Department of Health and Human Services

Centers for Medicare & Medicaid Services

Utah Focused Program Integrity Review

Final Report

June 2022

Table of Contents

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Executive Summary

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, the Centers for Medicare & Medicaid Services (CMS) set forth its strategy to safeguard the integrity of the Medicaid program.[1] State Medicaid programs are required to have a fraud detection and investigation program and oversight strategy that meet minimal federal standards. To ensure states are meeting these requirements, CMS conducts focused program integrity reviews on high-risk areas, such as managed care, new statutory and regulatory provisions, nonemergency medical transportation, and personal care services. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. The value of performing focused program integrity reviews include: (1) providing states with effective tools/strategies to improve program integrity operations and performance; (2) providing the opportunity for technical assistance related to program integrity trends; (3) assisting CMS in determining/identifying future guidance that would be beneficial to states; and (4) assisting with identifying and sharing promising practices related to program integrity.

This report summarizes information gathered during a focused review of the Utah Medicaid managed care program. The primary objective of the review was to assess the state's program integrity oversight efforts for Medicaid managed care. A secondary objective was to provide the state with useful feedback, discussions, and technical assistance resources that may be used to enhance program integrity in the delivery of these services.
Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that receive a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

In August 2021, CMS conducted a virtual focused review of Utah's single state Medicaid agency, the Utah Department of Health (UDOH), Division of Medicaid and Health Financing, which is responsible for administering and overseeing the Utah Medicaid program. Additionally, interviews were held with representatives from the Utah Office of the Inspector General (UOIG) for Medicaid Services, who is responsible for the overall program integrity operations. This focused review helped CMS assess the program integrity activities performed by selected MCOs under contract with the state Medicaid agency. In Utah, an MCO that provides physical health care services is known as an Accountable Care Organization (ACO). CMS interviewed key staff and reviewed other primary data to assess the state's and selected ACOs' program integrity practices. CMS also evaluated the status of Utah's previous corrective action plan, which was developed by the state in response to a managed care focused review conducted by CMS in 2016.

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

During this review, CMS identified a total of six recommendations based upon the completed focused review modules, supporting documentation, and discussions and/or interviews with key staff. CMS also included technical assistance resources for the state to consider utilizing for its oversight of managed care. The review and recommendations encompass the following six areas:

1. State oversight of managed care program integrity activities
2. Provider screening and enrollment
3. ACO investigations of fraud, waste, and abuse
4. Encounter data
5. Payment suspensions based on credible allegations of fraud
6. Terminated providers and adverse action reporting

Overview of Utah Medicaid

The UDOH Division of Medicaid and Health Financing is the single state agency charged with overseeing the medical assistance plans in Utah. The UOIG has primary responsibility for the overall program integrity operations.

In FY 2019, Utah's Medicaid expenditures were approximately $3B, and the state had approximately 294,599 beneficiaries enrolled. The Federal Medical Assistance Percentage matching rate was 69.71 percent. Approximately 74 percent of the Medicaid population was enrolled in four ACOs contracted under Utah's physical health care program. Utah managed care expenditures were approximately $1,297,933,400, which included both Medicaid and the Children's Health Insurance Program (CHIP); CHIP represented approximately 1.2 percent of Utah's total Medicaid and CHIP expenditures.

Three of Utah's four operating ACOs were selected for interview during the virtual program integrity review: Health Choice Utah, Molina Healthcare, and SelectHealth Community Care. CMS did not interview Healthy U. Table 1 and Table 2 below provide enrollment, Special Investigations Unit (SIU), and expenditure data for each ACO that CMS interviewed.

Table 1. Summary Data for Utah ACOs

	Health Choice Utah	Molina Healthcare	SelectHealth Community Care
Total enrollees	33,661	106,543	155,825
Provider enrollment total	12,549	80,909	8,015
Year originally contracted	2012	1994	2013
Size and composition of SIU (FTEs)	2	1.5	6
National/local plan	Local	National	Local

Table 2. Medicaid Expenditure Data for Utah ACOs

ACO	FY 2017	FY 2018	FY 2019
Health Choice Utah	$91,679,600	$73,144,100	$97,311,400
Molina Healthcare	$351,732,900	$264,205,300	$223,227,300
SelectHealth Community Care	$436,274,400	$416,023,300	$504,925,900

Results of the Review

CMS evaluated the following six areas of Utah's managed care program:

1. State oversight of managed care program integrity activities
2. Provider screening and enrollment
3. ACO investigations of fraud, waste, and abuse
4. Encounter data
5. Payment suspensions based on credible allegations of fraud
6. Terminated providers and adverse action reporting

CMS identified six areas of concern with Utah's managed care program integrity oversight that may create risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible through implementation of a corrective action plan. These areas of concern and CMS' recommendations for improvement are described in detail below.

1. State Oversight of Managed Care Program Integrity Activities

In accordance with the state monitoring requirements set forth in 42 CFR 438.66 and 438.602, the SMA must have in effect a monitoring system for all managed care programs that includes mechanisms for the evaluation of ACO performance in several key areas. In the state of Utah, these requirements are met through the Bureau of Managed Health Care, within the Division of Medicaid and Health Financing, which is responsible for monitoring compliance and providing programmatic oversight of the managed care contracts. Utah has operational guidelines, policies and procedures, or interagency agreements that govern the interaction between Utah's program integrity efforts and programmatic oversight for each ACO.

In addition, Utah includes language in its ACO model contract that describes steps each ACO must take to verify, by sampling or other methods, that services provided by network providers were received by enrollees, as required under 42 CFR 438.608(a)(5). Verification of services is a valuable tool for identifying potential fraud not detected through data mining, post-payment reviews, and predictive modeling. Utah's ACO model contract states, "(A) The contractor shall have policies and procedures to verify that services billed by providers were received by the contractor's enrollees. The contractor's policies and procedures must include: (1) annually, the contractor shall randomly select a minimum of 50 individual enrollees who received a covered service during the state fiscal year for service verification; and (2) the contractor shall keep a record of each enrollee contacted for service verification. (B) By November 1st of each year, the contractor shall submit a report to the Department, in a Department specified format: (1) the names and ID numbers of all enrollees contacted for service verification; (2) whether the enrollees were contacted via telephone, email, or other methods; (3) whether the enrollee responded to the service verification; and (4) whether the enrollee indicated he or she obtained the service during the prior fiscal year."

CMS confirmed that Health Choice and SelectHealth follow this verification of services contract requirement; however, **Molina did not conduct enrollee service verifications for FY 2017**. In

addition, the review revealed inconsistent verification procedures across the Utah managed care program; for example, one ACO was conducting targeted verifications and another ACO claimed it was prohibited from doing targeted enrollee verifications per the ACO contract. **This inconsistent interpretation of the enrollee verification contract language should be clarified by the state to ensure all ACOs are appropriately meeting CMS requirements for verification of services.**

Recommendation #1: The state should ensure that all ACOs have enrollee verification policies and procedures that comply with their contractual requirement to verify with managed care enrollees whether services billed by network providers are valid. In addition, the state should provide guidance and oversight relative to the ACO enrollee verification policies and procedures to facilitate consistency among the ACOs, while adopting verification methods that are effective and meet CMS requirements in § 438.608(a)(5).

2. Provider Screening and Enrollment

To comply with §§ 438.602(b)(1) and (b)(2), 438.608(b), 455.100-106, 455.400-470, and Section 5005(b)(2) of the 21st Century Cures Act, all providers furnishing services to Utah Medicaid members, including providers participating in an ACO provider network, are required to be screened and enrolled with the SMA. The ACOs must ensure that all providers are registered in Utah's provider enrollment system prior to contracting and credentialing with the provider. This rule applies to all provider types and specialties and is inclusive of the billing, rendering, ordering, prescribing, referring, sponsoring, and attending providers.

The UDOH screens and enrolls providers in accordance with § 455.436. All Utah providers who seek participation in the Medicaid managed care program must first enroll in Medicaid through the Provider Reimbursement Information System for Medicaid, and the state's online provider portal. The state performs all of the required provider enrollment activities in accordance with the requirements of § 455, subparts B and E. Upon the state's approval of the application, the providers may seek to secure contracts with participating ACOs. Based upon this information, CMS did not identify any recommendations regarding Utah's provider screening and enrollment process of Medicaid providers.

In accordance with § 455.450, the SMA is required to screen all initial applications, including applications for a new practice location, and any applications received in response to re-enrollment or revalidation of enrollment request, based on a categorical risk of "limited," moderate," or "high." States in compliance with these requirements subject high risk and moderate risk providers to enhanced screening that may include onsite visits, Federal Bureau of Investigation (FBI) background checks, and FBI fingerprinting. **Although the single state agency assigns providers as high, moderate, or low risk at the time of enrollment screening, the three ACOs reviewed confirmed that they have not incorporated the state's categorical risk levels into their provider re-enrollment process**. The state is responsible for the enrollment of providers prior to contracting; therefore, the program integrity risk associated with this gap lies within ACO revalidation of its providers, responsibility for which the state delegates to ACOs. Additionally, because the ACOs do not assign categorical risk levels for providers who pose an increased financial risk of fraud, waste, or abuse to the Medicaid program, their SIU

activities do not align with the enhanced oversight that is appropriate for moderate and high-risk providers. Without appropriately established categorical risk levels and the essential tracking of moderate and high-risk providers, or individuals with a five percent or more direct or indirect ownership interest, the Utah managed care program, and consequently the Medicaid program overall, is vulnerable to an increased financial risk of fraud, waste, and abuse.

CMS encourages the state to ensure that all ACOs develop written policies and procedures for assigning categorical risk levels for its Medicaid managed care program in accordance with § 455.450 and utilize those risk levels for revalidation.

3. *ACO Investigations of Fraud, Waste, and Abuse*

State Oversight of ACOs

As required by § 438.608(a)(1)(viii), Utah has an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and ACOs. Utah's Medicaid contracts with its ACOs state that, "[p]ursuant to Utah Code Ann. 63A-13-101 *et seq*., if the contractor or a provider becomes aware of potential provider-related fraud, waste, or abuse, the contractor or the provider shall report the incident in writing to the UOIG [Utah Office of the Inspector General], and the Medicaid Fraud Control Unit (MFCU) in the Utah Attorney General's Office. If the contractor or provider reports an incident to the UOIG or MFCU, the contractor or provider shall electronically submit a copy of the report to the Department. Reports of fraud, waste, or abuse made by the contractor, or a provider shall be made to the UOIG or MFCU and the Department within fifteen working days of detection of the incident of provider-related fraud, waste, or abuse." In accordance with § 455.17(a), the state must report the number of complaints of fraud and abuse made to the agency that warrant preliminary investigation. In an effort to remain compliant with this requirement, the Utah ACO general contract specifies that, "…the contractor shall report to the Department on a quarterly basis the number of complaints of fraud, waste, and abuse that has warranted a preliminary investigation. The report shall be submitted to the Department no later than 30 days after each quarter. Additionally, the contractor shall provide a quarterly report of the providers which the contractor has taken any adverse action against for program integrity reasons."

The state agency conducts quarterly collaborative program integrity sessions with the ACOs and other stakeholders to discuss pertinent program integrity issues pertaining to fraud, waste, and abuse matters and relevant contractual concerns. The attendees include representatives from the ACOs' compliance department and SIU, UOIG, and MFCU. These meetings are an open discussion unless a specific focus has been identified.

The UOIG has the statutory responsibility and authority under Utah state law for identifying and investigating fraud, waste, and abuse in the Medicaid program. The UOIG partners closely with UDOH on its policy updates to ensure clarity and accuracy for Medicaid providers and consistency with existing policies. The UOIG also performs post-payment evaluations of the ACOs' network providers to identify any potential fraud, waste, and abuse that was not identified by the plans' SIUs during the 12-month recovery period. If the findings of a preliminary

investigation indicate that an incident of fraud or abuse involving substantial allegations or other indication of fraud may have occurred under the Medicaid program, a referral for a full investigation and possible prosecution is made directly to the MFCU.

ACO Oversight of Network Providers

Based on the review conducted, CMS is concerned with the quantity and quality of Utah's ACOs' investigations of fraud, waste, and abuse based on the data and information collected for this review, as well as the interviews conducted with the state and the ACOs. Details regarding these concerns are outlined below.

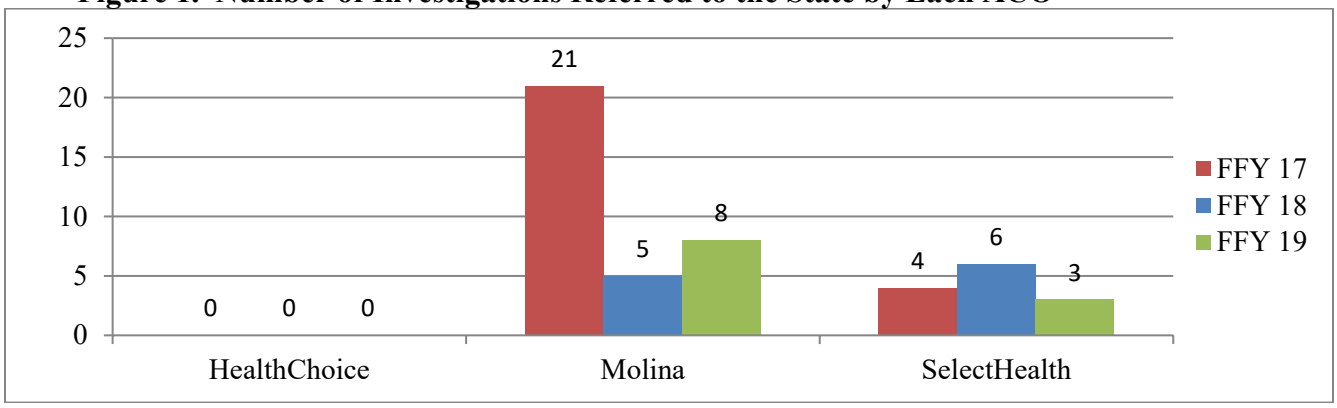
Health Choice Utah's SIU team operates as part of the compliance department and processes fraud, waste, and abuse referrals. Referrals originate from many sources, both internally and externally. All referrals are entered in the fraud, waste, and abuse tracking log, and a file is created for each referral. Investigations are initiated immediately upon receipt of the referral. Preliminary investigations are conducted by gathering information from various resources to adequately prove or disprove the allegation. If the preliminary investigation determines a credible allegation of fraud, a full investigation is conducted. The compliance officer or designee completes a final report summary detailing the referral, the investigation, persons interviewed, any documentation, and the findings. When fraud or abuse has been substantiated, the director of compliance is notified, and referrals are sent to UDOH, the UOIG, and MFCU within 15 business days. All referrals are tracked and reported to the compliance committee on a quarterly basis. **Health Choice did not refer any investigations to the state for the three FYs reviewed.**

Molina Healthcare's SIU conducts a preliminary investigation to determine if fraud, waste, and abuse issues warrant further examination. Once a referral is received, the matter is entered into Ethics Point, an incident management reporting software, and the complaint is referred to SIU for assessment. The SIU triage team performs a preliminary assessment of the allegation to determine if sufficient information is available to pursue an investigation. If there is sufficient information, the SIU triage team analyst builds an initial pre-case lead in the case management system, reviews scores in the fraud analytics system, and prepares a risk assessment within one business day. The preliminary investigation determines whether there is credible allegation of fraud and warrants a full investigation. Referrals of fraud, waste, and abuse are made to the UDOH, UOIG, and the MFCU within 15 working days. **Molina referred 34 investigations to the state for the three FYs reviewed.**

SelectHealth Community Care's SIU is responsible for the detection, prevention, investigation, and reporting of fraud, waste, and abuse. Once an initial data analysis is completed, the investigator and manager develop an investigative plan. The investigator follows the investigative plan, gathering evidence and conducting interviews to validate or invalidate the allegations received. Once a determination has been made that fraud, waste, and abuse has occurred, the SIU takes the case facts to the fraud, waste, and abuse Steering Committee for further guidance. If the Steering Committee agrees with the findings of the SIU and no further investigation is necessary, the SIU refers the case to the UDOH, UOIG, and the MFCU within 15 days. **SelectHealth referred 13 investigations to the state for the 3 FYs reviewed.**

Figure 1 lists the number of investigation referrals that Health Choice, Molina and SelectHealth SIU made to the state in the last three FYs. Overall, the number of Medicaid provider investigation referrals by each of the ACOs is low, relative to the size of the plan reviewed and the size of the Medicaid program in Utah. The level of investigative activity by the ACOs has not changed over time.

Figure 1. Number of Investigations Referred to the State by Each ACO



During the interview with the state, the UDOH stated it was attempting to work more closely with the ACOs to improve the quality and increase the quantity of cases referred. Additionally, it was stated that the UOIG and the MFCU believe the amount and quality of case referrals from the ACOs need to improve.

ACO Program Integrity Contract Language

In accordance with § 438.608(a)(1)(vii), ACOs are required to establish and implement procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks**.** While there is not a federally required ratio of staff-to-beneficiary population, the limited program integrity activity led CMS to conclude that ACO-dedicated staffing may be insufficient. Utah's ACO model contract does not address program integrity requirements of the SIU organizational structure and effectiveness. The state does not require the ACOs to maintain staffing ratios by contract. The general contract language also does not address staffing skills required of the SIUs that are contracted to address fraud, waste, and abuse in the managed care program. During their review interviews, both Health Choice and Molina stated they were unsure of the total staff positions that make up their SIU; however, Health Choice was able to confirm one full-time investigator located in Arizona, who dedicates 65 percent of their time to Utah Medicaid. Post review, Health Choice notified CMS that their SIU consists of two staff positions, reconfirming one is a full-time investigator; Molina confirmed their staff positions averaged 1.5 full-time employees for the review period.

Utah's ACO model contract also does not address conducting investigative unannounced provider site visits**.** During the interview, CMS confirmed that Health Choice, Molina, and SelectHealth did not conduct investigative unannounced site visits for the three FYs reviewed. Utah's Medicaid managed care program integrity oversight is likely to be enhanced by the

increased utilization of unannounced provider site visits and may favorably impact the quantity and quality of case referrals. Therefore, CMS encourages the state to discuss enhancing the ACO program integrity activities by incorporating strategies for the use of unannounced site visits.

Utah's ACO model contract does not specifically include program integrity provisions addressing corrective action plans for ACO network providers. However, all of the ACOs reviewed reported having a process for developing a corrective action plan for a network provider. **Molina issued 21 corrective action plans to network providers during the 3 FYs reviewed, while Health Choice and SelectHealth did not place any network providers on a corrective action plan for the review period.**

Health Choice Utah's network services department is responsible for monitoring its network providers for compliance issues through a variety of ways, such as claims audits, self-reporting, claims research discoveries, claim disputes process, and investigation of various issues. Once an inappropriate or questionable billing practice is discovered, the network services representative (NSR) addresses the issue with the provider. Education and/or resource support is provided and the provider is flagged and monitored as necessary. Network services determines when a corrective action plan is necessary. The NSR creates the corrective action plan and is presented to the provider, and monitors the provider for compliance. Failure to remediate the deficiency may result in a freeze to the provider's Health-Choice member panel, diversion or reassignment of members to another provider, reporting to the quality management committee for a peer review process, reporting to UDOH, or a termination of the provider contract.

Molina Healthcare's SIU delegation staff has two options for addressing performance concerns: notification of non-compliance or corrective action. The SIU is alerted to concerns via internal ongoing monitoring. Once the investigation is completed, the SIU communicates any findings to the provider with corrective action expectations and monitors until deficiencies are resolved or further action is taken against the provider. Corrective action plans resulting from SIU work are requested from providers as part of the audit findings, and overpayment letters are issued where a material finding was present. Corrective action plans are then reviewed for sufficiency to remediate the issues identified in the findings.

SelectHealth Community Care's SIU and provider development department is responsible for monitoring its network providers. Once a problem is identified and addressed with the provider, the provider generally self-corrects, which is validated through future claims data. If the provider does not self-correct, a letter is sent notifying the provider of the breach in contract and without resolution to the issues identified, the contract will be terminated. Often this results in a financial repayment that must be paid back over a certain amount of time.

Overpayments

Consistent with § 438.608(d), the state ACO contract, section 11.1.5(A)(1) Overpayments, specifies that ACOs must have an overpayment retention policy in place. Specifically, the ACO contract states the policy must include, "the retention policies for the treatment of recoveries of all overpayments from the contractor to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse." Utah's ACO model contract does not require ACOs to return overpayments recovered from the network

providers as a result of fraud and abuse investigations. However, consistent with § 438.608(a)(2), Utah's ACO model contract does require the ACOs to promptly report to the state all overpayments identified or recovered, specifying the overpayments due to potential fraud activities. During the interview, the state confirmed that ACOs are required to report overpayments on an annual basis via a report template specifying if the overpayment is due to potential fraud, waste, and abuse, consistent with § 438.608(d)(3).

Overall, the amount of overpayments identified and recovered by Health Choice, Molina, and SelectHealth appears to be exceedingly low for a managed care program of Utah's size. Further, although the ACOs are not normally required to return overpayments from their network providers to the state, the state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process. (§ 438.608(d)(4)) Without these adjustments, ACOs could be receiving inflated rates per member per month. Tables 3-A, 3-B, and 3-C describe each ACO's recoveries from program integrity activities.

Table 3-A. Health Choice Utah Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	14	-0-	$0	$0
2018	2	-0-	$0	$0
2019	8	-0-	$0	$0

Table 3-B. Molina Healthcare Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	37	-0-	$0	$0
2018	24	-0-	$1,137	$1312
2019	29	-0-	$164,249	$50,590

Table 3-C. SelectHealth Community Care Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	20	-0-	$194	$194
2018	18	-0-	$190,929	$187,830
2019	18	-0-	$25,795	$3,361

Health Choice Utah's identified and recovered overpayments from providers as a result of its fraud and abuse investigations are tracked by their SIU and reports are sent to the state on a

quarterly basis. During the interview, Health Choice confirmed that there were no applicable overpayments identified for the three FYs reviewed. Health Choice also stated that it believes

overpayments are not common due to work done on the forefront to prevent incorrect payments going out the door. CMS collected the methods claimed to be the rationale as to why there were no overpayments by Health Choice, but was unable to determine the effectiveness of the methods.

Molina Healthcare's overpayments identified and recovered from providers as a result of its fraud and abuse investigations are tracked by their payment integrity office and reported to the state in a quarterly cadence. During the interview, Molina confirmed that there were no applicable overpayments identified for FY 2017. Molina had some overpayment recoveries in the amount of $1,137 in FY 2018, which continued to grow in FY 2019 due to continuous system improvements. The addition of select vendors that are best in class to assist in driving recoveries and cost avoidance were also attributed to the increased overpayments that were identified and recovered in FY 2019.

SelectHealth Community Care's overpayments identified and recovered from providers as a result of its fraud and abuse investigations are tracked by their SIU and reported to the UDOH on a semi-annual basis. During the interview, SelectHealth confirmed they did not have internal written policies and procedures for the recoveries of overpayments, during the review period. SelectHealth reported $194.00 identified and recovered for FY17. SelectHealth identified $190,929.00 and recovered $187,830.00 in FY 2018. SelectHealth recovered $3,361.00, which represents approximately 13 percent of the $25,795.00 overpayment amount identified in FY 2019.

Recommendation #2: The state should ensure that the ACOs are allotting sufficient resources to prevent, detect, investigate, and refer suspected provider fraud given the limited number of provider investigations being conducted by the ACOs. In addition, the state should work with the ACOs to develop more case referrals and routinely provide specific program integrity training in identifying, investigating, and referring potential fraudulent billing practices by providers to enhance the quality of cases being referred by the ACOs. The state should provide specific feedback to the ACOs regarding the quality and quantity of the ACO case referrals.

Recommendation #3: The state should ensure that ACOs have sufficient corrective action procedures for its Medicaid providers and utilize them appropriately to address non-compliant providers.

Recommendation #4: The state should establish an effective mechanism to monitor, track, and verify the accurate reporting of overpayments identified and collected by the ACOs. Furthermore, the state should ensure the ACOs develop and maintain accurate overpayment identification/collection/reporting policies and procedures consistent with § 438.608(d).

4. Encounter Data

The UDOH receives complete encounter data from the ACOs. ACOs are contractually required to submit encounter data to the state within 45 days of the ACO claim adjudication date. The UDOH receives and validates data submitted by the ACOs through the Utah Medicaid systems MMCS. The state utilizes the encounter data for validating member eligibility; capitation rate development, utilization monitoring; and program integrity activities. Additionally, the UOIG

uses encounter data to initiate investigations, pulling a random sample of encounter claims on a monthly basis. UOIG also uses encounter data as part of performance audits to ensure ACO covered services are not inappropriately billed to fee-for-service Medicaid. In addition, Utah contracts with the actuarial firm Milliman for the purpose of developing capitation rates.

CMS did not identify any recommendations regarding Utah's use of encounter data for Medicaid oversight.

5. Payment Suspensions Based on Credible Allegations of Fraud

Consistent with § 438.608(a)(8), Utah's ACO model contract includes a provision regarding the suspension of payments to a network provider for which the state determines there is a credible allegation of fraud in accordance with § 455.23. Specifically, Utah's ACO model contract states that, "The contractor's compliance plans shall include a description of the contractor's payment suspension process and how this process is in compliance with Article 6.1.5. The contractor's (and subcontractors to the extent that the subcontractor is delegated responsibility for coverage of services and payments of claims) shall implement and maintain management arrangements or procedures and compliance plan to guard against fraud, waste and abuse shall include as detailed in Article 6.1.5, a provision for the contractor's suspension of payments to a network provider for which the department determines there is a credible allegation of fraud."

In addition, Utah's ACO model contract also states under Article 6.1.5 that, "The contractor shall develop policies and procedures to comply with 42 CFR § 455.23." This means that when the state Medicaid agency determines that there is credible allegation of fraud, it must suspend all Medicaid payments to a provider, unless the agency has good cause not to suspend payments or to suspend payment only in part in accordance with § 455.23(e).

CMS confirmed that Molina follows this requirement; however, Health Choice and SelectHealth did not have internal written policies and procedures for payment suspensions during the review period. The state confirmed that there was no payment suspension process in place during the review period; however, the state reported that they have addressed this issue since and developed and implemented policies and procedures in accordance with the requirements at § 455.23.

Specifically, the review found that when the state determined credible allegations of fraud for the Molina and SelectHealth case referrals, the state did not consistently suspend payments and refer the matter to the MFCU as required by §§ 455(a)(1), (d)(1). Although all ACO referrals did adhere to the Referral Performance Standards at § 455(d)(2)(ii), improvement is needed by the state to ensure the Referral Performance Standards are adhered to by all ACOs, as well as ensure good cause exceptions are effectively considered on a case-by-case basis for the suspension not to compromise an investigation in accordance to § 455.42(e)(1). Finally, the state should ensure on a quarterly basis they request certification that the matter is continuing, thus warranting continuation of the suspension in accordance with § 455.23(d)(3)(ii), and relay the information to the ACOs.

Recommendation #6: The state should ensure all ACOs develop written policies and procedures for payment suspensions in cases of credible allegations of fraud that comply with § 455.23. The state must maintain documentation on its ACO payment suspensions and annual reporting to the Secretary as required by § 455.23.

6. Terminated Providers and Adverse Action Reporting

Consistent with §§ 438.608(b) and 455, subparts B and E, Utah's ACO model contract requires ACOs to meet CMS' provider enrollment and screening requirements, including the requirement at § 455.416 to terminate network providers in certain circumstance, including for cause, which may include, but is not limited to, fraud, integrity, or quality. Specifically, Utah's ACO model contract states, "The contractor must terminate a network provider immediately upon notification from the department that the network provider cannot be enrolled or failed to enroll during the 120-calendar day period. Upon notification of termination from the department, the contractor must notify affected enrollees in accordance with Section 3.6.7, termination of contracted provider." Utah's ACO model contract under Section 3.6.7 states, "The contractor shall make a good faith effort to give written notice of termination of a network provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by the terminated network provider." Utah's ACO model contract also states, "The contractor shall report to the department when a provider is denied network provider status. Such denial can include when a provider is denied admission to the contractor's provider panel, is removed from the contractor's panel, or voluntarily withdraws from the panel when the denial, removal, or withdrawal is due to a substantive issue. Substantive issues include violations of the Department of Occupational and Professional Licensing's regulations, and allegations of fraud, waste or abuse. The contractor shall electronically submit information relating to the non-inclusion of providers to the department within 30 calendar days of the non-inclusion action using the department specified form."

During the virtual interview, Utah's Program Integrity Unit (PIU) confirmed there is a monthly process in place to ensure that the ACOs are terminating providers for cause. Additionally, Utah's PIU notifies ACOs of any terminated providers from other plans during the UDOH quarterly meetings, so that the ACOs may ensure that terminated providers are not operating in another plan.

Health Choice Utah submits a monthly termination report, which includes the reason for termination, to the UDOH. In addition, Health Choice sends notification to UOIG, MFCU, and notifies other ACOs that attend the quarterly UDOH meetings. Health Choice's network services department receives notifications via email from the state's PIU that it has terminated a provider for cause. If Health Choice determines that a provider should be terminated, the network services director sends a termination letter to the provider within seven business days of the decision. The letter contains the reason for the termination (for cause or not-for-cause) and the date for which the termination is effective. A copy of the termination letter is filed in the provider's file and distributed to the affected departments including member services and medical services. A decision to terminate for cause will be reviewed and approved by the Health Choice legal department.

Molina Healthcare submits a monthly termination report, which includes the reason for termination, to the UDOH. Provider terminations tend to be proprietary to contracts or protected by peer review law, and are generally not shared. Molina's government contract team receives notifications from the state regarding providers who have been terminated for cause, and notice is then disseminated to network, credentialing and operational teams as required. Provider records are terminated in Molina's core operating system (QNXT) in accordance with the applicable governing policies and procedures maintained by their functional business unit. Termination letters are then sent to the providers. Additionally, Molina makes a good faith effort to provide written notice of termination to affected enrollees as soon as possible, but no less than thirty calendar days prior to the effective date of the change.

SelectHealth Community Care's provider development notifies the UDOH when terminating a provider for fraud, waste, or abuse. The ACOs Medicaid program management receives notifications via email from the state regarding providers who have been terminated for cause. The ACOs provider operation team immediately removes the provider from that line of business. Termination letters are then sent to the providers. During the interview, SelectHealth confirmed they do not have written policies and procedures addressing the provider termination process for its Medicaid line of business.

The state uploads the for cause terminated providers to the CMS-Data Exchange (DEX) managed file transfer server.

Overall, the number of providers terminated "for cause" by the plans appears low, compared to the number of providers enrolled with the ACOs and compared to the number of providers dis-enrolled or terminated for any reason. Table 5 depicts the number of provider terminations by ACO.

Table 5: Provider Terminations in Managed Care

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FYs		Total # of Providers Terminated for Cause in Last 3 Completed FYs	
Health Choice Utah	2017 2018 2019	1 1 5	2017 2018 2019	-0- -0- -0-
Molina Healthcare	2017 2018 2019	1451 27,025 2420	2017 2018 2019	45 18 18
SelectHealth Community Care	2017 2018 2019	580 987 486	2017 2018 2019	-0- -0- -0-

Recommendation #7: The state should develop a comprehensive process to initiate more frequent information sharing within its contracted ACOs regarding all adverse actions taken to limit managed care provider participation to include, but not limited to, terminated, de-credentialed, or disenrolled network providers. In addition, the state should provide training to its

contracted ACOs regarding termination of providers for cause and ensure all ACOs develop written policies and procedures for terminated providers.

Status of Utah's 2016 Corrective Action Plan

Utah's last CMS program integrity review was in August 2016, and the report for that review was issued in June 2017. The report contained eight recommendations. During the virtual review in August 2021, CMS conducted a thorough review of the corrective actions taken by Utah to address all issues reported in calendar year 2016. Although progress has been made, the review team found that the findings from the 2016 Utah focused PI review report were not fully satisfied and reiterated the recommendations within this report.

Technical Assistance Resources

To assist the State of Utah in strengthening its program integrity operations, CMS offers the following technical assistance resources for Utah to consider utilizing:

- Access COVID-19 Program Integrity educational materials at the following links:
  - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf.
  - Risk Assessment Template (DOCX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx.
  - Risk Assessment Template (XLSX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.xlsx.
- Access the Provider Requirements website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Provider-Requirements to address site visit requirements.
- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCU.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address Overpayment and Recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. http://www.riss.net/.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute.
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid program integrity Promising Practices information posted in the RISS as a tool to identify effective program integrity practice

Conclusion

CMS supports Utah's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified nine areas of concern and instances of non-compliance with federal regulations that should be addressed immediately.

We require the state to provide a corrective action plan for each of the recommendations within 30 calendar days from the date of issuance of the final report. The corrective action plan should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies have been addressed and will not reoccur. The corrective action plan should include the timeframes for each corrective action along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the corrective action plan, such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of issuance of the final report. If the state has already acted to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

CMS looks forward to working with Utah to build an effective and strengthened program integrity function.