • 18 USC 1001	Money Laundering • 18 USC 1956
USA PATRIOT Act	Congressional acts	State-specific laws	HHS OIG published guidance about compliance plans	Key components of the ACA
	HIPAA (Title 2)	The Health Information Technology for Economic and Clinical Health Act (HITEC)	Federal antitrust laws	

The program integrity spectrum

- Program integrity is not limited to intentional deception. It also includes mistakes, inefficiencies and bending the rules.



The program integrity spectrum

- Fraud occurs when someone intentionally executes or attempts to execute a scheme to obtain money or property of any health care benefit program.

- Abuse occurs when health care providers or suppliers perform actions that directly or indirectly result in unnecessary costs to any health care benefit program.

  – The primary difference between fraud and abuse is intention.

The program integrity spectrum

- Medicaid program integrity is not limited to intentional deception. Program integrity is also mistakes, inefficiencies and bending the rules.

- Organizations must investigate mistakes and inefficiencies to understand their cause.
  - They may be more than just mistakes.
  - They may uncover a pattern of abusive or fraudulent behavior.

Oversight of MCEs

OHA responsibilities

Oversight of MCEs

- When states contract with MCEs, they are privatizing some portion of their Medicaid program subject to state oversight.
- States must have a strong contracting, compliance, and monitoring process to reduce risk.
- The MCE and SMA:
  - Must have a joint commitment to protect public funds from FWA.
  - Share their successes and failures.
  - Should work closely together and align program integrity efforts to mitigate risk.

Oversight of MCEs

- The overall responsibility of a SMA is to the providers, enrollees, and public
- Any success and failure of the contracted MCEs will ultimately be the SMA's as well. Working closely together will help mitigate that risk.

Aligning program integrity efforts

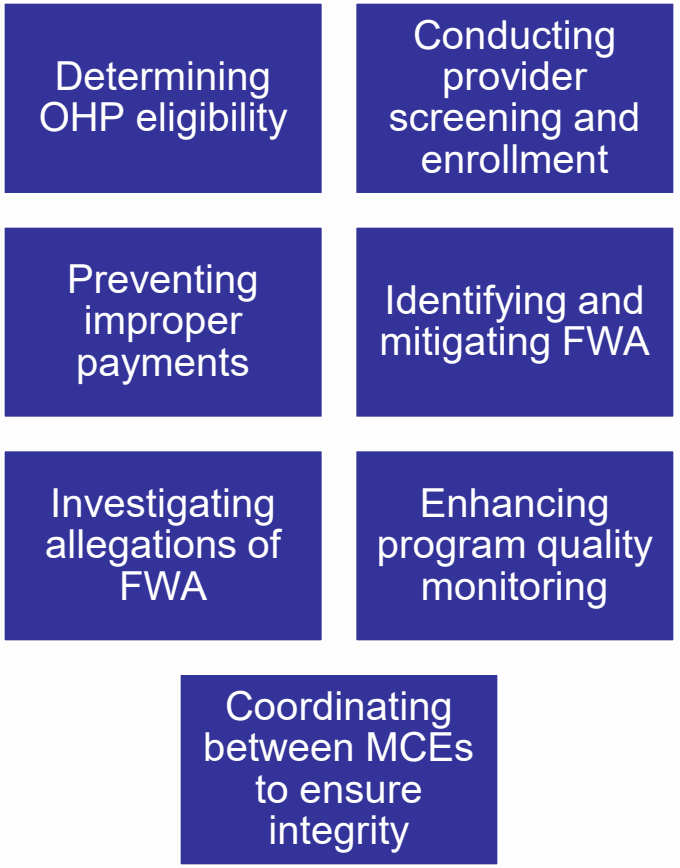
- Alignment requires:
  - Open and productive communication and
  - Coordination between state and federal agencies and MCEs.
- Coordination can include:
  - Effective communication of policy changes
  - Coordinated system testing
  - Consistent training that includes program integrity components
  - Root-cause identification, appropriate mitigation, and corrective action
  - Proper referral of potential fraud

SMA oversight requirements

- 42 CFR § 438.66(a) directs SMAs to have "a monitoring system for all managed care programs."
- This includes oversight of compliance with Medicaid requirements for MCE claims management, finance and program integrity policies and operations.

SMA responsibilities

- Pay MCE for services to members
- Track compliance and deliverables
- Enforce terms of the contract
- Assess recommended damages or withholds
- Program integrity responsibilities.
  - Examples are listed here.



SMA program integrity CFRs

- SMA have many program integrity responsibilities for FFS and managed care.
- These are some of the foundational CFR for SMAs.
- There are multiple CFR that further specify and define state requirements for oversight of managed care and MCEs.

42 CFR § 455

- Program Integrity: Medicaid

42 CFR §§ 457.900–457.990

- Program Integrity: CHIP

42 CFR §§ 1000–1099

- Office of Inspector General – Health Care, Department of Health and Human Services

SMA managed care oversight CFRs

Requirements for SMA oversight and integrity of Medicaid managed care programs

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

438.608(d)

- Contractually specify overpayment recovery procedures, including retention policies, reporting procedures, and procedures for repayment to the state

SMA managed care oversight CFRs

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 effective of the strategy

438.364
- Develop an annual external quality review technical report

438.2
- Definitions: “Rating period,” “overpayment,” “network provider,” among others

SMA managed care oversight CFRs

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

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

OPI responsibilities

OHA OPI responsibilities

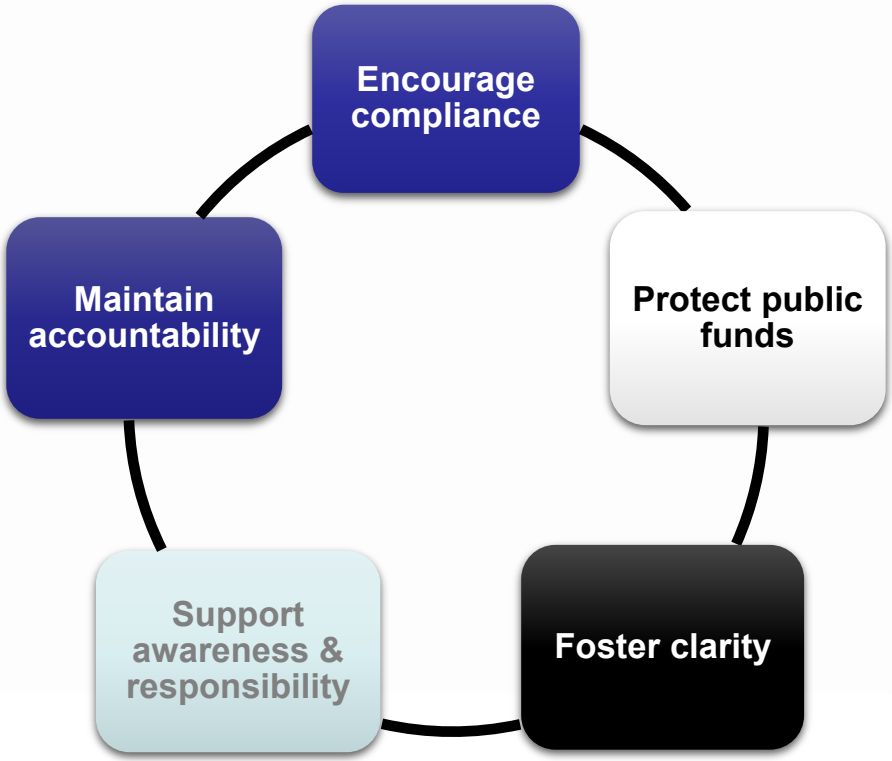
- The Office of Program Integrity (OPI) sits within OHA's Fiscal and Operations Division.
  - OPI performs many of the program integrity activities federally required of SMAs.
  - Here are some of OPI's work areas.

OPI responsibilities

- Establish good working relationships with MCEs, partner agencies, the provider community and OHP members
- Investigate allegations of FWA
- Audits
  - Medical records of FFS and MCE providers
  - Appeals: Participation in ALJ hearings
  - Recoupment of overpayments
  - Reporting of recoveries
- Review of MCE FWA compliance plans and FWA policies and procedures
- Provider suspensions/terminations
- Affect positive change to Oregon and MCE rules, policies and benefit limits

OHA OPI mission

- To detect and deter FWA to safeguard the fiscal health of the Oregon Medicaid program.
- Demonstrate responsible stewardship of public funds through:
  - Business strategies to detect, prevent and investigate FWA.
  - Cutting-edge research, policy analysis, and professionally recognized auditing compliance and oversight strategies.



OHA OPI partnerships

State

- Oregon Department of Justice (DOJ) Medicaid Fraud Control Unit (MFCU)
- Oregon Department of Human Services Fraud Investigation Unit (ODHS FIU)
- OHA divisions

Federal

- Department of Health and Human Services Office of Inspector General (HHS OIG)
- Healthcare Fraud Prevention Partnership (HFPP): Voluntary, public-private partnership between the federal government, state and local agencies, law enforcement, private health insurance plans, employer organizations, and healthcare anti-fraud associations to identify and reduce FWA across the healthcare sector
- Unified Program Integrity Contractor (UPIC)

National associations

- National Health Care Antifraud Association (NHCAA)
- National Association for Medicaid Program Integrity (NAMPI)

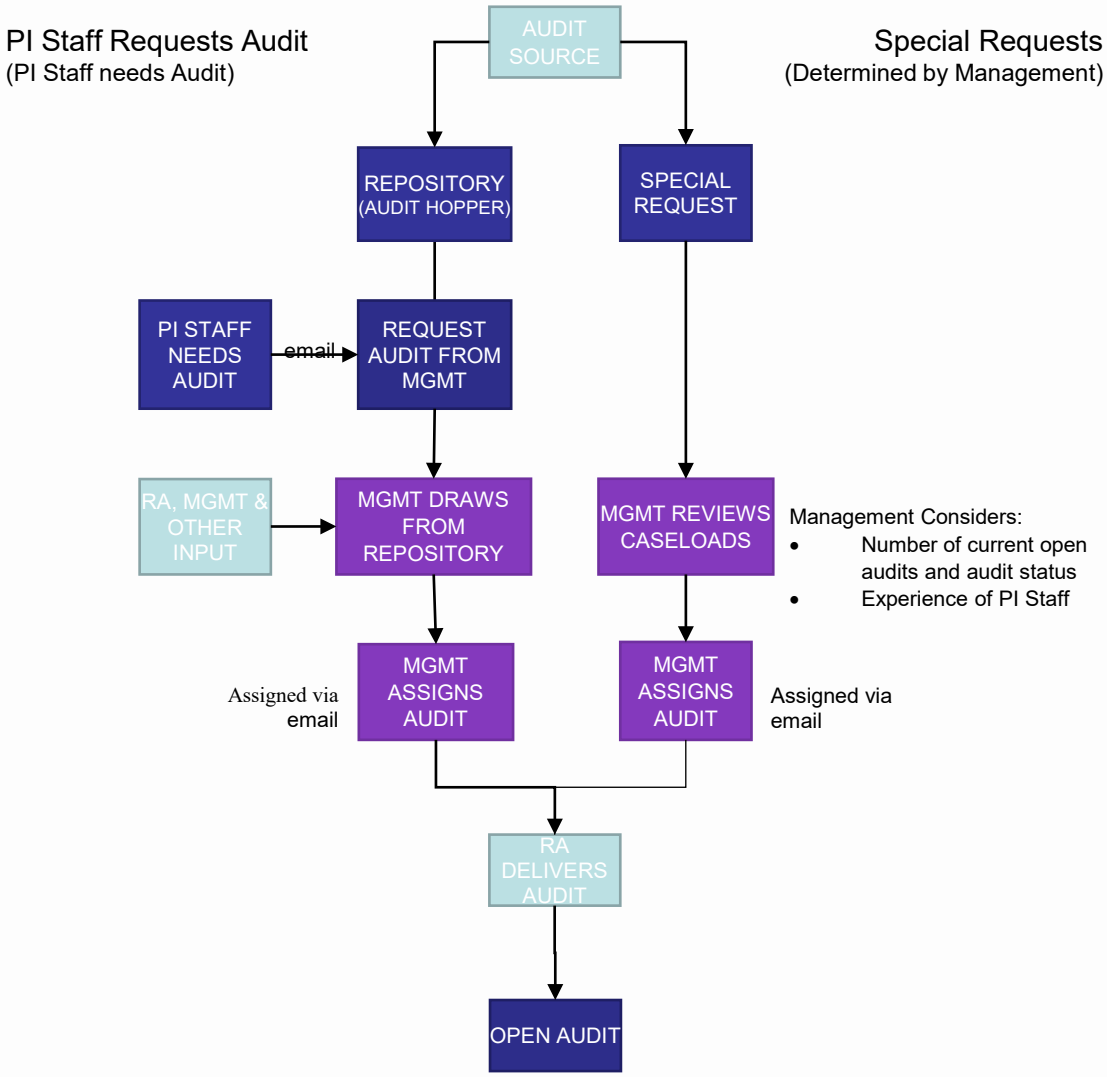
Law enforcement

OHA OPI Audit Process

OPI's work includes auditing of FFS and MCE providers.

This is an example of the flow of an OPI audit selection and vetting process.

It provides planning, scope set, process controls, specialties consideration, internal controls and data analytic foundation.



FWA allegations and referrals

- OPI is tasked by OHA with receiving and handling FWA allegations and referrals from all parts of the Medicaid program.
- OPI is a central point of contact for FFS and MCEs.

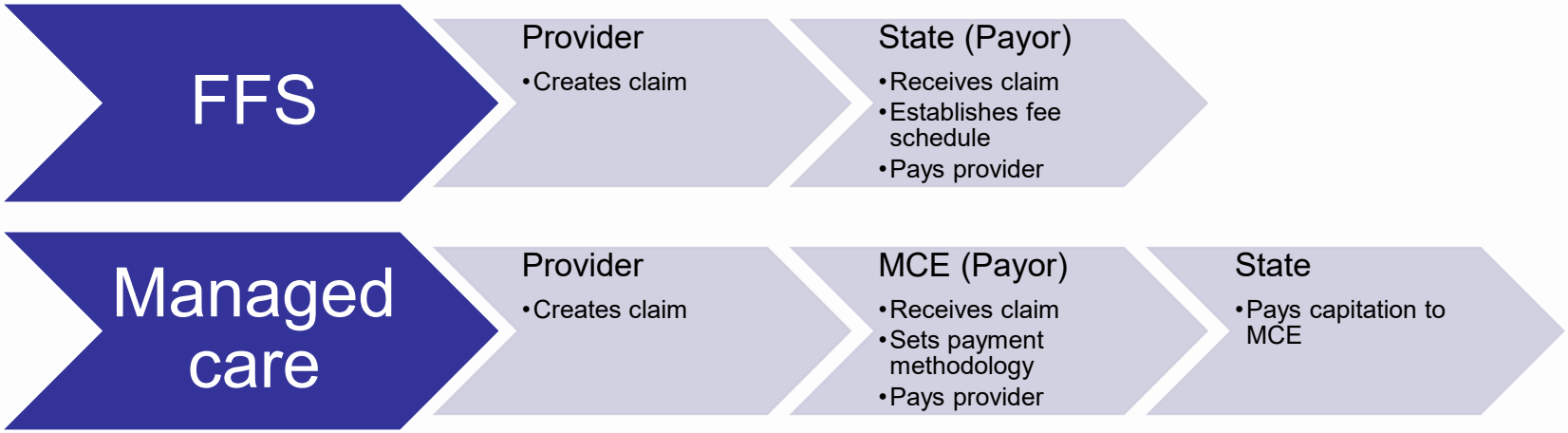
What does OPI do with a referral?

- Looks into both FFS and managed care to determine exposure.
- When exposure is identified, OPI:
  - Notifies any potentially impacted MCEs.
  - Coordinates with fraud prevention partners, Oregon DOJ's Medicaid Fraud Control Unit (MFCU) and law enforcement.

FFS vs. managed care

Managed care is a health care delivery system organized to manage cost, utilization, and quality. Health benefits are delivered using contracted arrangements between SMAs and MCEs that accept a capitation payment for services (per member per month).

- There are different program integrity risks in FFS than in managed care.
- In FFS, the state is at risk. In Managed care, the MCE is at risk.
- As the intersection between FFS and managed care, OPI works to address all risks.



Program integrity risks in managed care

State pays MCE a capitated payment

Risk Incorrect or inappropriate payment to MCE.

Underutilization of services by MCE members.

MCE processes claims

Risk Inaccurate encounter (claims) data submitted by MCE.

MCE staff may fail to cooperate with state investigations and prosecutions of fraudulent claims.

Focuses on cost avoidance, not recovery of state dollars.

State oversees MCE contract. MCE can subcontract

Risk Incomplete or inaccurate information about MCE performance.

Cannot access subcontractor information about contract performance or falsification of information.

Program integrity risks in managed care

MCE can pay providers using subcapitation, alternate methodologies or other incentives

Risk Underutilization by MCE members.

Inappropriate physician incentive plans.

MCE only covers their enrolled members

Risk State may pay MCE for services to non-enrolled members.

Marketing or enrollment fraud by the MCE.

MCE contracts with a select provider network

Risk Network inadequacy.

MCE must choose between removing risky providers and maintaining network adequacy.

Disqualified provider terminated from one MCE may be hired by another MCE.

MCE responsibilities

MCE Responsibilities

- As a condition of receiving payment under the Medicaid managed care program, MCEs are required to identify, investigate, and address potential fraud and abuse.

- If the MCE uncovers evidence of suspected fraud or abuse, it refers the case to the SMA. When the MCE refers a case, it submits the case to the SMA, the Medicaid Fraud Control Unit (MFCU), or both. 42 CFR §438.608(a)(7) requires MCEs to promptly refer any suspected fraud, waste, or abuse to the State.

- The MCE is also responsible for identifying and recovering overpayments associated with abuse or waste, such as simple billing errors.

MCE Program Integrity CFRs

438.3
- Submit audited financial reports specific to the Medicaid contract

438.242; 438.604(a)(1)
- Maintain health information systems; 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

MCE Program Integrity CFRs

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 response 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 eligibilities to participate in the program

438.604(a)(6); 438.608(c)

- Submit information on ownership, control, and disclosure of any prohibited affiliation of managed care plans and subcontractors

MCE Program Integrity CFRs

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 u8nit 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

MCE Responsibilities

Develop an effective and robust program integrity program within the health plan while ensuring compliance with Federal and State Regulations.

- Methods of proactively identifying Fraud, Waste and Abuse
- Methods of preventing Fraud, Waste and Abuse
- Effective reporting and oversight

MCE Responsibilities

Coordinating with OHA to strengthen the Medicaid program through program integrity:

- Effective communication of policy changes
- Coordinated system testing
- Consistent training that includes program integrity components
- Root-cause identification, appropriate mitigation, and corrective action
- Proper referral of potential fraud and abuse

MCE Responsibilities

An effective Medicaid fraud and risk management approach encompasses program integrity controls that have three objectives:

- **Prevent** instances of fraud and misconduct from occurring.
- **Detect** instances of fraud and misconduct.
- **Respond** appropriately when integrity breakdowns are identified:
  - Take corrective action
  - Recover misspent Medicaid dollars
  - Refer cases to Federal and State agencies and law enforcement

The FWA prevention planning process is dynamic and adjustments are made by an MCE throughout the year to meet priorities and to anticipate and respond to emerging issues with the resources available.

MCE Responsibilities

In addition to making referrals, MCEs take other actions against providers suspected of fraud, waste or abuse. For example:

- Conducting prepayment and post-payment reviews of provider claims to ensure that all claims are appropriately submitted and paid
- Conducting provider education
- Initiating corrective action plans
- Contracting – oversight and terminating the contract of a provider or the MCE may remove the provider from the network by not renewing the provider's contract

OHA relies on MCEs to be the leaders in quality for Oregon Medicaid and healthcare champions for Medicaid clients

Working Together

Working Together

When SMAs and MCEs work together:

- Client safety is protected
- Medicaid dollars are used effectively and efficiently
- Lawbreakers are penalized – remove bad actors from the healthcare system
- Fraud deterrent – proactive efforts impact future behavior of FFS and managed care providers

Resources and Partners

There are many resources available. A few of those resources are:

OHA OPI

Oregon DOJ MFCU

CMS Center for Program Integrity

National Health Care Anti-Fraud Association (NHCAA)

Health Care Fraud Prevention Partnership (HFPP)

National Insurance Crime Bureau (NICB)

Office of Inspectors General (OIG)

Federal and State Law Enforcement