

Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICAID MANAGED CARE:
FRAUD AND ABUSE CONCERNS
REMAIN DESPITE SAFEGUARDS**



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E X E C U T I V E S U M M A R Y

OBJECTIVES

To determine:

1. to what extent selected Medicaid managed care entities (MCE) took steps to meet Federal program integrity requirements,
2. how States oversee MCEs' fraud and abuse safeguards, and
3. what major concerns that MCEs and States have regarding fraud and abuse in Medicaid managed care.

BACKGROUND

Medicaid expenditures almost doubled during the past decade, from over \$200 billion in 2000 to \$374 billion in 2009. States have increasingly adopted managed care as a response to these growing expenditures. States may contract with different types of MCEs to provide health care services on a statewide or a community basis. The Centers for Medicare & Medicaid Services (CMS) requires MCEs to meet specific program integrity requirements as a condition for receiving payment. These requirements include a written compliance plan, effective training and education for MCE employees, and internal monitoring and auditing. CMS also requires MCEs and other Medicaid providers to disclose to States certain information related to ownership and control. CMS's Medicaid Integrity Group (MIG) conducts program integrity reviews of States and MCEs. In 2000, CMS issued guidelines for addressing Medicaid managed care fraud and abuse. States are directly responsible for monitoring MCE operations.

We reviewed MIG's files from its program integrity reviews of a purposive sample of 13 States and 46 MCEs. We sent a questionnaire to those 46 MCEs and received responses from 45. We also conducted structured telephone interviews with the 13 States, all 10 CMS regional offices, and MIG.

FINDINGS

All MCEs in our sample reported taking steps to meet Federal program integrity requirements. All 46 MCEs in our sample reported to MIG that they met Federal program integrity requirements. The 45 MCEs that responded to our questionnaire provided fraud and abuse safeguard training to their staffs in 2010, and 41 also offered such training to providers in their networks in 2010. In 2009, 33 MCEs

reported cases of suspected fraud and abuse to their State Medicaid agencies, with a median of 9 cases. Twenty MCEs recovered payments from providers in 2009 that resulted from fraud and abuse.

All 13 States in our sample reported taking steps to oversee MCEs' fraud and abuse safeguards. All 13 States conduct desk reviews of MCEs' compliance plans, and 11 States conduct onsite MCE reviews. All 13 States reported requiring that MCEs disclose ownership information (8 of the States recently updated their reporting requirements as a result of MIG's program integrity reviews). Eleven States hold recurring meetings with MCEs; these meetings often include fraud and abuse training.

Although MCEs and States are taking steps to address fraud and abuse in managed care, they remain concerned about their prevalence. We asked MCEs, States, and CMS to identify their major concerns regarding Medicaid managed care fraud and abuse. The primary concern related to services billed but not rendered. MIG also identified this vulnerability in its program integrity reviews. MCEs and States expressed concerns about provider and beneficiary fraud and abuse, including rendering services that are not medically necessary, upcoding by providers, questionable beneficiary eligibility, and prescription drug abuse by beneficiaries. The major concerns identified in our review largely reflect only one of six areas highlighted in CMS's 2000 guidelines.

RECOMMENDATIONS

CMS should:

Require that State contracts with MCEs include a method to verify with beneficiaries whether services billed by providers were received. CMS could require States to implement one of several options, such as sending explanations of medical benefits to beneficiaries. Other options could include contacting beneficiaries by telephone or mailing them a questionnaire.

Update guidance to reflect concerns expressed by MCEs and States. CMS could update and reissue the fraud and abuse guidelines it published in 2000. CMS could also share best practices and innovative methods that States and MCEs have used to address fraud and abuse concerns and strengthen program integrity oversight.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with both recommendations. CMS stated that it will advise States to work with their MCEs to determine and implement effective strategies for verifying that services billed by network providers are received. CMS also stated that it has been developing a strategy to effectively address managed care program integrity and will revise its guidelines once that strategy is complete. Finally, CMS stated that it provides a compendium of States' noteworthy and effective practices in key program integrity areas, including Medicaid managed care, on its Web site. We made no changes to the report based on CMS's comments.



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BACKGROUND

Medicaid expenditures almost doubled in the past decade, from over \$200 billion in 2000 to \$374 billion in 2009.¹ States have increasingly adopted managed care as a response to these growing expenditures. Managed care is a health delivery system that aims to maximize efficiency by negotiating rates, coordinating care, and managing the use of services. State Medicaid agencies contract with MCEs to provide comprehensive health services in return for a fixed, prospective payment (capitated payment) for each enrolled beneficiary.

Medicaid Managed Care

As of June 2009, 36 million Medicaid beneficiaries (72 percent) were enrolled in managed care.² Some States, such as Tennessee, enroll all Medicaid beneficiaries in managed care, whereas others, such as Wyoming, do not enroll any.³

States may contract with different types of MCEs to provide health care services on a statewide or a community basis.⁴ Two types of MCEs are subject to specific Federal program integrity requirements: Managed Care Organizations (MCO) and Prepaid Inpatient Health Plans (PIHP).⁵

¹ Centers for Medicare & Medicaid Services (CMS), *National Health Expenditures by Type of Service and Source of Funds, CY 1960–2009*. Accessed at <http://www.cms.gov> on April 21, 2011.

² CMS, *Medicaid Managed Care Enrollment as of June 30, 2009*. Accessed at <http://www.cms.gov> on April 14, 2011.

³ Ibid.

⁴ Social Security Act § 1932(a)(3).

⁵ 42 CFR § 438.608.

An MCO provides comprehensive medical services through a prepaid risk contract with the State. Under a risk contract, the contractor assumes the risk for the cost of covered services and incurs a loss if the cost exceeds the payments under the contract.⁶ A PIHP generally provides inpatient hospital or institutional services and does not enter into a comprehensive risk contract with the State.⁷ For example, a mental health PIHP would provide only inpatient mental health services.⁸ In this report, we refer to MCOs and PIHPs collectively as managed care entities, or MCEs.

Fraud and Abuse in Medicaid Managed Care

In 2000, CMS issued *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care*.⁹ In the guidelines, CMS adapted the general Medicaid definitions of fraud and abuse¹⁰ to the managed care environment:

- Fraud means any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, himself, or some other person.¹¹
- Abuse means practices that are inconsistent with sound fiscal, business, or medical practices and that result in unnecessary costs to Medicaid or reimbursement for services that are not medically necessary or that fail to meet professional standards or contractual obligations for health care.¹²

The guidelines also identified six areas of concern: (1) managed care contract procurement, (2) marketing and enrollment, (3) underutilization of services, (4) claims submission and billing procedures, (5) fee-for-service payments within managed care, and

⁶ 42 CFR § 438.2.

⁷ Ibid.

⁸ Ibid.

⁹ CMS, National Medicaid Fraud and Abuse Initiative, *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care*, pp. 10–11, October 2000.

¹⁰ 42 CFR § 455.2 defines fraud and abuse for general Medicaid purposes.

¹¹ Fraud or abuse can be committed by a contractor, a subcontractor, a provider, an MCE, a State employee, or a Medicaid beneficiary/enrollee. CMS, National Medicaid Fraud and Abuse Initiative, *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care*, pp. 10–11, October 2000, p. 12.

¹² Ibid., p. 13.

(6) embezzlement and theft. They provided examples for each area, as well as some successfully prosecuted cases.¹³

The Florida Office of Inspector General noted “the need to recognize the distinctively different issues in fraud detection and prevention in a capitated environment versus the traditional fee-for-service environment.”¹⁴ For example, in a capitated system, providers could commit fraud by providing as few services as possible, or by treating only healthier patients.¹⁵ CMS also noted that fraud could harm States’ ability to operate managed care programs by threatening MCEs’ viability. Additionally, fraudulent MCE data could raise State costs. For example, if MCEs manipulate data to give the appearance of providing services to beneficiaries who are not enrolled, the MCEs would receive enhanced payments in the future.¹⁶

Medicaid Managed Care Program Integrity Requirements

To protect against fraud and abuse, Federal regulations require MCOs and PIHPs to comply with program integrity requirements as a condition of receiving payment.¹⁷ In establishing program integrity requirements, CMS viewed MCOs and PIHPs as larger, more complex types of MCEs with higher enrollment levels, greater administrative resources, and higher chances of needing sophisticated methods to combat fraud and abuse.¹⁸ They must have administrative and management procedures, including mandatory compliance plans, that contain the following seven program integrity provisions:

- written policies, procedures, and standards of conduct that articulate the organization’s commitment to comply with all applicable Federal and State standards;
- designation of a compliance officer and a compliance committee that are accountable to senior management;

¹³ Ibid, p. 13.

¹⁴ Florida Agency for Health Care Administration, *Office of Inspector General Annual Report 2010*, p. 47.

¹⁵ National Association of Medicaid Fraud Control Units, *Model Criminal Enforcement Statutes For Managed Care*, p. i, October 1996.

¹⁶ CMS, National Medicaid Fraud and Abuse Initiative, *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care*, pp. 10–11, October 2000.

¹⁷ 42 CFR § 438.602. This section also applies to two other types of MCEs.

¹⁸ 67 Fed. Reg. 40989, 41066 (June 14, 2002).

- effective training and education for the compliance officer and the organization’s employees;
- effective lines of communication between the compliance officer and the organization’s employees;
- enforcement of standards through well-publicized disciplinary guidelines;
- internal monitoring and auditing; and
- prompt response to detected offenses, and for development of corrective actions relating to the MCO’s or the PIHP’s contract.¹⁹

Medicaid Disclosure Requirements

CMS also requires every provider to disclose certain information related to ownership and control, business transactions, and persons convicted of crimes. Each provider must furnish information to the State on:

- any person with an ownership or control interest or any subcontractor in which it has direct or indirect ownership of 5 percent or more,²⁰
- any subcontractor with which it had business transactions totaling more than \$25,000 in the prior year,²¹ and
- any person with ownership or control interest who has been convicted of a criminal offense related to Federal health programs.²²

State Medicaid Program Integrity Efforts

States are directly responsible for monitoring MCE operations.²³ States must have a method for verifying with beneficiaries whether services billed by providers were received.^{24, 25} As of 2007, 27 States incorporated program integrity activities under their State Medicaid

¹⁹ 42 CFR § 438.608.

²⁰ 42 CFR § 455.104. For purposes of provider disclosure requirements under this section, the definition of Medicaid provider under 42 CFR § 455.101 does not include individual practitioners or groups of practitioners.

²¹ 42 CFR § 455.105.

²² 42 CFR § 455.106.

²³ 42 CFR § 438.66.

²⁴ 42 CFR § 455.20.

²⁵ CMS’s Medicaid Integrity Group (MIG) does not interpret 42 CFR § 455.20 to apply to managed care entities. See: Medicaid Integrity Program, *Florida Comprehensive Program Integrity Review Final Report*, p. 7, September 2009 and Medicaid Integrity Program, *Washington Comprehensive Program Integrity Review Final Report*, p. 6.

agencies, 7 used an Inspector General model, and 16 used a hybrid of both to monitor their Medicaid programs.²⁶

In addition, every State must either create a State Medicaid Fraud Control Unit (MFCU) or demonstrate that operation of a MFCU would not be cost effective.²⁷ A MFCU's mission is to investigate and prosecute Medicaid provider fraud and incidences of patient abuse and neglect.²⁸ Forty-nine States and the District of Columbia operate MFCUs. The majority of MFCUs are located in Offices of State Attorneys General.

Federal Medicaid Program Integrity Efforts

CMS regional offices (RO) are responsible for reviewing all State contracts with MCEs.²⁹ ROs review the contracts using a checklist to ensure that the contracts meet all applicable Federal criteria, including program integrity provisions.

The Deficit Reduction Act of 2005 (DRA) created the Medicaid Integrity Program, operated by MIG.³⁰ Since 2006, MIG has conducted triennial onsite reviews of States' program integrity operations. In addition to assessing compliance with Federal requirements, the reviews identify vulnerabilities and effective practices, help States improve program integrity, and identify opportunities for CMS to provide technical assistance to States. After each review, MIG issues a report to the State.³¹

In 2007, CMS collaborated with the Department of Justice to develop the Medicaid Integrity Institute. The Institute's mission is to provide effective training to meet the needs of State Medicaid program integrity staff, with the goal of raising national program integrity performance standards and professionalism. It offers training at no cost to States on

²⁶ CMS, Medicaid Integrity Group, *State Program Integrity Assessment: Federal Fiscal Year 2007 Executive Summary*, December 2009. Accessed at <http://www.cms.gov> on April 14, 2011.

²⁷ Social Security Act § 1902(a)(61).

²⁸ Social Security Act § 1903(q).

²⁹ 42 CFR § 438.6(a).

³⁰ Social Security Act § 1936, added by section 6034 of the DRA, P.L. 109-171.

³¹ CMS, Medicaid Integrity Program, *Program Integrity Review Annual Summary, May 2009*. Accessed at <http://www.cms.gov> on April 15, 2011.

topics such as fraud investigation, data mining and analysis, and case development.³²

METHODOLOGY

Scope

Our evaluation focused on MCEs that had Medicaid contracts in selected States in 2009 and the States that contracted with them.

Sample

We identified 37 States and the District of Columbia (States) that contract with MCEs subject to the program integrity requirements in 42 CFR § 438.608. We divided these States into quartiles based on the percentage of their Medicaid beneficiaries enrolled in MCEs. We then took a purposive sample of 13 States by selecting 4 States from the top quartile and 3 States from each of the other quartiles so as to include States from every CMS region (see Appendix A). These 13 States were also subject to a MIG State program integrity review in fiscal year 2009 or 2010. From each of these 13 States, we chose up to 6 MCEs that were included in the MIG review; we purposively selected the MCEs so as to include both larger and smaller ones. In States with fewer than six MCEs, we included all of them. This resulted in a final sample of 46 MCEs.

Data Sources and Collection

MCEs. We mailed a questionnaire in October 2010 to the 46 MCEs in our sample asking about actions they take to protect against fraud and abuse in their organizations and networks and about their major concerns regarding fraud and abuse. Two of the forty-six MCEs were no longer in operation; we received completed questionnaires from the remaining 44 MCEs. One of these MCEs used two subcontractors for its fraud and abuse activities; each subcontractor completed its own questionnaire, which we counted separately, for a total of 45 respondents.

States. We conducted structured telephone interviews with Medicaid agency staff from the 13 States in our sample. We asked how they oversee MCEs and what other actions they take to prevent fraud and

³² *Medicaid Integrity Institute Fact Sheet*. Accessed at <http://www.justice.gov> on April 13, 2011.

abuse. We conducted the interviews between December 2010 and March 2011.

CMS ROs. We conducted structured telephone interviews with Medicaid staff at each of the 10 CMS ROs. We conducted the interviews between March and April 2011.

CMS MIG. We reviewed MIG's program integrity review files for the States and MCEs in our sample. These files include survey modules completed by the States and MCEs, as well as additional supporting documentation. We reviewed the files to collect data on State requirements addressing Federal program integrity requirements, Federal disclosure requirements, MCE reporting of suspected fraud and abuse, and training and education that States provided to the MCEs. We also reviewed the MIG final reports on CMS's Web site to identify areas of State noncompliance and vulnerabilities; MIG had issued final reports for 9 of the 13 States in our sample.

Analysis

We performed qualitative data analysis on responses from State and CMS interviews and on responses from the MCE questionnaires. For example, we reviewed the responses for common themes. We analyzed MIG data and MCE questionnaire responses by performing frequency counts of State and MCE responses.

Limitations

The results of our State and MCE analyses are limited to the entities we reviewed; we cannot project the results on a national basis. We did not independently verify the data we collected.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

► FINDINGS

All MCEs in our sample reported taking steps to meet Federal program integrity requirements

All 46 MCEs in our sample reported to MIG that they had administrative and management

arrangements in place to prevent fraud and abuse, as required by Federal regulations.³³ These arrangements included, but were not limited to, compliance plans, written policies and procedures, and training of MCE staff and providers. In our questionnaire, we asked MCEs for more detail about the type and extent of fraud and abuse safeguard training that MCEs provided and the extent to which MCEs reported suspected fraud and abuse cases to their States' Medicaid Agencies.

All MCEs provided fraud and abuse safeguard training to their staffs; most MCEs also offered this training to providers in their networks

All 45 MCEs that responded to our questionnaire reported providing fraud and abuse training to staff in 2010, as required by the program integrity regulations. The training provided by every MCE addressed identifying and reporting suspected fraud and abuse. Most MCEs also included training on protecting confidential beneficiary information and on ethics. See Table 1 for a list of topics included in MCE staff training.

Table 1: Topics of MCE Staff Training on Fraud and Abuse Prevention (n=45)

Topic	Number of MCEs
Identifying Suspected Fraud and Abuse	45
Reporting Suspected Fraud and Abuse	45
Ethics	43
Protecting Confidential Beneficiary Information	43
Compliance Plan Review	39
Other	20

Source: OIG survey of MCEs, 2010.

The program integrity regulations require training to be effective; 37 of the 45 MCEs that responded to our questionnaire reported evaluating the effectiveness of staff training.³⁴ MCEs employed several

³³ 42 CFR § 438.608.

³⁴ 42 CFR § 438.608. Although the regulation requires training to be effective, it does not require MCEs to evaluate the effectiveness of training.

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methods to evaluate the effectiveness of training, such as surveying (23 MCEs) and testing (20 MCEs) staff on the topics covered. Eight MCEs also analyzed staff job performance after the training, and five MCEs used some other method.

Most MCEs also reported that they offered fraud and abuse safeguard training to providers in their networks in 2010 (41 of the 45 MCEs). The most common topics in provider training were coding accuracy, recognizing suspected beneficiary fraud, and protecting confidential beneficiary information. See Table 2 for a list of topics addressed during provider training.

Table 2: Topics of MCE Provider Training on Fraud and Abuse Prevention (n=41)

Topic	Number of MCEs
Coding Accuracy	36
Recognizing Suspected Beneficiary Fraud	31
Protecting Confidential Beneficiary Eligibility	31
Federal Fraud and Abuse Laws	30
Determining Beneficiary Eligibility	30
Other	13

Source: OIG survey of MCEs, 2010.

In contrast with staff training, only 15 MCEs evaluated the effectiveness of provider training. The most common method that MCEs used to measure effectiveness was claims analysis (seven MCEs). These MCEs conducted analyses to determine whether billing errors decreased following training. Other methods that MCEs used were conducting provider satisfaction surveys (six MCEs), performing audits (four MCEs), and measuring beneficiary satisfaction via surveys and appeal data (three MCEs). Four MCEs used other methods to evaluate provider training.

MCEs in our sample identified and reported cases of suspected fraud and abuse to their States and recovered payments from providers that resulted from fraud and abuse

In 2009, 33 of the 45 MCEs that responded to our questionnaire reported cases of suspected fraud and abuse to their States' Medicaid agencies, and 22 MCEs reported suspected cases to their States' MFCUs. MCEs reporting to State Agencies ranged from 1 case of

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suspected fraud and abuse to 140 cases, with a median of 9 cases; MCE reporting to MFCUs ranged from 1 case to 290 cases, with a median of 7 cases. Twenty MCEs reported that they recovered payments from providers in 2009 ranging from \$2,615 to \$2,769,900, with a median recovery payment of \$96,302.

All 13 States in our sample reported taking steps to oversee MCEs' fraud and abuse safeguards

States contract with MCEs to provide Medicaid services and are responsible for oversight of all contract provisions. Program

integrity requirements are included in these contracts.

All 13 States conduct desk reviews of MCEs' compliance plans

Six States that we interviewed review compliance plans annually. The remaining seven States vary in when they conduct their reviews; most review plans when MCEs apply to Medicaid and when MCEs update their plans.

Regardless of the frequency of their reviews, all States assess whether compliance plans contain the relevant Federal requirements. Some States look for provisions that exceed Federal requirements and that address fraud and abuse. These include measures to ensure that providers have sound fiduciary practices, methods to identify providers with unusual billing patterns and beneficiaries with unusual usage patterns, and goals to improve program integrity for the upcoming year.

Eleven of the thirteen States conduct onsite reviews

States told us that a compliance plan has little value if it is not implemented, so many conduct onsite reviews of MCEs to augment their desk reviews of compliance plans. Eleven States in our sample visit MCEs to ensure they comply with Federal program integrity requirements. Seven of those States conduct the reviews themselves; the other four use an external quality review organization (EQRO) to conduct site visits and ensure program integrity compliance.³⁵ Six of the eleven States conduct onsite reviews annually. The others vary in their onsite review cycles.

³⁵ EQROs are independent entities with which States contract to conduct statutorily mandated reviews of Medicaid MCE quality outcomes, timeliness, and access to items and service. Social Security Act § 1932(c)(2)(A)(i).

During site visits, States ensure that MCEs implement the provisions of their compliance plans. For example, to assess the effectiveness of MCE employee fraud and abuse training, States ask MCE staff where compliance plans are located and to whom staff report fraud. Some States also evaluate the timeliness and content of training by determining whether MCEs train employees upon hiring and annually thereafter, as well as whether training includes pertinent Federal requirements, such as the False Claims Act. To assess whether lines of communication are effective, States evaluate MCEs' fraud hotlines. One State reviews MCE fraud and abuse safeguard materials provided to beneficiaries to ensure that the materials are appropriate and understandable.

All 13 States reported requiring that MCEs disclose ownership information

Although all 13 States in our sample require MCEs to disclose required information on ownership and control, they vary in how often they require MCEs to submit data. Eight States require MCEs and providers to submit ownership information during their initial application to their States' Medicaid programs but vary in their submission requirements thereafter. These States may subsequently require submission annually or as ownership changes. States that do not require ownership disclosure at enrollment typically require it annually, monthly, or as changes occur.

Eight States in our sample recently updated their reporting requirements as a result of MIG's program integrity review. Four strengthened reporting requirements, primarily by enhancing contract language to specifically address all ownership disclosure provisions, such as disclosure of owners' siblings. Two States implemented new processes to require that MCEs report ownership information. Two States amended their contracts to specify sanctions and other penalties for noncompliance.

Some States told us that they would like further guidance from CMS regarding disclosure requirements. For example, one State reported that it is unclear how far downstream MCEs should disclose ownership information. Another State was unsure how to treat information about owners that are not individuals, such as publicly traded companies or large hospitals.

Most States found MCEs to be compliant with disclosure requirements (the two States that recently implemented ownership disclosure requirements had not yet evaluated compliance). Although States did

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not need to take action against noncompliant MCEs, they told us that they would use corrective actions, if needed, including sanctions, contract termination, and corrective action plans.

States reported interacting regularly with MCEs

Eleven of thirteen States hold recurring meetings with MCEs. Nine States incorporate training into these meetings. The meetings typically involve MCE and State concerns, review of ongoing fraud and abuse cases, and provide training on identifying fraud and abuse and on reporting requirements.

MCE compliance officers typically attend these meetings; MFCU staff sometimes attend, as well. Meetings typically are held monthly or quarterly. Five of the eleven States have more than one recurring meeting, such as quarterly meetings, which all their MCEs attend, and separate monthly meetings with each MCE.

Ten of thirteen States interact with MCEs on an ad hoc basis, mostly to discuss specific fraud and abuse cases and other MCE concerns. One of the two States that does not have recurring meetings with MCEs reported that it interacts with them almost daily.

Although MCEs and States are taking steps to address fraud and abuse in managed care, they remain concerned about its prevalence

We asked MCEs and States to identify their major concerns regarding Medicaid managed care fraud and abuse. These concerns

included services billed but not rendered, medically unnecessary services, and questionable beneficiary eligibility. CMS has offered guidelines for addressing Medicaid managed care fraud and abuse in the past, although the major concerns identified in our review largely reflect only one area highlighted in CMS's guidelines: claims submission and billing procedures.

The primary concern—shared by MCEs and States—relates to services billed but not rendered

MCEs and States reported concerns with providers that bill MCEs for medical services not actually provided to beneficiaries. Twenty-six MCEs and four States shared this concern. The MIG program integrity reviews identified services billed but not rendered as a vulnerability in eight of the nine States in our sample for which final reports were available. Further, MIG reviews found that only 19 of the 46 MCEs in our sample verified with beneficiaries that services were received.

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One tool MCEs can use to try to verify whether services were received is an explanation of medical benefits (EOMB). MCEs send EOMBs to beneficiaries, who can then inform the MCEs if they did not receive the listed services. MIG reviews found that 8 of the 46 MCEs in our sample used EOMBs to verify whether services were received. Two of these MCEs recovered payments as a result of this practice.

Without such verification, States and MCEs have no way of knowing whether they are paying for fraudulent claims or whether beneficiaries are receiving services. Fraudulent claims unnecessarily inflate the capitation rate paid to MCEs.

In responses to our questionnaire, MCEs reported using other means to address this concern, such as reviewing their payment systems and working with outside entities, for example, OIG or State medical boards.

MCEs and States expressed concerns about provider and beneficiary fraud and abuse

MCEs reported additional concerns regarding provider fraud, such as services provided that were not medically necessary and upcoding. MCEs also reported concerns regarding beneficiary fraud, such as beneficiary eligibility and drug abuse. See Table 3 for these additional concerns.

The most common method by which MCEs reported addressing medically unnecessary services and upcoding was through analysis of their payment systems, such as audits or claims analysis. MCEs also used prior authorization processes and medical record reviews. To address upcoding, MCEs educated providers about proper coding and alerted providers to atypical billing patterns.

Table 3: Additional MCE Concerns About Medicaid Managed Care Fraud and Abuse

Concern	Number of MCEs
Services Provided to Beneficiaries That Are Not Medically Necessary	16
Upcoding by Providers	10
Verifying Beneficiary Eligibility	8
Beneficiary Drug Abuse and/or Diversion	7

Source: OIG survey of MCEs, 2010.

F I N D I N G S

To address beneficiary eligibility concerns, MCEs encouraged providers to verify eligibility when treating new patients and offered resources such as a provider Web portal and telephone line with eligibility verification capabilities. To address drug abuse and diversion, MCEs conducted monitoring activities, such as providing case management services to beneficiaries, analyzing data to identify high-volume prescription trends of providers, and investigating suspected cases. MCEs also collaborated with State and Federal agencies in reporting and monitoring suspected drug abuse and diversion cases.

About half of the States we interviewed expressed concerns regarding beneficiary fraud and abuse. Examples include beneficiaries' fraudulently enrolling in Medicaid, abusing pharmaceuticals, and excessively visiting hospital emergency rooms. States expressed frustration that they could not apply the same sanctions to address beneficiary fraud as they could provider fraud.



R E C O M M E N D A T I O N S

Managed care presents challenges in addressing fraud that differ from those in fee-for-service Medicaid. For example, managed care's capitated payments create incentives for providers to render fewer services to beneficiaries, and States must bear financial risk that could threaten the viability of their Medicaid managed care programs. CMS guidelines on addressing Medicaid managed care fraud and abuse have not been updated since 2000.

As States increasingly use managed care to deliver Medicaid services, implementing safeguards to protect against fraud and abuse remains essential. MCEs, States, and CMS all have a stake in protecting the integrity of the program. Overall, we found that MCEs and States reported taking steps to monitor and protect against fraud and abuse. However, they also expressed major concerns.

More than half of the MCEs in our sample reported concerns with services billed but not provided to beneficiaries. CMS's MIG similarly identified this vulnerability, finding that most States and MCEs in our sample do not verify with managed care beneficiaries whether services were received, despite regulations requiring States to do so for fee-for-service Medicaid.

CMS guidelines on addressing Medicaid managed care fraud and abuse identified six areas of concern. However, the majority of concerns identified in our review fall under only one of these six areas: claims submission and billing procedures. The other five areas were seldom, if at all, reflected in the concerns. Therefore, we recommend that CMS:

Require that State contracts with MCEs include a method to verify with beneficiaries whether they received services billed by providers

CMS could require States to implement one of several options. One is for MCEs to send EOMBs to beneficiaries. As one State Agency told us, EOMBs are the "best, most effective tool" to determine whether billed services were actually received. Other options include contacting beneficiaries by telephone or mailing them a questionnaire. To minimize the cost of verifying services, MCEs could contact a representative sample of beneficiaries. MCEs could also sample beneficiaries based on billing analyses.

Update guidance to reflect concerns expressed by MCEs and States

CMS could update and reissue its Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care. Because most of the concerns

R E C O M M E N D A T I O N S

reported to us fall under the “Claims Submission and Billing Procedures” section, CMS could use that as a starting point from which to expand. CMS could also share best practices and innovative methods that States and MCEs have used to address fraud and abuse concerns and strengthen program integrity oversight. CMS could also share best practices via the Medicaid Integrity Institute and its Technical Advisory Groups (TAG). CMS has two relevant TAGs—one focused on Medicaid managed care and one on fraud and abuse—that could collaborate to share best practices across all their member States.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with both recommendations, stating that it will advise States to work with their MCEs to determine and implement effective strategies for verifying that services billed by network providers are received. CMS will work with States to identify efficient and effective strategies based on States’ and MCEs’ experiences. CMS also stated that it has been developing a strategy to effectively address managed care program integrity and will revise its guidelines once that strategy is complete. Finally, CMS stated that it provides a compendium of States’ noteworthy and effective practices in key program integrity areas, including Medicaid managed care, on its Web site. We made no changes to the report based on CMS’s comments. See Appendix B for the full text of CMS’s comments.

► **A P P E N D I X ~ A**

**Percentage of Medicaid Beneficiaries Enrolled in Managed Care Organizations
as of June 30, 2008**

State	CMS Region	Medicaid Enrollment	Medicaid Managed Care Enrollment	Percentage Enrolled in Managed Care
Tennessee	Region IV	1,207,136	1,207,136	100%
Vermont	Region I	141,260	128,571	91%
Arizona*	Region IX	1,048,635	949,404	91%
Hawaii	Region IX	211,105	166,948	79%
Oregon	Region X	417,946	306,957	73%
New Jersey*	Region II	914,503	659,586	72%
Ohio*	Region V	1,783,993	1,274,549	71%
Delaware*	Region III	152,899	106,267	70%
Maryland*	Region III	710,790	491,274	69%
Indiana*	Region V	881,888	582,714	66%
Alabama	Region IV	764,914	504,466	66%
Connecticut	Region I	435,419	284,465	65%
New York	Region II	4,147,101	2,685,186	65%
Michigan	Region V	1,547,246	993,832	64%
District of Columbia	Region III	146,072	92,985	64%
Minnesota	Region V	617,397	385,025	62%
New Mexico	Region IV	472,629	292,456	62%
Rhode Island*	Region I	178,119	110,195	62%
Georgia	Region IV	1,271,355	723,621	57%
Virginia	Region III	753,714	419,904	56%
Washington*	Region X	960,881	515,545	54%
Pennsylvania	Region III	1,833,489	968,887	53%
Wisconsin	Region V	907,455	472,612	52%
California	Region IX	6,606,893	3,388,651	51%
Kansas	Region VII	278,705	132,832	48%
Nevada*	Region IX	188,831	88,871	47%
West Virginia	Region III	311,064	138,699	45%
Texas*	Region VI	3,041,201	1,311,046	43%
Missouri	Region IV	833,112	345,868	42%
Florida*	Region IV	2,276,014	878,067	39%
Massachusetts	Region I	1,155,134	402,469	35%
Utah	Region VIII	208,009	59,904	29%
South Carolina	Region IV	689,338	184,526	27%
Kentucky	Region IV	731,911	145,066	20%
Nebraska*	Region VII	202,297	32,716	16%
Colorado*	Region VIII	429,895	59,989	14%
Illinois	Region V	2,106,700	164,100	8%
Iowa	Region VII	362,807	4,764	1%

Note: States with an * are included in this evaluation.

Source: Office of Inspector General Analysis of Centers for Medicare & Medicaid Services Medicaid Enrollment data as of June 30, 2008.

APPENDIX ~ B

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: OCT 26 2011

TO: Daniel R. Levinson
Inspector General

FROM: Donald M. Berwick, M.D. */SI/*
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards (OEI-01-09-00550)

Thank you for the opportunity to review and comment on the OIG Draft Report entitled, "Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards (OEI-01-09-00550)." The objectives of the report are to determine--(1) To what extent selected Medicaid managed care entities (MCEs) took steps to meet Federal program integrity requirements; (2) How States oversee MCEs' fraud and abuse safeguards; and (3) The major concerns that MCEs and States have regarding fraud and abuse in Medicaid managed care. The OIG reviewed CMS' program integrity reviews for a sample of 13 States and 46 MCEs, collected questionnaires from 45 MCEs, and conducted structured interviews with the 13 States and CMS.

The OIG's report found that all MCEs in the sample reported taking steps to meet the Federal program integrity requirements, and all 13 States reported taking steps to oversee MCEs' fraud and abuse safeguards. However, MCEs and States remain concerned about the prevalence of fraud and abuse in managed care.

OIG Recommendation

The CMS should require that State contracts with MCEs include a method to verify with beneficiaries whether services billed by providers were received.

CMS Response

The CMS concurs with OIG's recommendation to implement a mechanism for verifying that billed services are delivered. Title 42 CFR §455.20 already requires States to implement a method for verifying with recipients whether services billed by providers were actually received, but the regulation does not prescribe the method States must use. This language gives the States flexibility to determine the most effective -- and cost-effective -- mechanisms for accomplishing this, consistent with their administrative infrastructure, delivery systems and beneficiary populations. Consistent with OIG's recommendation, CMS will advise States to work with their MCEs to determine and implement effective strategies for verifying that services billed by network providers are received and CMS will work with States to identify efficient and effective strategies based on States and MCE experiences. CMS appreciates the work of the OIG in

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addressing this issue and understands the importance of this task in the effort to address fraud and abuse in Medicaid managed care.

OIG Recommendation

The CMS should update guidance to reflect current concerns expressed by MCEs and States.

CMS Response

The CMS concurs with this recommendation. Independent of this report, CMS has been working to develop a strategy to most effectively address program integrity in the managed care environment. Once complete, we will revise our guidelines on program integrity in Medicaid managed care in consultation with the Medicaid Fraud and Abuse Technical Advisory Group. We anticipate completing draft revisions in fiscal year 2012.

The OIG also suggested that CMS share best practices and innovative methods that States and MCEs have used to address fraud and abuse concerns and strengthen program integrity oversight. The CMS regularly provides a compendium of States' noteworthy and effective practices in key program integrity areas including Medicaid managed care in the *Program Integrity Review Annual Summary Reports*. Another example of this type of guidance is the CMS publication, *Best Practices for Medicaid Program Integrity Units' Collection of Disclosures in Provider Enrollment*, issued in August 2010. All of these reports are available on the CMS website.

The CMS would like to thank the OIG for their efforts in determining the extent to which States and their MCEs are working to meet Federal program integrity requirements, and assessing their concerns regarding fraud and abuse in Medicaid managed care. We look forward to working with the OIG on this and other issues in the future.



A C K N O W L E D G M E N T S

This report was prepared under the direction of Joyce M. Greenleaf, Regional Inspector General for Evaluation and Inspections in the Boston regional office, and Russell W. Hereford, Deputy Regional Inspector General.

Ivan Troy served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Boston regional office who contributed to the report include Alyson J. Cooper and Shreya M. Patel; other central office staff who contributed include Kevin Manley and Tasha Trusty.

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