

*Guidelines for Addressing
Fraud and Abuse
in Medicaid Managed Care*



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EXECUTIVE SUMMARY

As health care costs continue to rise to unprecedented heights, States are seeking new approaches in providing health care services for their citizens. More and more States are moving their Medicaid program away from the traditional fee-for-service (FFS) environment to a managed care system or a capitated environment. With this shift in health care comes new challenges in containing costs and new opportunities for fraud and/or abuse to occur.

The original thinking of many within the industry was that fraud did not exist in managed care. However, experience has proven that fraud does, in fact, exist in many ways within a managed care environment.

States are required by Federal mandate to have an effective fraud and abuse detection and prevention program; however, few formal managed care fraud and abuse programs have been initiated by States. The purpose of these guidelines is to assist the Health Care Financing Administration, State Medicaid Agencies, Medicaid Fraud Control Units, and managed care organizations in preventing, identifying, investigating, reporting, and prosecuting fraud and abuse in a Medicaid managed care environment, and to better equip States with new measures and initiatives to protect against fraud and abuse in Medicaid managed care programs.

These guidelines are meant to help States implement effective standards for improving fraud and abuse prevention, detection, and investigation. They do not in and of themselves constitute program requirements. This report is being published in order to promote implementation of these guidelines in State Medicaid programs nationwide.

This document consists of five major topics. A brief description of each topic and the respective section is listed below.

Section 1

Defining Fraud and Abuse in a Medicaid Managed Care Environment

In addition to defining fraud and abuse in a Medicaid managed care environment, this section identifies six broad areas in which fraud and abuse may arise, and discusses each in detail. One of the major features of this section is the citing of case examples of ongoing investigations and successful prosecutions of fraud in managed health care settings. These examples can assist Federal, State, and managed care organizations in identifying situations in which fraud and abuse might occur.

Section 2

Roles of Medicaid Purchasers in Controlling Fraud and Abuse

The primary responsibility for program integrity in the Medicaid program lies with the State and Federal

governments, regardless of what service delivery system is used. In a managed care environment, however, other entities will play important roles in support of State and Federal efforts to prevent, detect, investigate, report, and prosecute fraud and abuse. This section identifies the roles of the Health Care Financing Administration, State Medicaid agency, the managed care organization, the Medicaid Fraud Control Unit, and the Office of the Inspector General in the control of fraud and abuse in a Medicaid managed care environment.

Section 3

Data Needed to Detect and Prosecute Fraud and Abuse in Managed Care

This section discusses the need for effective managed care data. It stresses the importance of data collection, integration, certification, validation and analysis, and provides suggestions for using incentives and penalties to ensure the submission of accurate data.

Section 4

Key Components of an Effective Managed Care Fraud and Abuse Program

All participants in managed care programs should recognize the importance of and their responsibility for prevention and detection of fraud and abuse. This includes the State Medicaid Agency, MCOs, provider networks, subcontractors, recipients, MFCU, OIG and HCFA. This section describes the key components of an effective managed care fraud and abuse program which include: (1) formal plans, with clear goals, assignments, measurements and milestones; (2) prevention strategies; (3) coordination strategies; (4) detection strategies; (5) enforcement strategies; and (6) reporting strategies. This section also contains a recommended procedure for the exchange of information and collaboration among involved parties to determine the preferred course of action in cases of suspected fraud, and two suggested Medicaid Managed Care Fraud and Abuse Reporting Flow Charts.

Section 5

Fraud and Abuse in Managed Care Contracts, Programs, and Waivers

States can promote program integrity in Medicaid managed care programs by incorporating language with explicit fraud and abuse measures into contracts, programs, and waivers. This section, in conjunction with Appendix 1, provides suggested strategies that States may use to strengthen efforts to combat fraud and abuse and identifies the provisions that are required by Federal statute and/or regulation promulgated for achieving this goal.

A Sample Certification Form (Appendix 2), List of Acronyms (Appendix 3), a Chart of Civil Monetary Penalty (CMP) Authorities Applicable to Medicaid Managed Care Organizations (MCOs) (Appendix 4), and a List of Workgroup Members (Appendix 5) is also contained in this document.

Through the use of these tools, the Health Care Financing Administration, the States, Medicaid Fraud Control Units, OIG and managed care organizations should develop partnerships dedicated to the prevention, detection, investigation, reporting, and prosecution of managed care fraud and abuse.

BACKGROUND

In August 1997, the Health Care Financing Administration met with State Medicaid Program Integrity Staff to discuss ways of improving the State/Federal partnership as it related to the detection and prevention of fraud and abuse within the Medicaid program. One recommendation was to develop guidelines, procedures, new approaches, and data systems to help States control fraud and abuse in managed care. To accomplish this, HCFA established a Fraud and Abuse in Managed Care workgroup consisting of representatives from the Managed Care and Program Integrity Sections of State Medicaid Agencies, State Attorneys' General Medicaid Fraud Control Units, and the Health Care Financing Administration. This document is the direct result of their efforts.

Until recently, the risk for fraud and abuse in managed care was thought to be small, as the responsibility for prevention and detection was implicitly transferred to the managed care entity. Purchasers thought that managed care organizations (MCOs) would absorb abusive or fraudulent payments through capitation payments and that strong contract language would prevent the provision of too little service.

Experience contradicts these assumptions. Managed care fraud can harm an MCO's profitability; however, that is not the only area it impacts. Money taken by provider or recipient fraud can threaten an MCO's viability. This is important to States trying to stem declining MCO participation in managed care.

This document focuses on fraud and abuse in risk-based, capitated managed care programs. Capitated programs are those programs whereby services are provided to members based on a per member/per month payment fee. The managed care program is then required to provide contracted, medically necessary services to those members included in the program. If the cost of providing services to enrollees exceeds the per member/per month payment fee, managed care programs could suffer a loss of capital; however, if the costs of providing services to enrollees is less than the per member/per month payment fee, managed care programs could experience a gain in capital. This concept is known as risk since the program is at risk to provide all of the medically necessary services provided for in the contract with the intention that the costs would not exceed the per member/per month payment fee.

Included in this category are MCOs/Health Insuring Organizations (HIOs) and Prepaid Health Plans (PHPs). MCOs/HIOs provide comprehensive services on an at risk basis. PHPs are also risk-based, but usually provide less than a comprehensive set of services, e.g., only behavioral health or only dental care. Consequently, in instances where the principles of guarding against fraud and abuse for MCOs/HIOs are referenced, these principles also apply to PHPs.

Because MCOs are typically paid on a capitated basis they have a built-in incentive to control health care expenditures. Managed care regulators have a crucial role in ensuring that managed care organizations meet their contractual obligations and provide enrollees with the required standard of medical services. The

provision of health care services must be monitored carefully to ensure that individual enrollees are receiving appropriate medical care and to detect any systematic problems in access to or provision of appropriate health care services. Depending upon the level of intent, abuse and/or fraud occurs when the organization demonstrates a pattern of consistently failing to provide enrollees with appropriate medical care. Furthermore, depending upon the level of intent, examples of abusive and/or fraudulent practices by the organization include the consistent failure to provide an adequate health care network for enrollees, or a pattern of denying enrollees necessary medical care. By deliberately failing to establish adequate networks, MCOs can jeopardize enrollee access to care. Their enrollment of substandard providers can degrade the quality of care an enrollee receives. Also, managed care fraud can raise State costs despite capitation. For example, if data is manipulated by the MCO to give the appearance of providing services to enrollees that are not truly enrolled within the organization, the MCO may be attempting to receive enhanced future capitation payments. Thus, State costs could be increased based on inflated data.

For non-capitated programs (i.e., those programs reimbursed on a fee-for-service basis), such as Primary Care Case Management (PCCM) programs, existing fee-for-service (FFS) fraud and abuse prevention and detection strategies may be best. (PCCM is a Medicaid managed care delivery system using a FFS gatekeeper model.) However, it should be recognized that PCCM programs present some unique opportunities for aberrant referral practices that may not be present in regular FFS programs. For example, patient “channeling”^{*} is a vulnerability, particularly for services that have questionable medical necessity and could potentially raise kickback concerns. Additionally, some of the strategies outlined in this document may be useful for combating fraud and abuse in non-capitated programs.

Managed care presents new and familiar opportunities for beneficiaries, providers, and MCOs to commit fraud and abuse. HCFA, States, MFCUs, and MCOs should develop partnerships dedicated to the elimination of fraud and abuse. The material in this document will assist in that effort and will work toward improving the prevention, detection, investigation, reporting, and prosecution of fraud and abuse in the managed care environment.

* “Channeling” by a provider is the referring of patients to an entity in which the referring provider has a vested interest.

SECTION 1

DEFINING FRAUD AND ABUSE IN A MEDICAID MANAGED CARE ENVIRONMENT

This document is primarily about the prevention, detection, investigation, reporting, and prosecution of fraud and abuse in a Medicaid managed care environment. The first step in combating fraud and abuse is to identify fraud and abuse. This section provides definitions and examples of fraud and abuse so that States and the Federal government will be better equipped in identifying and preventing these activities. It should be noted that this list of definitions is not meant to be exhaustive but rather a sample of practices that States should be aware of. **NOTE:** Many of the health plan transgressions described in this section may be considered merely failures to perform contractual obligations or undesirable practices, for which plans should be held accountable. However, in the extreme or combined with other undesirable practices, they may appropriately be considered abusive tactics and may, consequently, rise to the level of fraud.

The workgroup began with the current regulatory definitions of Medicaid fraud and abuse found in 42 CFR 455.2. Those definitions are as follows:

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

The workgroup defined fraud and abuse in Medicaid managed care in the following manner:

Medicaid Managed Care Fraud means any type of intentional deception or misrepresentation made by an entity or person in a capitated MCO, PCCM program, or other managed care setting with the knowledge that the deception could result in some unauthorized benefit to the entity, himself, or some other person.

Fraud can be committed by many entities, including:

- an MCO,
- a contractor,
- a subcontractor,
- a provider,

a State employee, or
a Medicaid beneficiary/Medicaid managed care enrollee.

A provider can be defined as any individual or entity that receives Medicaid funds in exchange for providing a service (MCO, contractor, or subcontractor).

Medicaid Managed Care Abuse means practices in a capitated MCO, PCCM program, or other managed care setting that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations for health care. The abuse can be committed by an MCO, contractor, subcontractor, provider, State employee, Medicaid beneficiary, or Medicaid managed care enrollee, among others. It also includes beneficiary practices in a capitated MCO, PCCM program, or other managed care setting that result in unnecessary cost to the Medicaid program or MCO, contractor, subcontractor, or provider. A provider can be defined as any individual or entity that receives Medicaid funds in exchange for providing a service (MCO, contractor, or subcontractor). It should be noted that Medicaid funds paid to an MCO, then passing to subcontractors, are still Medicaid funds from a fraud and abuse perspective.

Health care fraud and abuse can occur in many areas, including the following:

Procurement of the managed care contract,
Marketing, enrollment, and disenrollment
Underutilization,
Claims submission and billing procedures,
Antitrust violations,
FFS fraud, and
Embezzlement and theft.

While kickbacks are generally recognized as a potential problem in a managed care setting, kickback schemes may exist in many, if not all, of the identified areas. Other types of fraud may be found as well.

Below is a discussion of each of the likely areas for fraud and abuse in managed care. Each category contains a definition, identifies the incentive for committing fraud or abuse, states the potential damage, and provides examples of successfully prosecuted cases.

Procurement of the Managed Care Contract

NOTE: Some of these health plan transgressions may be considered failures to perform contractual obligations or undesirable practices, for which plans should be held accountable. However, in the extreme or combined with other undesirable practices, they may appropriately be considered abusive tactics and may, consequently, rise to the level of fraud.

This category examines the types of fraud that might occur in the procurement of both contracts and subcontracts for Medicaid managed care. The incentive to procure an MCO contract fraudulently is the receipt of payment of money to which the company would not be otherwise entitled. The following is a list of examples.

Falsification of health care provider credentials -- This can occur either at the MCO or subcontract levels. Falsification of health care provider credentials can put patients at risk because they may be receiving care from an unqualified, unlicensed, or a debarred provider. This can also occur at the subcontract level, where providers are frequently paid at a FFS rate. Falsification of provider credentials may result in the improper payment for the services of a provider who does not meet the required professional qualifications.

Falsification of financial solvency -- An MCO can purport to have sufficient assets to cover claims when, in fact, it lacks financial solvency. This may result in the failure to pay providers at all or in a timely manner, and thereby affect patient care. While most insolvency problems are inadvertent, some, called “bust outs” may be deliberate, e.g., the owners may embezzle the money or claim it as “salaries” or “administrative fees” and then file bankruptcy or simply disappear. Most often, solvency issues will also involve a State’s Insurance Department or other licensing agencies. For more information on “bust outs” see the category below called “Embezzlement/Theft and Related FFS Fraud.”

Falsified or an inadequate provider network -- An MCO’s provider network indicates that it has a sufficient number of providers and/or specialists to accept new patients and to cover the needs of persons enrolled, when in fact, an inadequate network exists. This can result in: (1) over enrollment (more members than the plan can adequately handle, which can lead to inadequate care), and (2) lack of provider availability, or difficulty in an enrollee’s ability to access certain types of care. Because networks are very fluid, temporary provider network deficiencies may not be fraud; however, in the extreme, an inadequate provider network may jeopardize the quality of care for all enrollees. Moreover, intentional misrepresentation of the number of providers and/or specialists would constitute fraud.

Fraudulent subcontract -- The definition of a fraudulent subcontract is an agreement between parties that contains materially misleading information, which has been pre-dated or post-dated, and/or contains

a forged signature or a signature of a person that would not have authority to approve the agreement.

Fraudulent subcontractor -- The definition of a fraudulent subcontractor is a provider who has intentionally performed or billed improperly; e.g., intentionally denies appropriate services or intentionally submits false claims. If an MCO does not properly check out a subcontractor's performance and billing history prior to being included in the network, the MCO may be paying for services not provided.

Sometimes certain conditions can exist that can create incentives for a provider to act fraudulently. For example, if excessive risk is shifted to the subcontractor, the reimbursement structure of a subcontract may create incentives for the subcontracted provider to withhold needed care (if reimbursement is too low) or deny needed referrals (if the provider is at risk for too great a portion of referral costs. The provider could also inflate its bills to reach prematurely the MCO's threshold for providing the stop/loss protection required by section 1903(m)(5)(A)(v) (prohibiting MCOs from placing providers at substantial financial risk - defined as more than 25 percent of total reimbursement to providers being at risk - without offering stop/loss protection and monitoring enrollee satisfaction). An example of this is the following:

The provider has a stop loss arrangement with the MCO that has an attachment point of \$5,000. The provider is paid one-hundred percent FFS charges after that point. The provider inflates his bills to prematurely meet the \$5,000 stop loss threshold offered. Then he inflates his FFS bills in order to maximize his income. He provides unnecessary services and may waive copayments so members are not as vigilant to bolster billings.

Bid-rigging or self-dealing -- Bid-rigging involves collusion between State employees and those submitting Request for Proposals and/or contracts. Self-dealing is defined as the award of Medicaid contracts based on friendship or family relationships with those in control of the selection process.

Collusion among providers -- Collusion among bidders or providers occurs when a community's competing providers agree on minimum fees charged and capitation rates accepted. Collusion may also include carving up service areas.

Contracts with related parties -- Contracts with related parties, such as subsidiaries or other entities owned by persons with a financial interest in the health care plan, may provide an opportunity for diversion of funds without the provision of services, or payment of exorbitant amounts for legitimate services.

Antitrust violations are also included in this category and can result from efforts to reduce or eliminate competition through the use of illegal tying agreements. Without competition, higher rates and price fixing can occur. Victims can include the MCO, enrollees, or the Medicaid program.

Illegal tying agreements -- In some programs, if an MCO lacks expertise in a certain area, such as

behavioral health, the MCO may subcontract with entities that have such expertise. If the subcontractor requires the MCO to contract with other entities as a condition for the subcontractor to provide services, the MCO could incur inflated costs. For example, if an MCO wished to contract with one entity in one part of the State, but was required, as condition of obtaining the subcontractor's services, to contract with all of the groups owned by that subcontractor statewide, the MCO may be paying for services that are not needed.

In one State, Behavioral Health Organizations (BHO) were established to provide behavioral health services much in the same fashion that MCOs provide medical services. By December 1995, BHOs were required to have one or more mental health centers in their delivery system of care or they would not be allowed to contract with the Medicaid program. The mental health centers joined together, forming an organization to negotiate their contracts. This organization negotiated with the BHOs a requirement that all mental health centers be included in their contracts or no contract would be signed. As a result, this organization forced the BHOs to contract for services with mental health centers that were not needed. The State Attorney General's office estimated the net effect of this arrangement would result in the transfer of at least \$7 million to as much as \$17 million to the mental health centers with no-cost savings to the State. In 1996, a civil judgement was filed against the organization for \$300,000.

Marketing and Enrollment Fraud and Abuse

NOTE: Some of these health plan transgressions may be considered failures to perform contractual obligations or undesirable practices, for which plans should be held accountable. However, in the extreme or combined with other undesirable practices, they may appropriately be considered abusive tactics and may, consequently, rise to the level of fraud.

Generally, marketing and/or enrollment fraud is considered a “startup” type of fraud. Once the targeted population is enrolled, there is a diminished demand for marketing and thus, a reduced opportunity for fraud. However, marketing activities can be ongoing and the possibility for fraud has been uncovered in MCOs that have years of operational history. Consequently, if the fraud goes undetected, the potential damage can be felt in several ways. Depending on the State's enrollment process, it may be possible that a beneficiary who is ineligible or nonexistent is enrolled. When this occurs, the MCO will inappropriately receive a monthly capitated payment from the State Medicaid agency to cover services for that ineligible or nonexistent person. Even if the person is eligible, other plans can be damaged if they are unable to have a fair chance to enroll the beneficiary. Finally, the beneficiary could end up enrolled in a plan that cannot meet his or her needs.

Generally, the incentive to commit fraud relating to the marketing or enrolling of new members can be found where the MCO has established the practice of paying its employees, or representatives, a fee or bonus for those individuals that they enroll. The very nature of a managed care system establishes the potential of marketing or enrollment fraud in that the MCO is paid a monthly fee dependent on the number of members enrolled. Consequently, the larger the number of members enrolled, the greater the capitation income the MCO will receive from the State Medicaid agency. It is important that States approve all marketing plans and materials. In addition, States should monitor how marketing plans are carried out. Below are examples of marketing and enrollment fraud.

MARKETING FRAUD

Misrepresentation to beneficiaries (also known as “Slamming”)-- An MCO representative fails to properly identify himself/herself as an employee of the MCO, misleading the prospective beneficiary into believing that he/she is actually an employee of the program itself (a State Medicaid agency employee, for example). By enrolling the beneficiary into that one MCO that he or she represents, the beneficiary forgoes the opportunity to enroll in another MCO which is better suited to his or her needs. Another form of misrepresentation occurs when the potential enrollee is misled about the benefits offered by the health plan.

Misrepresentation to beneficiaries by charging non-existent fees -- The marketing representative (MCO employee or independent operators) charges the beneficiary a fee for enrolling when there actually is no charge. The primary victim would be the prospective beneficiary. However, if the Medicaid beneficiary fails to enroll because she or he cannot or will not pay the fee, the MCO is a victim because it loses capitation payments until the beneficiary is properly enrolled. If the marketing representative is not actually affiliated with the State Medicaid agency or an MCO, the enrollee loses not only the fraudulent enrollment fee, but also coverage until properly enrolled.

In 1993, after one State announced plans to implement its new managed care program, a number of Medicaid and Medicare beneficiaries were victimized by one individual, who was able to pass himself off as an employee of either the State Medicaid agency or an MCO. By falsely impersonating a Medicaid program representative, the man was able to convince numerous area residents into paying him approximately \$40 each for promising to enroll them in the upcoming Medicaid program, a program that was actually free for these individuals. Since this individual was not affiliated with the State or an MCO, the residents lost the \$40 fee and were also not enrolled into the program until the scam was uncovered. This individual was convicted of two counts of forgery and eight counts of theft and was sentenced to one year in jail and ordered to pay a \$500 fine on each of the two counts of forgery. He was also sentenced to eleven months and twenty-nine days and \$50 fines for each of the eight counts of theft.

ENROLLMENT AND DISENROLLMENT FRAUD

Enrolling ineligible individuals -- All capitation payments made to an MCO for ineligible persons would be improper. An ineligible person could be one who has access to insurance elsewhere, resides in another State or, in many cases, has income or resources that exceed a particular State's limit. If MCO representatives receive a bonus or "bounty" for submitting applications or enrollment forms, there is little incentive for them to watch for, or identify, an ineligible person.

A marketing representative for one MCO was convicted of five counts of mail fraud and two counts of making false statements as a result of her submitting fraudulent enrollment information to the State for ineligible individuals to the Medicaid program. She worked as a consultant assigned to the automobile manufacturing plant, had access to plant personnel records and used these records to submit information regarding plant employees without their knowledge or consent. The loss to the State for those enrolled, who were ineligible because they had access to insurance through the automobile plant, was approximately \$136 per month per person. The marketing representative was sentenced in 1996, to 15 months in a Federal penitentiary, 24 months' probation, and was ordered to pay \$78,212 in restitution and \$350 in costs.

Another individual was convicted in 1995 of seven counts of mail fraud and eight counts of false statements as a result of his submitting false enrollment information for prison inmates to the State Medicaid Agency. This person, a corrections counselor at the prison and an MCO Marketing Representative, submitted information on more than 200 inmates. At the time, inmates were ineligible to be enrolled in Medicaid. Recoupment was approximately \$100,000. This person was sentenced to 14 months of incarceration, and three years supervised release, and was ordered to pay \$3,636 in restitution and a \$600 fine.

Enrolling nonexistent individuals -- All capitation payments made to an MCO for nonexistent persons would be fraudulent. In such cases, the MCO would not bear the cost of providing services, and the full capitation would be profit. Again, this would be most prevalent in an environment where the MCO or independent marketing representative receives a fee for each person enrolled.

In 1994, approximately 4,500 fictitious persons with a mailing address of a homeless shelter were enrolled in the Medicaid program. These fictitious persons were enrolled in Medicaid because an MCO, who received a monthly capitation payment for each person enrolled, submitted falsified enrollment applications. By the time the scheme was uncovered, more than \$1.8 million had been paid to the MCO by Medicaid. Recoupment was for the entire \$1.8 million from the MCO, through reduced future capitation payments. Four individuals were convicted on a total of 41 counts of mail fraud, false statements, Social Security violations, and conspiracy. The first individual was convicted of 28 counts of mail fraud, false statements, Social Security violations, and conspiracy and sentenced to 68 months of incarceration, and three years of supervised probation, and was ordered to pay \$1.4 million in restitution to the MCO. The second was convicted on one count of conspiracy and one count of false statements, was sentenced to one year and one day in jail, and three years of supervised release, and was ordered to pay \$5,000 restitution to the MCO. The third individual was convicted of one count of conspiracy, received three years of supervised release and was ordered to pay \$246,400 in restitution to the MCO. The last person was convicted on eight counts of mail fraud, conspiracy, and Social Security violations, and was sentenced to 27 months of incarceration, and three years of supervised release, and was ordered to pay \$126,800 in restitution to the MCO.

Enrolling nonexistent or ineligible family members -- This occurs when the MCO representative is paid "per head" for those individuals that are enrolled. Additional names are added to the application, thus allowing the MCO representative to receive a higher bonus.

"Cherry-picking" or selecting the healthiest segment of the enrollment population -- By doing so, the MCO assures itself of higher profits by having to make fewer payments to its providers. Those individuals who are the most ill thus find it difficult to get adequate care, especially those in rural areas where few MCOs exist. Cherry-picking is much more difficult to control in voluntary MCO programs than in mandatory ones because, in the latter, MCOs cannot reject enrollees who are auto-assigned to them. Federal statutes clearly prohibit discrimination on the basis of health status or "cherry-picking". Subtle forms of cherry-picking include the following:

- ' misuse of health needs questionnaires;
- ' attempts by marketers stationed in Social Service offices or at health fairs to discourage clients with potentially high utilization needs from joining a specific MCO;
- ' choosing to hold a health fair in a third floor walkup location, which would discourage or preclude disabled clients from attending;
- ' distribution of marketing materials in locations where only "healthy" potential enrollees are likely to access them; and
- ' reducing the likelihood that persons with Human Immunodeficiency Virus (HIV) would enroll by not contracting with clinics and specialists experienced in treating persons with HIV.

Kickbacks for referrals -- The MCO pays a kickback to an outside party for potential (usually healthy) enrollees. In this situation, the enrollee may become limited in his choices for prospective MCOs and the MCO can select the healthiest of the referrals.

Disenrolling undesirable members -- The MCO uses encounter data to identify and encourage undesirable or unhealthy members to disenroll. By doing so, the MCO reduces the cost of services and improves its profitability.

Failing to notify State of deceased members -- By failing to notify the State or its agent in a timely manner that a member has expired or to initiate the proper disenrollment action in a timely manner, the MCO continues to receive a monthly capitation fee, even though the MCO will no longer incur costs for services. Once the date of death is obtained, States should routinely recoup inappropriate payments.

Beneficiary enrollment fraud -- Enrollment fraud is not limited to activities by MCOs or their agents. Beneficiaries may commit fraud against the State by presenting fraudulent Medicaid eligibility information (e.g., understating income or asset levels, or incorrectly claiming to be a resident of the State).

Underutilization

NOTE: Some of these health plan transgressions may be considered failures to perform contractual obligations or undesirable practices, for which plans should be held accountable. However, in the extreme or combined with other undesirable practices, they may appropriately be considered abusive tactics and may, consequently, rise to the level of fraud.

One of the primary goals of managed care is to reduce unnecessary health care utilization so that only medically necessary services are provided. In certain cases, questions about possible underutilization may actually relate to evolving standards of medical care. However, depending upon the level of intent, underutilization abuse and/or fraud occurs when an organization shows a pattern of failing to provide its members with medically necessary health care services on a timely basis. The following examples of potential fraud and/or abuse need to be evaluated in terms of whether it is part of a pattern of denying enrollees appropriate access to and provision of appropriate health care services.

Untimely first contact with clients -- If an MCO has thirty days to notify an individual of their membership in the organization, but takes longer, the monthly capitated payments received are not used to provide any services.

Untimely assignment of a primary care physician (PCP) -- If an MCO has forty-five days to notify

individuals of their PCP, but delays assignment until after forty-five days, the monthly capitated payments received are not used to provide any services.

Delay in reassigning PCP upon an individual's request --The MCO contract allows thirty days to act on a request for a new PCP, but instead takes sixty days, thereby collecting two months of Medicaid payments without providing any services.

Discouragement of treatment using geographic or time barriers -- An MCO discourages treatment through geographic or time barriers by assigning an enrollee to a PCP whose office is far from the beneficiary's home, has limited office hours, has long waiting times for appointments, or whose office is difficult-to-reach by public transportation.

Engagement in any Federally-prohibited discrimination activities -- If an MCO or one of its providers illegally discriminates against an eligible individual, the result would likely be a decrease in service, and a commensurate increase in profit for the offending party.

Failure to serve individuals with cultural or language barriers -- If the MCO contract requires interpreters' and/or cultural competence, an MCO can avoid meeting these requirements by defining away the problem. For example, an MCO's contract could require an unreasonably high concentration of foreign-language clients, which is unlikely to be reached, before having to address cultural or language barriers. As a result, individuals with these barriers may not be adequately served.

Failure to provide educational services -- If the MCO contract requires health education or certain preventive services, e.g., smoking cessation education, an MCO can save expenses if it does not advertise or provide these services. Consequently, beneficiaries can be underserved in these areas since they are not provided with education/information that would prevent or control specific health problems.

Failure to provide outreach and follow-up care or Federally-required referrals -- An MCO or its providers can save expenses by not advertising services, and therefore, enrollees do not receive these services because they do not know they can be provided. An MCO or its providers can also save expenses by not providing outreach and follow-up for contractually-obligated physicals, early periodic screening diagnosis and treatment (EPSDT) screens, initial health assessments, individual health education behavioral assessments, immunizations, referrals to women, infants, and children, and EPSDT follow-up or by not advertising or providing outreach and follow-up for other services provided for under the contract.

Failure to provide court-ordered treatment -- The MCO refuses to provide court-ordered services for health care that is considered medically necessary.

Failure to provide managed care beneficiaries comparable services such as those provided to commercial or fee-for-service beneficiaries -- An MCO or its providers attempt to diagnose and treat commercial or fee-for-service beneficiaries with more quality services and/or professionalism than managed care beneficiaries. (*Defined and presented by the Department of Justice*)

Defining “appropriateness of care” and/or “experimental procedures” in a manner inconsistent with standards of care -- An MCO attempts to interpret what constitutes “appropriateness of care,” narrowly, and attempts to broaden the definition of “experimental procedures” (which can be excluded under Medicaid) to exclude as many services as possible, resulting in excluding services that have already been determined to be covered benefit services under the contract.

Slow or nonexistent drug formulary updates -- An MCO delays including approved pharmaceuticals on its formulary thereby avoiding the use of expensive new drugs.

Strict Utilization Review (UR) standards -- An MCO can hide its poor performance and lack of service delivery by adopting inappropriate utilization review guidelines. For example, the MCO adopts inappropriately strict utilization review guidelines and denies necessary services.

Cumbersome appeal process for enrollees -- An MCO can save or delay expenses by inhibiting appeals or by creating burdensome appeal procedures for clients who are refused specific care. This practice can also make it too burdensome for enrollees to file appeals in the first instance.

Ineffective grievance process -- An MCO can appear to have fewer complaints than it actually does by adopting difficult-to-follow grievance procedures. One example is the use of a narrow definition of what constitutes a grievable incident or circumstance.

Inadequate prior authorization “hotline” -- An MCO requires a provider to obtain prior approval before performing a certain procedure, but fails to respond in a timely manner to such requests. Once the procedure is performed, the claim may be denied because of lack of prior approval.

Unreasonable prior authorization requirements -- The MCO has a prior authorization process that makes it stringent or otherwise difficult to acquire approval for standard or routine care. Beneficiaries could experience delays in receiving health care.

Cumbersome appeals process for providers -- An MCO can discourage providers from filing appeals by routinely delaying or “losing” appeals.

Delay or failure of the PCP to perform necessary referrals for additional care -- The members may be discouraged from seeking specialty referrals from the PCPs.

“Gag orders”-- An MCO can establish restrictions that prevent a PCP from freely advising the patient about his or her health status and limit discussion of alternative medical care or treatment for a condition or disease. Federal directives prohibit this practice.

Incentives to PCPs and specialty providers to illegally limit services or referral -- PCPs may share in illegal compensation for limiting services.

Routine denial of claims -- An MCO can routinely deny claims that unquestionably qualify as medically necessary services under the plan, such as emergency or out of network services.

A routine examination and subsequent investigation by the State revealed that an MCO consistently denied payment of emergency room claims without a proper investigation. The company failed to interview consumers whose claims were denied, or to take other actions that would be deemed a reasonable investigation before denial. In this instance, State law prohibited the denial of claims where liability has become reasonably clear. The MCO was found to have violated this law in several instances, including cases where members were referred to emergency rooms by trained medical personnel. The MCO was fined for improper claims denial.

Claims Submission and Billing Procedures

NOTE: Some of these health plan transgressions may be considered failures to perform contractual obligations or undesirable practices, for which plans should be held accountable. However, in the extreme or combined with other undesirable practices, they may appropriately be considered abusive tactics and may, consequently, rise to the level of fraud.

Claims and billing fraud may be perpetrated by either providers or subcontractors who manipulate the claims submitted to the MCO. MCOs can also commit this type of fraud by over billing members or submitting false encounter claims to the State or purchasers of health care in the hope that future capitation payments will be based on inflated service records.

The following are examples of this type of fraud and abuse.

Balance billing -- The contracting provider or MCO bills the beneficiary directly for the total amount of the bill or for the amount of the charge that the provider has agreed to write off after the MCO has paid.

An MCO agreed to refund about \$1.4 million to 19,000 members who were overcharged for their co-insurance payments between 1987 and 1994. The MCO agreed to settle the suit filed by the State's Department of Insurance. The MCO calculated the payments due based on the billed amount charged by the providers rather than the amount actually charged to the organization. As a result, members overpaid more than the stated coinsurance amount by as much as 20 percent. Under the consent decree, the MCO agreed to refund the difference between what members actually paid and the amount they would have paid if the negotiated savings had been passed on to them, plus 6 percent interest.

Inflating the bills for services and/or goods provided -- The contracting provider bills the MCO at full FFS rates even though a lower rate was negotiated in the managed care contract.

An MCO agreed to pay more than \$2.3 million to settle a lawsuit involving negotiated discounts. It was alleged that the MCO negotiated secret discounts with providers, and then failed to pass those savings to the members. While members paid their portion of the bill based on the face value, the plan was paying its portion based on a negotiated discount price. The MCO also agreed to pay about \$350,000 in attorneys' fees as part of the settlement.

Double-billing -- This occurs when the provider receives more than one payment for the same service and keeps the money. Examples of this include the following:

- C Both an MCO system and the State MMIS are designed to pay providers for family planning services, and the provider keeps payments from both sources.
- C An individual provider accepts full payment from a Medicaid MCO and also collects payment from a third-party insurer or the Medicaid enrollee. This assumes that capitation rates are set providing that the MCO collects third party payments.
- C A provider bills other carriers and government programs even when such payers are secondary to the Medicaid MCO. The provider keeps a portion of collection for bills paid by the MCO.

Medicare health maintenance organizations (HMO) received \$15 million in fraudulent billings for mischaracterizing enrollees as Medicare-Medicaid dual eligibles between October 1990 and July 1995. The Inspector General recommended that the overpayments be collected, and that HMOs be barred from requesting extra money in States that pay Medicare Part B premiums for Medicaid beneficiaries. In those States that do not pay such premiums, the HMOs are required to verify an enrollee's Medicaid eligibility before requesting extra payments.

Improper Coding (upcoding and unbundling) -- By using the wrong billing code or unbundling the codes included in a larger, more inclusive set of codes, the contracting provider is able to be reimbursed at a higher rate than if the correct billing codes were used and the services were billed together. Examples of this include the following:

- C Prenatal/post-partum care and deliveries are normally billed with a single global code. A provider uses the wrong billing codes and unbundles services to maximize payment for providing prenatal care and delivery services.
- C A provider codes a service in a way that would not be covered under the MCO contract and would be paid by the State on a FFS basis

Billing for ineligible consumers or services never rendered -- The provider signs a contract to obtain capitated payments each month for 100 enrollees; however, because of contract wording or a contact inside the MCO, the provider receives payment but is assigned no enrollees.

Inappropriate physician incentive plans -- Under a capitated arrangement, specialists may be paid by the PCPs using a portion of the PCP's capitation payment if a referral is made. Fraud can occur if the PCP receiving capitation payment does not reimburse specialists or does not refer members to specialists even if medically necessary. This situation can occur when the MCO misrepresents to the State the amount of the physician incentive plan. See also "Fraudulent subcontractor" in "Procurement of Managed Care Contract" category above.

Reporting phantom patient visits and improper cost reporting -- Providers submit inflated reports of patient traffic and treatment costs in order to induce payers to increase future per-patient capitation fees. Examples of this include the following:

- C The MCO falsifies its encounter data on immunizations to reflect higher than actual immunization rates.
- C The MCO inflates the number of visits in encounter data and the costs in financial statements to show a loss on capitation, then asks for a supplemental payment and/or higher capitation payment for next year.

Inappropriate cost-shifting to carved-out services -- In a managed care setting, certain services or provider groups may be "carved out" and either be paid FFS or be paid by another managed care entity. An MCO may attempt to have providers bill other payers, perhaps by changing diagnoses or procedure codes.

Beneficiary fraud and abuse -- Beneficiaries may abuse the system through inappropriate utilization of services, such as selling narcotics prescribed to them. The fraudulent sale of prescription drugs or medical equipment to others has a high potential for conspiracy between providers and enrollees. Other forms of fraud may include lending an enrollment card to an ineligible person in order for that person to receive health care services to which he or she is not entitled.

Fee-for-Service Fraud in Managed Care

NOTE: Some of these health plan transgressions may be considered failures to perform contractual obligations or undesirable practices, for which plans should be held accountable. However, in the extreme or combined with other undesirable practices, they may appropriately be considered abusive tactics and may, consequently, rise to the level of fraud.

Traditional FFS fraud can still occur in a managed care environment if the contracts the MCOs have with their subcontractors or providers are not capitated but are paid on a FFS basis. Examples of FFS fraud in managed care include the following:

Billing for unnecessary services or overutilization -- A provider who is paid on a FFS basis bills an MCO for office visits, tests, prescriptions, treatments, or other medical services that are unnecessary in order to increase payments.

Double billing -- A provider bills an MCO twice (or more) for the same service.

Unbundling -- A provider bills an MCO separately for services that are normally billed collectively. By billing the services separately, the provider is reimbursed at a higher rate than if the services were billed together. For example, deliveries are normally billed as a global service, but a provider may try to bill separately for each prenatal visit, the delivery, and post-partum visits. Other examples include unbundling sets of laboratory tests (called panels) or psychiatric tests.

Upcoding -- A provider bills an MCO for a more expensive service than was actually performed.

Ghost billing or billing for services not provided -- A provider bills for services never performed.

Embezzlement, Theft, and Related Fee-For-Service Fraud

NOTE: Some of these health plan transgressions may be considered failures to perform contractual obligations or undesirable practices, for which plans should be held accountable. However, in the extreme

or combined with other undesirable practices, they may appropriately be considered abusive tactics and may, consequently, rise to the level of fraud.

MCOs, contractors, subcontractors, providers, Medicaid beneficiaries or Medicaid managed care enrollees are generally subject to the same fraud and abuse rules applied to the FFS health care system. For instance, embezzlement of funds or theft of property are impermissible actions under both managed care and FFS systems. Certain payment practices fall under a “safe harbor,” however, and will not be subject to criminal prosecutions or serve as the basis for exclusion from the Medicaid program. See 42 CFR § 1001.952.

Embezzlement and theft -- Officers of the MCO or subcontracting providers steal or appropriate property entrusted to their care for their own use.

An MCO accepted monthly premiums for a member and then would not pay for appropriately authorized health care services for that member. The MCO took \$243 per month from an enrollee to cover him and his wife. In April 1995, the enrollee suffered a heart attack, and the MCO authorized its doctors and hospitals to treat him. Later, the MCO refused to pay the enrollee's medical bills, which totaled more than \$60,000. The plan said it terminated the enrollee's coverage for lack of payment, yet banking records show that the MCO continued cashing his checks, and hospital records indicate that the MCO continued to authorize his treatment through the end of 1996.

Diversion of funds for medical service to unnecessary administrative costs -- Officials in the MCO fraudulently divert corporate funds for personal gains. For example, the MCO pays excessive salaries and fees to owners or their close associates.

Three former officials of a Medicaid MCO were indicted in 1989 on charges of fraudulent schemes, conspiracy, theft and illegally conducting an enterprise. The three were charged with conspiring to defraud the programs by diverting funds lawfully belonging to the enterprise to themselves and their businesses. The investigation revealed that the monies were taken out of the enterprise in various fraud schemes and thefts in the guise of capitalization, management fees, medical directors' fees, bonuses, medical equipment, and excessive rental charges. The officials pled guilty to one count of fraudulent schemes and two counts of facilitation of theft.

“Bust outs” -- Premiums are paid to the MCO, but the MCO avoids paying vendors/providers by deliberately declaring bankruptcy. “Bust outs” also occur when management embezzles or steals the money, or other inappropriate diversion of funds occurs.

SECTION 2

ROLES OF MEDICAID PURCHASERS IN CONTROLLING FRAUD AND ABUSE

As States move their Medicaid programs to managed care delivery systems, fraud and abuse will continue to be of concern as threats to program integrity occur in new and different ways than in the previous FFS systems. The primary responsibility for program integrity in the Medicaid program lies with the State and Federal governments, regardless of what service delivery system is used. In managed care, other entities, including the MFCUs and MCOs, will play important roles in support of State and Federal efforts to prevent, detect, and control fraud and abuse and safeguard Title XIX program funds. Each of these entities performs unique functions as well as some that overlap with other stakeholders. The ability to reduce fraud in managed care substantially will be greatly enhanced as these entities develop methods and strategies to coordinate efforts across agencies. Working together, these four groups can strive to create structures to improve prevention and to develop new and comprehensive approaches to detect and control fraud and abuse in a managed care setting. This section identifies the roles of HCFA, the SMA, the MCO, the MFCU, and the OIG in the control of fraud and abuse in the Medicaid managed care environment.

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Funding

- C HCFA plays a major role in the funding of the Medicaid program by matching qualified State expenditures at rates up to 90 percent for services qualifying for an enhanced match.

Broad oversight responsibility

- C HCFA is responsible for developing and implementing effective oversight plans to assure that program funds are used only for legitimate purposes. As part of this responsibility, the agency should assure that resources from all stakeholders are used as efficiently as possible to prevent and detect fraud and abuse, and to recover funds whenever such activities have occurred.
- C HCFA assures that States have effective program integrity systems in place, including the collection and validation of sufficient service delivery data to assess utilization and quality of care. Appropriate safeguards include requiring certification of the truth and accuracy of information submitted to the State by program participants and to HCFA by States.

- C HCFA approves State Medicaid Agencies' MCO contracts. As part of that review, HCFA ensures that fraud and abuse detection and prevention requirements are addressed in the contracts.
- C HCFA reviews current laws and regulations and develops legislative proposals to encourage appropriate statutes to support effective control of fraudulent or abusive activities.

Technical assistance to State agencies

- C HCFA provides technical assistance to States in a number of areas, including the following:
 - ' Development of strong contracts with MCOs, within State Plans or waiver programs,
 - ' Institution of effective internal controls or other means to prevent and detect prohibited practices,
 - ' Implementation of procedures to monitor program integrity in a comprehensive way, and
 - ' Training staff on fraud and abuse detection and program integrity issues.
- C HCFA allows considerable flexibility in the review and approval of demonstration projects. This helps States test innovative approaches to delivering services while safeguarding program resources.
- C HCFA promotes the exchange of information among States to disseminate best practices that may improve program operations.
- C Through partnerships with States, HCFA provides information and assistance that enable States to operate their Medicaid programs as effectively as possible.

**STATE MEDICAID AGENCY
(SMA)**

Funding

- C Each State funds a substantial portion of its Medicaid program. State contributions vary up to 50 percent.

Design of program that assures program integrity

- C States design and implement cost-effective programs to combat fraud and abuse.
- C States develop contract provisions related to program integrity, and require MCOs to implement program integrity programs.

- C For maximum effectiveness, States should require the establishment of fraud and abuse units within MCOs.

Technical assistance to MCOs

- C States provide technical assistance to MCOs to identify fraud and abuse, promote best practices in program integrity, and improve program outcomes related to the legitimate use of funds.
- C States should provide periodic training to MCOs on how to prevent and detect fraud and abuse.

Monitoring program

- C In order to promote a culture of compliance and cooperation, States disseminate information and coordinate efforts and comply with all reporting requirements to prevent and detect fraud and abuse.
- C States have procedures to report suspected cases of fraud and abuse to the MFCUs and to HCFA.
- C Audits and contract reviews assess compliance with fraud and abuse requirements and procedures.
- C When irregularities are discovered, effective follow-up via appropriate administrative, civil, or criminal referral actions contribute to efforts to maintain program integrity, as does timely recovery of misspent funds.
- C States analyze managed care EQRO data to identify potential managed care fraud and abuse and inform the MCO and MFCU as appropriate.

Advocacy for statutes supporting effective fraud and abuse enforcement

- C State agencies review relevant managed care statutes, regulations, and contracts to address fraud and abuse issues, and work with MFCU personnel to create effective criminal and civil sanctions for fraud and abuse committed by Medicaid program participants.

MANAGED CARE ORGANIZATION (MCO)

Development of effective program integrity functions

- C MCOs develop comprehensive internal programs to prevent and detect program violations. They recover funds misspent due to fraudulent or abusive actions by the organization or its subcontractors. MCOs operate required fraud and abuse programs and comply with all reporting and other anti-fraud and abuse requirements.
- C MCOs must report suspected cases of fraud and abuse to the State Medicaid Agency.
- C MCOs must submit a certification to the State as to the truth, accuracy, and completeness of each submission of their data.

Coordination with other program stakeholders

- C MCOs cooperate with MFCUs/DAs and other agencies that conduct investigations.
- C MCO cooperation with States and MFCUs/DAs includes the exchange of information and strategies for addressing fraud and abuse, as well as allowing access to documents and other available information related to program violations.

MEDICAID FRAUD CONTROL UNIT (MFCU)

Coordination with other program stakeholders

- C MFCUs interact with State and, when appropriate, MCO officials to discuss potential fraud and abuse issues and investigations and develop effective cases.
- C MFCUs work with States and MCOs to develop methods and assist with procedures to identify,

detect, and investigate potential fraud and abuse.

Advocacy for statutes supporting effective fraud and abuse enforcement

- C MFCUs review relevant managed care statutes, regulations, and contracts to address fraud and abuse issues, and work with State agency personnel to propose legislation to create effective criminal and civil sanctions for fraud and abuse committed by Medicaid program participants.

OFFICE OF INSPECTOR GENERAL (OIG)

Elimination of fraud, waste, and abuse

- C The OIG in HHS is responsible for conducting investigations, audits, and evaluations, and protecting HHS programs and operations against fraud, waste and abuse.
- C Inconjunction with the U.S. Department of Justice, the OIG has the responsibility for establishing and administering a nationwide Fraud and Abuse Control Program, as authorized by the Health Insurance Portability and Accountability Act of 1996. Among the objectives of this program are the coordination of “Federal, State, and local law enforcement programs to control fraud and abuse with respect to health plans ... ,” and the “conduct [of] investigations, audits, evaluations and inspections relating to the delivery and payment for health care in the United States.”
- C OIG is responsible for overseeing the operation of the MFCUs through their certification process and distribution of Federal matching funds.
- C OIG has the authority within HHS to exclude from participation in Medicare, Medicaid, and other Federal health care programs individuals and entities determined to pose a risk to the programs and/or beneficiaries. (Section 1128 of the SSA)
- C OIG has the authority within HHS to impose civil monetary penalties (CMPs) on individuals and entities that submit false or fraudulent claims to Medicare, Medicaid, or other Federal health care programs. (Section 1128A of the SSA). The OIG also has the authority to impose CMPs on Medicaid managed care organizations that engage in certain improper activities, as specified in section 1903(m) of the SSA. See Appendix 4.

Coordination with law enforcement agencies

- C OIG works with other law enforcement agencies and investigates cases involving potential fraud and abuse. Cases warranting enforcement action are either referred to the U.S. Department of Justice for criminal/civil action, or handled administratively in coordination with HCFA.

SECTION 3

DATA NEEDED TO DETECT AND PROSECUTE FRAUD AND ABUSE IN MANAGED CARE

Accurate and complete data can be a powerful source of information for HCFA, State Medicaid and public health programs, surveillance and utilization review staff (SURS) or SURS-like units, MFCUs, OIG, MCOs, and Medicaid providers. Data can be used to do the following:

- C monitor service utilization, access to care, comparability of care, and quality of care,
- C update and evaluate capitation payment rates,
- C monitor MCO and provider contract performance, and
manage and enforce managed care contracts.

This section outlines types of Medicaid managed care data that may be captured for fraud and abuse prevention, detection, investigation, reporting, and prosecution.

Data Sources/Collection

Data can be obtained from a number of sources including managed care enrollment and disenrollment data, enrollee demographic data, EQRO findings, quality assurance (QA) studies, and MCO financial, access, quality, and grievance reports. However, the most critical data is claims or encounter data.

Encounter Data

States have some latitude in how they define encounters. The way in which States define an encounter has considerable impact on the content and value of the managed care information that is collected. Each State should choose a definition that best suits the purposes for which it plans to use the data, and then communicate that definition clearly to its MCOs.

In the early stages of managed care, an encounter was defined as an interaction between a patient and one or more health care providers without a resulting claim. In effect, it was service(s) provided by capitated or salaried providers. Today, the term encounter generally means a service or procedure provided to a managed care enrollee by a provider compensated by any possible means (e.g., FFS, capitation, fee-for-time, or salary). Another definition of an encounter is any health care service provided to an enrolled Medicaid client either directly by the MCO or indirectly through its subcontractors.

Some states define an encounter as a specific service. In that case, a single outpatient visit to a provider

by a managed care enrollee can result in multiple encounter claims, such as separate claims for an office visit, laboratory procedure, and x-ray. Other states define encounters as consisting of all services provided in a single visit. In this instance, the same three services would be included in a single encounter claim.

States need to ensure encounter data requirements are comprehensive and simple enough to ensure utility and collection. It is important that States define data elements in a way that enables SURS or SURS-like units, MFCUs, or other fraud and abuse review units to conduct fraud and abuse reviews. By including the MCO and provider representatives in the data system design process, a State can better ensure both effective data collection and the buy-in of the data suppliers. States need to select a common minimum data set and develop standard definitions and valid values for each of those data elements. Without this, the utility of the data is greatly compromised. Most important, when defining data elements, existing data standards should be used whenever possible. The standard format for encounter data submission includes the following: Form HCFA-1500 for professional services, Form UB-92 for institutional care, and National Standard Drug Claim Form for prescription and over-the-counter drugs.

Data standards should be stipulated in the request for proposal (RFP) and in the individual MCO contracts. RFPs/contracts should also specify how frequently data should be submitted, the maximum lag between date of service and encounter data submission, and the time lines for correcting and resubmitting rejected claims. If the language in these documents clearly addresses data standards, it will increase the quality, uniformity, and timeliness of the information submitted to the State.

Data Certification

The MCO must attest to the truthfulness, accuracy, and completeness of all data submitted, each time data is submitted to the State, based on best knowledge, information, and belief, even if the actual provider of services has a Medicaid provider agreement with the State. The data certification also applies to related entities, contractors, and subcontractors. These data include enrollment information, encounter data, and other information that the State may specify. This type of data certification strengthens the MFCUs' ability to prosecute claims under the False Claims Act. See Appendix 2 for a sample certification form.

Data Validation

To conduct credible analyses of managed care, the State must have confidence in the quality of the data. Data validation encompasses the concepts of data completeness as well as data accuracy. That is, a State must ensure that not only are encounters submitted for 100 percent of the Medicaid services provided, but also that critical data elements are present on all encounters and coded correctly.

There are four stages in the information flow where data accuracy and completeness can break down. The four stages are as follows:

- (i) getting the data into the MCO's management information system (MIS)
- (ii) getting the data through the MCO's MIS
- (iii) getting clean data out of the MCO's MIS and into the State's Medicaid management information system (MMIS), and
- (iv) getting the data through the State's MMIS.

Data accuracy is verified with basic system edits. These edits are automated checks that should exist in both the MCO's MIS and in the State's MMIS system. They ensure that the encounter claim contains valid values for key fields, such as Medicaid client identification (ID) number, provider ID number, date of service, procedure code, etc. The edits also ensure that the enrollee is a member of the managed care plan, that the date of service does not occur prior to the client's enrollment date, etc. Encounter claims that fail such basic edits should not progress through the information system. Instead, they should be returned to the MCO for correction and resubmission.

Data completeness edits should also be performed. These edits are more complex than data validation edits. Data completeness edits encompass strategies that determine if the database contains an encounter for each service rendered to a Medicaid enrollee. These strategies generally include comparison to FFS historical and current data to project likely service delivery and utilization, and comparison among MCOs. States and MCOs should have the capacity to conduct other analyses that will shed light upon the accuracy and completeness of their managed care data, including such things as on-site medical records reviews, client surveys, comparison to national data, hotline referrals/complaints, quality improvement focused studies, EQRO on-site reviews, etc. Additionally, States should require that MCOs perform utilization trending or other analyses. States may want to review HCFA's "A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data" for more detail.

Finally, States should partner with the MCO and provider community to ensure that the problems identified with data are improved. As noted above, States should include contract provisions for sanctions and incentives to get required, timely, and valid data from MCOs.

Data Integration

Once encounter and other data (e.g., enrollment) are defined, States must decide how to process the data received and manage the linkages among a State's automated systems, i.e., files within the MMIS and eligibility. For encounter data, two major options are available: send the data through the State's MMIS, or send it to a separate database such as a decision support system (DSS). Monitoring access to services is one process that often requires that data be linked to other Medicaid data sources, such as enrollment, client eligibility, and provider files.

Data Analysis

Under FFS, health care utilization analyses have historically included reviews of the following four components: overutilization, underutilization, and appropriate utilization defined in terms of the proper setting of care, and appropriate utilization within clinical focus areas. Utilization analyses under managed care have a different focus from those that are conducted under traditional FFS care. In particular, capitation creates incentives that are more likely to lead to underutilization than to overutilization. As a result, some measures should be designed to identify potential underutilization.

However, this should not eliminate the need to look at overutilization, utilization by setting of care, and utilization within clinical focus areas. Underutilization is one area that will often result in overutilization and/or inappropriate utilization in another area. For example, the underutilization of PCP services by enrollees can result in the overutilization of emergency room services. There are many established quality assurance criteria for determining this, such as the relationship between treatment of pediatric asthma and emergency room usage and other focused studies in disease done both by the State and MCOs. In addition to traditional SURS or SURS-like analysis, utilization review and manipulation of data could be done by using decision support systems, data warehousing, etc. Shifts in utilization should be critically reviewed for fraud or abuse when utilization is shifted to services carved out of the managed care benefit package or capitation reimbursement.

Penalties and Incentives

States must include in the MCO contracts provisions requiring the MCO to submit accurate and complete data in a timely manner. This requirement can be enhanced by including incentives for good performance and/or sanctions for bad performance. There should be an intermediate means to penalize and to provide incentives.

SECTION 4

KEY COMPONENTS OF AN EFFECTIVE MANAGED CARE FRAUD AND ABUSE PROGRAM

All participants in managed care programs should recognize the importance of and their responsibility for prevention and detection of fraud and abuse. This includes the State Medicaid agency, MCO, provider networks and subcontractors, recipients, MFCUs, OIG and HCFA. Each plays a role in awareness and knowledge of situations that may require investigation or referral.

This section describes the key components of an effective and comprehensive effort to prevent, detect, investigate, report, and prosecute fraud and abuse in managed care. The key components are: (1) formal plans, with clear goals, assignments, measurements and milestones; (2) prevention strategies; (3) coordination strategies; (4) detection strategies; (5) enforcement strategies; and (6) reporting strategies.

FORMAL PLANS

State Medicaid Agency Fraud and Abuse Plan

The State Medicaid agency should have a plan that outlines all of the State's fraud and abuse prevention and detection activities, key partners and stakeholders, and roles and responsibilities. This would encompass FFS and managed care programs. The plan should outline goals of fraud and abuse efforts; measurements to assess progress toward goals; areas of vulnerability and approaches to address vulnerabilities; and milestones for completion of key activities. The managed care portion of the plan should be incorporated into the State's Quality Improvement Strategy (QIS) for managed care.

The State Medicaid agency should also have adequate data systems and staff resources to maintain a successful plan. If the current data systems and resources are inadequate, the plan should include strategies to strengthen identified weaknesses and make the necessary investments in order to develop a successful program.

MCO Fraud and Abuse Plan

The MCO must have a formal commitment to prevent, detect, investigate, and report potential fraud and abuse occurrences as established by a State-approved fraud and abuse plan or program. In addition, some States are seeking to establish requirements for MCOs to adopt effective compliance programs. It is recommended that all States undertake similar action. Whether established as a compliance program or a State-approved fraud and abuse plan, managed care organizations should undertake such efforts as:

- (1) conducting regular reviews and audits of operations to guard against fraud and abuse;

- (2) assessing and strengthening internal controls to ensure claims are submitted and payments are made properly;
- (3) educating employees, network providers, and beneficiaries about fraud and how to report it;
- (4) effectively organizing resources to respond to complaints of fraud and abuse;
- (5) establishing procedures to process fraud and abuse complaints by the MCO;
- (6) establishing procedures for reporting information to the State Medicaid agency and;
- (7) developing procedures to monitor service patterns of providers, subcontractors, and beneficiaries.

The MCO should be monitoring provider fraud for underutilization of services and beneficiary/provider fraud for overutilization of services. An MCO might identify provider fraud and abuse by reviewing for a lack of referrals, improper coding (upcoding and unbundling), billing for services never rendered or inflating the bills for services and/or goods provided. An MCO might identify beneficiary fraud by reviewing access to services, such as improper prescriptions for controlled substances, inappropriate emergency care or card-sharing.

PREVENTION

Medicaid agencies should adopt successful fraud prevention activities, which may include:

Provider enrollment and contract requirements

As discussed earlier, setting appropriate requirements for MCOs to identify and report fraud and abuse can be a useful tool for Medicaid agencies in ensuring that they have fully committed partners in the anti-fraud and abuse effort. States should also ensure that key personnel in MCOs (owners, directors, managers, etc.) meet State requirements for experience, licensure, etc.; that networks are adequate; and that the MCO has adequate reserves and capital.

Beneficiary and provider outreach and education

States should ensure, either directly or through MCOs with appropriate oversight, that beneficiaries, providers, and their employees are effectively educated about their responsibilities, the responsibilities of others, what fraud and abuse is, and how and where to report it.

State hotlines

States should provide 24-hour toll-free hotlines to respond to complaints.

Assess program vulnerabilities

States should explore alternative ways of assessing program vulnerabilities, including: identifying potential program weaknesses; reviewing completed investigations; and conducting role playing sessions.

Agencies will also find that proactive enforcement actions combined with ongoing monitoring of MCO operations will deter fraud as well.

Identification of Debarred Individuals or Excluded Providers in MCOs

Exclusions of providers may occur due to OIG sanctions, failure to renew license or certification registration, revocation of professional license or certification, or termination by the State Medicaid agency. A good practice is to notify all MCOs of an exclusion initiated by any State or Federal agency so appropriate exclusion occurs by all MCOs and future participation is precluded.

It is recommended that the SMA inform MCOs how to access debarred and OIG sanction information on the Internet and advise that such individuals cannot be included in the Medicaid managed care program (also see 2/28/98 "Dear State Medicaid Director Letter"). The State is obligated to implement any exclusion of an individual or entity imposed by the OIG, and no payment may be made under the State plan with respect to any item or service furnished by such individual or entity during such period as authorized by Section 1902(a)(39) of the Social Security Act. A listing of parties excluded from Federal procurement and non-procurement programs can be found at the following Internet addresses:

<http://www.arnet.gov/epl>

<http://www.dhhs.gov.oig/>

The State Medicaid agency may choose to conduct periodic reviews of the MCO provider/subcontractor credentialing process and network to determine if appropriate exclusions have occurred. The State may be able to use encounter data to determine if any claims billed after the Federal/State exclusion date occurred and if any corrective action is required by the MCO.

COORDINATION

A number of key coordination activities are necessary within the State in order to fully take advantage of resources available to work on fraud and abuse issues.

MCO Networking with MFCU/DA, State Medicaid Agency, and EQRO

The Flow Charts on Reporting of Suspected Cases of Medicaid Managed Care Fraud and Abuse shown on pages 45 and 46 suggest a method for a timely and consistent exchange of information regarding potential fraud and abuse occurrences. This should include regular meetings with the MCO fraud and abuse staff, State Medicaid agency, MFCU, and EQRO to discuss a plan of action. MCO reporting procedures and time lines for abuse complaints and the outcomes should be established in the State-approved MCO fraud and abuse detection plan with monitoring by the State Medicaid agency. It is important with suspected fraud cases that the MFCU be involved in the initial planning stage of the investigation. The MFCU and SMA should identify and provide training to the MCO and EQRO. Also, the MFCU and SMA should alert the MCO and EQRO of any additional staff training needs.

State Medicaid Agency Quality Improvement (QI) Staff Communication with SURS/SURS-like Staff

With the implementation of Medicaid managed care programs, a partnership between a States' managed care QI staff and SURS or SURS-like staff should be a primary objective. Some States may already have established QI communications with designated SURS/SURS-like staff.

The following is a list of potential fraud and abuse areas that may already be monitored by QI activities or that may require expanded monitoring with the assistance of State SURS or SURS-like staff:

- C inadequate provider networks,
- C ineffective grievance process,
- C failure to provide outreach and educational materials, and
- C failure to provide EPSDT screens, immunizations, or other preventive or other medically necessary services, etc.

In addition, SURS/SURS-like staff involvement might include participation in the review and approval of MCO fraud and abuse plans, attendance at case development meetings, review of MCO required reports regarding fraud and abuse activities, and/or random on-site monitoring during the QI review and feedback process. A State may also include, as part of the annual MCO contract compliance review, data validation monitoring, or elect to have focused fraud and abuse studies performed.

Coordination of reviews by different entities of same provider(s)

Communication among different investigating entities is crucial because individual providers participate in more than one Medicaid delivery system. For example, a FFS provider being reviewed by State program integrity (PI) and MFCU staff may also be enrolled in an MCO provider network; or an MCO may have identified a provider who participates in other MCO plans. There should be established collaboration between the SMA, MCO, and MFCU to develop and implement a review plan.

Communication with Medicare and other State Medicaid Staff

To complement Federal, State, MCO, and MFCU partnerships, it is recommended that Medicare staff be contacted when occurrences of fraud and abuse are identified. It is suggested that the State Medicaid agency be the contact agency so as to coordinate consistent exchange of information and to develop a process to receive referrals from Medicare staff.

Increasingly, fraud is perpetrated across state lines; therefore, it is useful for States to establish regional coordinating councils to exchange information.

Reporting to HCFA

Once fraud has been identified and the State Medicaid Agency is seeking to impose a sanction, this

information should be reported to HCFA. Regulations at 42 CFR 434.67 require that States give notice to HCFA whenever it recommends imposition of a sanction. HCFA will refer appropriate cases to the OIG for imposition of administrative sanctions, including civil monetary penalties.

DETECTION

The key to an effective anti-fraud and abuse program is to gather information on MCO and subcontractor provider performance. See Section 3, “Data Needed to Detect and Prosecute Fraud and Abuse in Managed Care” for more detail. Some sources of this information are:

- C Surveillance Utilization Reviews at the State Medicaid agency for FFS services carved out of the capitated rate,
- C Surveillance Utilization Reviews at the MCO for services covered under the capitated rate,
- C Complaint hotlines at the State or MCO for the identification of enrollee, provider, or MCO fraud and abuse,
- C MCO Credentialing Committee meeting minutes,
- C MCO Quality Assurance meeting minutes, reports, and special projects,
- C EQRO reports with indications of inadequate or inappropriate levels of service to enrollees,
- C Enrollment contractor identification of ineligible beneficiaries or inappropriate beneficiary disenrollments by the MCO,
- C Regular and unannounced monitoring of contract compliance by State staff supervising the MCOs,
- C Routine reviews of encounter data by State staff supervising the MCOs,
- C Review of the MCO’s protocols,
- C Use of the debarred provider list,
- C Reviews of standardized quality measures against minimum performance levels and Quality Performance Improvement Projects (PIP) conducted under the State’s implementation of the Quality Improvement System for Managed Care (QISMC).

State agencies should combine the following techniques to identify fraud: (1) data analysis comparing MCOs on such indices as utilization, performance, outcomes, referrals, disenrollments, followed by focused reviews on areas of aberrancy; (2) routine reviews on particular problem areas; (3) routine validation of MCO data; (4) random reviews and beneficiary interviews; (5) unannounced site visits; and (6) the use of feedback and quality improvement.

Comparative analysis

A State Medicaid agency may elect to perform a comparison of MCOs within regions or statewide. Individual patterns of providers or subcontractors may not be significantly unusual but the cumulative

pattern within an MCO may require further review. It is recommended that the State's data systems be used to identify managed care utilization patterns that may assist in the case development and in the review.

Routine reviews on problem areas

As part of its fraud and abuse strategy, State Medicaid agencies should identify areas of a particular focus that will receive special attention during routine monitoring of MCO activities. These areas should be identified through systematic risk assessment, and could include, but not be limited to, items such as:

- (1) ensuring that providers within networks are eligible to participate in Medicaid;
- (2) ensuring that beneficiaries claimed as enrolled in the MCO are in fact enrolled;
- (3) ensuring that MCO employees understand Medicaid rules, can define fraud, and know where, how, and when to report it.

For example, the State Medicaid agency may choose to conduct periodic reviews of the MCO provider/subcontractor credentialing process and network to determine if appropriate exclusions have occurred. The State may be able to use encounter data to determine if any claims billed after the Federal/State exclusion date occurred and if any corrective action is required by the MCO.

Validation of managed care service data

The State Medicaid agency should have a process to ensure accurate managed care service data. This might include examining a sample of provider descriptive data to verify provider identifying information, license, certification, and debarred/exclusion status. A similar type of beneficiary enrollment information for beneficiary eligibility, address, plan enrollment date/file, and PCP may be applicable.

Validation of encounter data with comparison to the medical record is a very important component to ensure that complete and accurate information is submitted by MCOs, and received by the State Medicaid agency. The State Medicaid agency may elect to perform monthly random samples of each MCO or incorporate validation in the QI or EQRO review. The MCO might also perform a medical record validation review with monitoring by the State Medicaid agency. See Section 3, "Data Needed to Detect and Prosecute Fraud and Abuse in Managed Care," for more details on data validation.

Random reviews and beneficiary interviews

States should plan for a minimum level of random reviews, in which a selected universe of beneficiaries are contacted for interviews. Medical records should also be reviewed to identify any possible errors or evidence of abuse and/or fraud.

Unannounced site visits

State plans should also call for unannounced site visits, particularly to MCOs for which some significant concerns exist. During unannounced site visits, reviewers can observe encounters, interview beneficiaries

or employees, confirm the accuracy of facility-based information, and/or review records.

Use of Feedback and Quality Improvement

The results of reviews and investigations should be used to improve managed care systems. The goal is to prevent the same fraud and abuse from recurring. This use of feedback is integral to managed care quality improvement. The use of quality assessment and improvement processes can help the State Medicaid agency determine how to do this.

ENFORCEMENT

It is essential that strong relationships exist between program managers and MFCU staff, so that potential fraud is referred quickly and MFCU staff can make the appropriate assessment of whether to initiate an investigation. Early referral by Medicaid Staff is the most appropriate vehicle for proper disposition. Specific protocols for referral of potential fraud should be developed on a State-by-State basis, considering the resources available in the State agency and MFCU, and the current caseload of the MFCU. Communication with the MFCU on whether to obtain additional information, or pursue administrative remedies, or that would allow MFCU staff to launch an investigation will assist the Medicaid staff in developing a complete and accurate case that may enhance the potential MFCU investigation.

MFCU staff should quickly assess the case, so that the Medicaid agency can pursue appropriate administrative or intermediate remedies under their authority, if necessary. At the Federal level, Medicare contractors are instructed via the Medicare Carriers Manual at Section 14000ff and Medicare Intermediary Manual at Section 3950ff to refer matters to law enforcement at the time they suspect fraud. For their part, Federal law enforcement officials must respond within 90 days. Similar protocols should be instituted at the State level.

States should also develop a complete “toolbox” of enforcement actions including analysis and investigation and enforcement remedies including fraud and abuse sanctions to address varying degrees of problems. Payment suspensions, intermediate sanctions, civil monetary penalties, exclusions, and other tools may allow State agencies to respond appropriately to fraud and abuse.

Analysis and Investigation

Once potential fraud or abuse is identified, the State Medicaid agency and the MFCU are the key players in deciding whether the information provided indicates fraud or abuse and what to do about it. As in a Medicaid FFS program, communication and cooperation between these two organizations is essential to assure timely action and to avoid duplication of effort. It may also be useful for the State Medicaid agency to give SURS/SURS-like units and MFCUs direct access to encounter data.

The proposed Flow Charts included in the back of this section on pages 45 and 46 demonstrate that an MCO or State should report a possible fraudulent situation once it becomes aware of it through one of the internal activities listed above. The facts and data provided should be reviewed to determine what future action should be taken on the case. The options may include the following:

- (i) referral back for additional information/investigation,
- (i) further development of the case (review of additional encounter claims, interviews, etc.) by the SURS/SURS-like unit or other appropriate State staff, or
- (ii) direct referral of the case to the MFCU/DA for prosecution.

Action taken on the case will determine whether the group needs to come together again after the case has been developed to determine the course of action to be taken (recovery, intermediate sanction, disenrollment, civil or criminal prosecution, etc.). Additionally, the MCO, the SMA, the MFCU/DA, and HCFA should be informed of the final outcome of the case. Collaboration by all of the parties involved will result in a conscious focus on fraud and abuse, a deterrent to future fraud, recoveries of inappropriately expended funds, and a strong fraud and abuse partnership.

Fraud and Abuse Sanctions

As in a Medicaid FFS program, fraud and abuse in a managed care program carries with it a variety of penalties. They include the following:

Administrative/Formal Actions

- C Suspensions: Provider claims can be processed but not paid or capitation payments could be withheld.
- C Permissive Exclusion by MCO/State: Either the MCO or the State, based on appropriate State law, can exclude a provider from participation for financial misconduct, including not having records to support claims.
- C Permissive and Mandatory Exclusions by Federal government: The Federal government, through the OIG, can impose various administrative sanctions, including civil money penalties and program exclusions. Medicaid MCOs can be excluded for failing substantially to provide medically necessary items and services that are required...to be provided to individuals covered under that plan...as authorized by Section 1128(b)(6)(C)

of the Social Security Act.

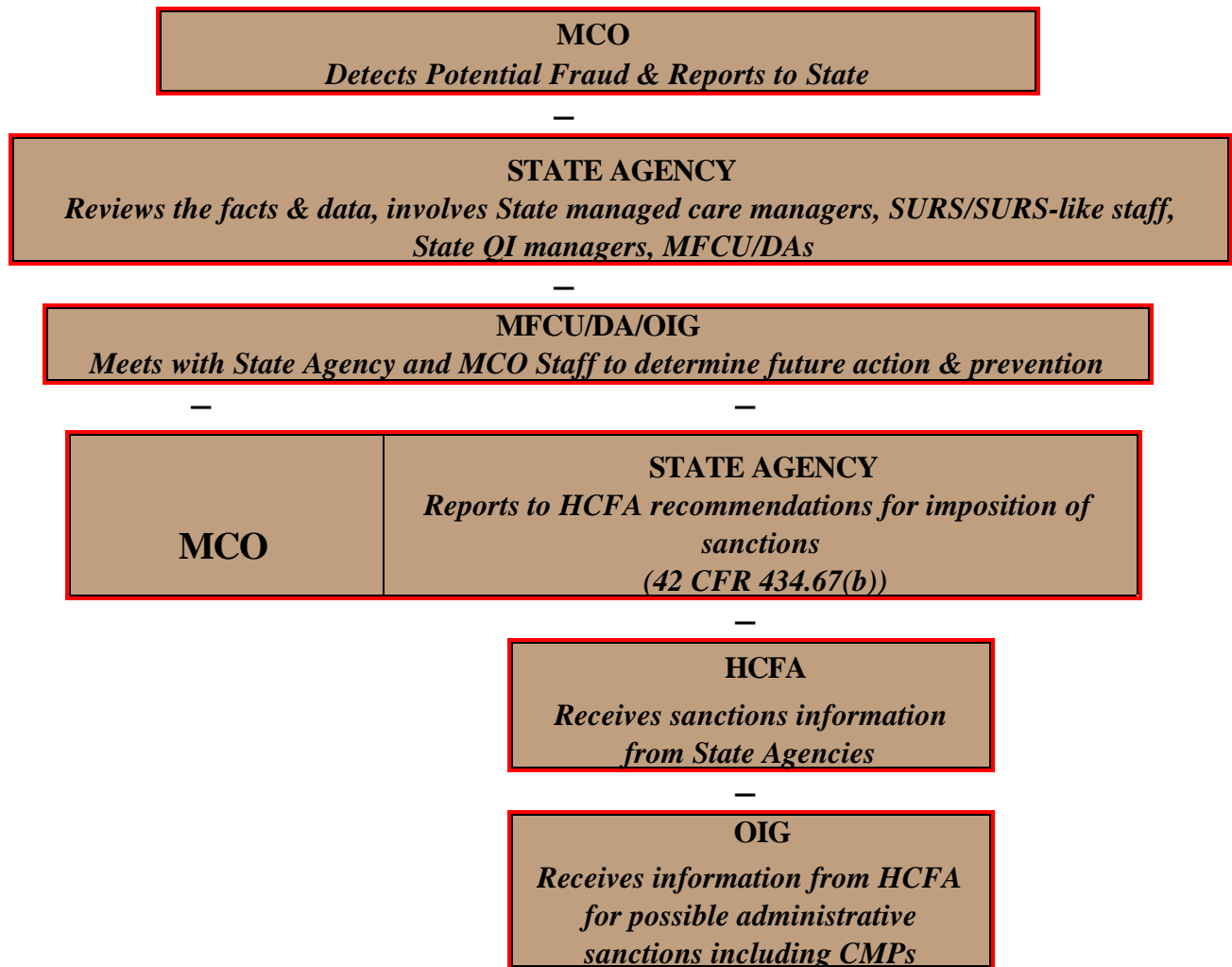
- C Corrective Action Plans: States can negotiate or mandate a list of actions that the MCO and/or its subcontractors must complete within a specified time to avoid informal or formal penalties.
- C Prosecution: Either civil or criminal by either the MFCU or a local District Attorney.
- C Overpayment Collection: Either directly from the entity committing fraud or abuse or by offsetting overpayments against allowable claims or capitated rates.
- C Civil Money Penalties: Additional charges over the amount of overpayments.
- C Temporary State Management: The State temporarily takes over management of the MCO because of repeated abuses.
- C Suspensions in Enrollment: Applied to MCOs for violations of contract compliance. The State suspends enrollment of new beneficiaries into the MCO.
- C Debarment: Working with State licensing boards to suspend or withdraw licenses.
- C Non-renewal: Refusing to extend an MCO contract or to allow MCO to bid on another one.
- C Contract Revision: Requiring an MCO to execute a change in its contract or in its subcontracts to address fraud and abuse issues.
- C Termination of a Managed Care Entity (MCE): Applied to an MCE for violations of contract compliance or for violations of section 1932, 1903(m) or 1905(t) of the Social Security Act.

REPORTING OF SUSPECTED CASES OF MEDICAID MANAGED CARE FRAUD AND ABUSE

State Medicaid Agencies and Managed Care Organizations should have procedures for exchange of information and collaboration among all involved parties to determine the best course of action for suspected cases of fraud. As discussed in previous sections, there should be general requirements stated in the MCO contract, the annual state contract compliance review protocol, the interagency agreement between the State and MFCU, and State operational procedures to support a State's Medicaid program integrity plan as federally required. The following Medicaid Managed Care Fraud and Abuse Reporting Flow Charts and other supporting functions recommended in this section will also assist in the achievement of the goal.

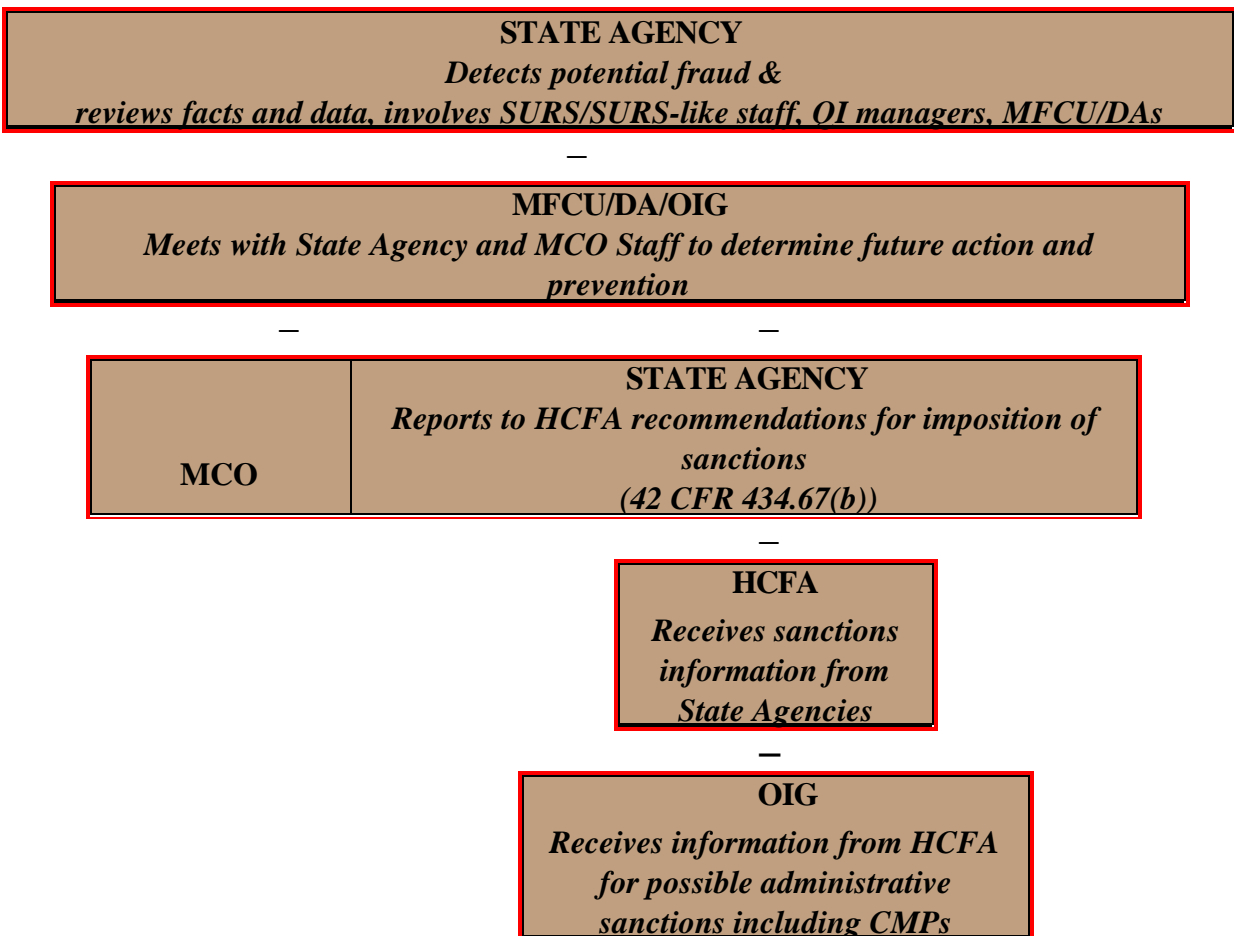
Potential Fraud Cases Detected by the MCO

Once the MCO detects a situation of potential fraud perpetrated by a provider of services or a beneficiary, it should notify the Medicaid agency. The State should ensure coordination with managed care managers, SURs or SURS-like unit staff, quality improvement staff and MFCU staff. In cases where SURS and QA staff are not the same, QA staff should be actively involved. (In most States, if the potential fraud involves a Medicaid beneficiary, reporting and prosecution is handled through local district attorneys' offices.) Once an appropriate course of action is determined, all stakeholders should be informed of the outcome of the case in order to develop corrective action plans and integrate follow-up and prevention into the relevant quality improvement strategies and plans. **States should report recommendations for imposition of sanctions to HCFA as required by regulations at 42 CFR 434.67.** This suggested reporting strategy is not meant to take the place of States' own administrative remedy processes, but has been developed as guidance if a State chooses to use sanctions outside of its purview.



Potential Fraud Cases Detected by the State

Once the State detects a situation of potential fraud perpetrated by the MCO, either by its SURS or SURS-like staff, data analysis, State hotlines, etc., the State should ensure coordination with SURS or SURS-like staff, managed care managers, quality improvement, MFCU, and HCFA staff. In cases where SURS and QA staff are not the same, QA staff should be actively involved. (In most States, if the potential fraud involves a Medicaid beneficiary, reporting and prosecution is handled through local district attorneys' offices.) Once an appropriate course of action is determined, all stakeholders should be informed of the outcome of the case in order to develop corrective action plans and integrate follow-up and prevention into the relevant quality improvement strategies and plans. **States should report recommendations for imposition of sanctions to HCFA as required by regulations at 42 CFR 434.67.** This suggested reporting strategy is not meant to take the place of States' own administrative remedy processes, but has been developed as guidance if a State chooses to use sanctions outside of its purview.



SECTION 5

FRAUD AND ABUSE IN MANAGED CARE CONTRACTS, PROGRAMS, AND WAIVERS

States can promote program integrity in Medicaid managed care programs by incorporating language with explicit fraud and abuse measures into contracts, programs, and waivers. The comparison chart in Appendix 1 suggests strategies that States may use to strengthen efforts to combat fraud and abuse and identifies requirements of Federal statutes and regulations. In some cases, these same provisions are explicitly required to be in the MCO contract. If there is not an explicit requirement for the mandatory provisions in the contract, or if the State has no statutory or regulatory authority, these requirements should appear elsewhere in the governing authority for the program, such as in the waiver providing authority to operate the program. For information on official State statutes relating to fraud and abuse in Medicaid managed care, refer to the Medicaid Fraud Statutes Web Site (<http://fightfraud.hcfa.gov/mfs>).

It is suggested that each State develop a definition of the terms “fraud” and “abuse” in their contracts with managed care organizations.

It is recommended that States require reporting of suspected fraud, and that States require the establishment of fraud and abuse units within MCOs.

Encounter data is an important part of the fraud and abuse monitoring function. It is suggested that States define encounter data, what constitutes data elements and validation of data. The Chief, Executive Officer or Chief, Financial Officer of MCOs should attest to the truthfulness, accuracy, and completeness of all data submitted, each time data is submitted to the State. Further, the States should define “timely” and what the State considers acceptable in encounter data submission. It would be useful for States to include contract provisions for sanctions and incentives to obtain required, timely, and valid data from MCOs.

States require MCOs to submit periodic written reports on their fraud and abuse activities, so that these can be monitored and assistance or guidance given as needed. The State should also specify the frequency and format of the report for consistency of information.

Marketing can be a potential source of fraud and abuse, especially if reimbursement or compensation for marketers is linked to the number of new enrollees. If marketing is permitted by States, it is recommended that States require information on incentives for marketing staff, and monitor activities to ensure that marketing practices are not coercive or fraudulent. For instance, the State could survey a sample of new

enrollees to verify the new enrollees had a choice in their selection of an MCO and monitor their enrollment experience.

The delivery of service is the essence of the program, and Federal regulations require States to have a process of verifying delivery of service (see 42 CFR 434.52 and 434.53). We also suggest that States require MCOs report results of this process. One example of an acceptable delivery of service verification is encounter data collection and validation. Another would be random medical record review as validation that the services were actually rendered as reported.

Education and training are imperative in new initiatives and it is suggested that States provide providers and beneficiaries' materials that include education about fraud and abuse identification and reporting. It is also recommended that State Medicaid agencies provide training to MCOs on the prevention, detection, reporting, and investigation of fraud and abuse. Collaboration with MFCUs could enhance such training.

For further guidance on new BBA provisions, the "Dear State Medicaid Director" letters on this subject can be reviewed on HCFA's Web site (<http://www.hcfa.gov/medicaid/bbasltrs.htm>). For ideas or examples of contract language, refer to the Center for Health Policy Research's, "Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts" at their Internet address: <http://www.gwumc.edu/chpr/introov.htm>.

Appendix 1

Comparison Chart of Fraud and Abuse Requirements and/or Suggestions for Medicaid Managed Care Contracts, Programs, and Waivers

Column explanations:

“Included in Contract” refers to MCO contracts in all Medicaid managed care programs (1915(a)--voluntary, 1915(b), 1115, and 1932(a)--State Plan Amendment).

“Included in Program” refers to a State’s program (State Plan Amendment).

“Included in Waiver” refers to waiver application for 1915(b) or 1115 program (column does not apply to voluntary programs).

“Suggested” refers to provisions that would be beneficial to have included in contracts, programs, and/or waivers.

“Required” refers to provisions that must be included in contracts, programs, and/or waivers.

PHP Applicability: Suggested provisions apply to both MCOs and PHPs
 Required provisions apply to PHPs only if indicated

THE DESCRIPTION UNDER THE SUBJECT HEADING IS A PARAPHRASE OF THE OFFICIAL REFERENCE.

Note: Those regulatory citations with an “*” are based on the Medicaid Managed Care Notice of Proposed Rulemaking of 9/29/98 and could become final rule at any time.

Legal Citation (as applicable)	Subject	Included in Contract	Included in SPA	
	Abuse Reporting - require MCOs to report physical/sexual/emotional abuse of enrollees by providers to appropriate State agency	Suggested	Suggested	Suggested
	Complaints - Fraud and Abuse - State should have a way to track separately fraud and abuse complaints	Suggested	Suggested	Suggested
	Complaints - Grievances - State should have a way to track grievances	Suggested	Suggested	Suggested
	Cooperation - require in the contract that MCO and subcontractors cooperate fully with federal and State agencies in any investigations and subsequent legal actions	Suggested	Suggested	Suggested
	Definition - define fraud and abuse in the contract	Suggested	Suggested	Suggested
1903(m)(2)(A)(viii) 42 CFR 455.100-104 SMM 2087.5(A-D) SMD letter 2/20/98	Disclosure of Ownership - MCO must provide full and complete information on the identity of each person or corporation with an ownership or controlling interest (5%+) in the managed care plan, or any subcontractor in which MCO has a 5% or more ownership interest	Yes (PHPs also)	Yes	Yes
	Education - include education about fraud and abuse identification and reporting in provider and beneficiary material	Suggested	Suggested	Suggested
	Encounter data - require encounter data, including data elements and valid values; require the timely submission of complete encounter data (and define timely); and schedule for correction and resubmission of rejected claims	Suggested	Suggested	Suggested

Legal Citation (as applicable)	Subject	Included in Contract	Included in SPA	
42 CFR 438.602* 42 CFR 438.608*	Encounter data and other data submitted to States - certification - Require the MCO attest to the truthfulness, accuracy, and completeness of all data submitted, each time data is submitted to the State. Claim certification should also be required from each provider submitting data to the MCO (see Appendix 2)	Yes (PHPs also)	Suggested	Suggested
	Encounter data - incentives/sanctions - include contract provisions for sanctions and incentives to get required, timely, and valid data from MCOs	Suggested	Suggested	Suggested
1903(b)(4) BBA 4707(b) 42 CFR 438.810*	Enrollment Broker - Independence - Must be independent of health care providers that provide coverage of services in the same State in which the broker is conducting enrollment activities (whether or not any such provider participates in the State Plan) (Note: Enrollment Broker contracts are agreements between the enrollment broker and the State and are not considered MCO contracts.)	Suggested	Yes	Yes
1903(b)(4) BBA 4707(b) 42 CFR 438.810*	Enrollment Broker - Prohibited Affiliations - Owner/employee/consultant who has direct or indirect financial interest in health care providers - or - who is excluded by Medicaid, Medicare, or other federal agency - or - against whom a civil monetary penalty has been assessed	Suggested	Yes	Yes
	Excluded providers - States notify all MCOs of any exclusion initiated by the State Medicaid agency for a FFS provider so MCO(s) can exclude from the network. Inform MCOs how to access debarred and OIG sanction information on the Internet. Conduct periodic reviews of the MCO provider/subcontractor credentialing process and network to ensure exclusions made by MCOs	Suggested	Suggested	Suggested

Legal Citation (as applicable)	Subject	Included in Contract	Included in SPA	
	Internal MCO/PHP Plan - Require MCOs to have in place internal controls, policies, and procedures to prevent and detect fraud and abuse, and that States monitor these.	Suggested	Suggested	Suggested
	Internal MCO/PHP Plan-Components - Require: - Contact name, - Procedures for prevention, detecting, reporting, and reviewing until resolution, - Reporting suspected and verified cases to State, - Training of staff - The information sharing structure/process and reporting between plan UR, QA, credentialing committees, and fraud and abuse	Suggested	Suggested	Suggested
1932(d)(2)(E) BBA 4707(a) 42 CFR 438.104* SMD 12/30/97	Marketing - Cold Call - MCO may not, directly or indirectly, conduct door-to-door, telephonic, or other cold call marketing	Yes (PHPs also)	Suggested	Suggested
1932(d)(2)(A) BBA 4707(a) 42 CFR 438.104* SMD 12/30/97	Marketing-Committee Review - State shall consult with Medical Care Advisory Committee when reviewing/approving marketing material	Suggested	Yes	Yes
1932(d)(2)(D) BBA 4707(a) 42 CFR 434.36, 438.104* SMM 2090.1 SMD 12/30/97	Marketing - Fraud - MCO must comply with federal requirements for provision of information which ensures potential enrollee is provided accurate oral and written information sufficient to make informed decision whether or not to enroll	Yes (PHPs also)	Suggested	Suggested

Legal Citation (as applicable)	Subject	Included in Contract	Included in SPA	
	Marketing - Monitoring Incentives - If States allow MCO marketing, and specifically, commission-based reimbursement for marketing representatives, State should monitor.	Suggested	Suggested	Suggested
1932(d)(2)(A) BBA 4707(a) 42 CFR 438.104* SMD 12/30/97	Marketing - Prior Approval - State must prior approve all marketing material.	Suggested	Yes	Yes
1932(d)(2)(A) BBA 4707(a) 42 CFR 434.36, 438.104* SMD 12/30/97	Marketing - Prohibit False Information - marketing materials may not contain false or materially misleading information	Yes (PHPs also)	Suggested	Suggested
1932(d)(2)(B) BBA 4707(a) 42 CFR 438.104* SMD 12/30/97	Marketing - Service Area - MCO must market to entire service area under contract.	Yes (PHPs also)	Suggested	Suggested
1932(d)(2)(C) BBA 4707(a) 42 CFR 438.104* SMD 12/30/97	Marketing - Tie-ins - MCO may not offer other insurance products as inducement to enroll	Yes (PHPs also)	Suggested	Suggested
1932(d)(4) BBA 4707	Physician Identifier - MCO must require each physician to have a unique identifier (Note: this requirement becomes effective when that system is put in place).	Future Suggestion	Future Requirement	Future Requirement

Legal Citation (as applicable)	Subject	Included in Contract	Included in SPA	
1932(e)(4) BBA 4707(a) 42 CFR 438.720* SMD letter 2/20/98	Pre-Termination Hearing - Opportunity - State must give MCO a hearing prior to terminating a contract (except when imposing temporary management).	Suggested	Yes	Yes
1932(d)(1) BBA 4707(a) 42 CFR 434.80 SMD letter 2/20/98	Prohibited Affiliations - MCO Employees - MCO may not knowingly have an individual who has been debarred, suspended, or otherwise excluded from participating in federal procurement activities or has an employment, consulting, or other agreement with debarred individual for the provision of items and services that are significant to the entity's contractual obligation with the State	Suggested	Yes	Yes
1932(d)(1)(A) BBA 4707(a) SMD letter 2/20/98	Prohibited Affiliations - Ownership - MCO may not knowingly have an individual who has been debarred, suspended, or otherwise excluded from participating in federal procurement activities, as a director, officer, partner, or person with beneficial ownership of more than 5% of the MCO's equity.	Suggested	Yes	Yes
42 CFR 434.6(a)(7) SMM 2080.13	Records - require MCO maintain appropriate record system for services to enrollees	Yes (PHPs also)	Suggested	Suggested
1903(m)(2)(A)(iv) 42 CFR 434.38 SMM 2087.7	Records - Financial Audit - State must be able to audit and inspect MCO and subcontractor books and records related to capacity to bear risk of potential financial loss.	Yes (PHPs also)	Suggested	Suggested
42 CFR 434.6(a)(5) 434.34, SMM 2080.9, 2091.2	Records - Inspection - State and DHHS may evaluate, through inspection or other means, the quality, appropriateness, and timeliness of services performed under the contract, and the reasonableness of their cost	Yes (PHPs also)	Suggested	Suggested

Legal Citation (as applicable)	Subject	Included in Contract	Included in SPA	
42 CFR 434.6(a)(7) 45 CFR 74.53, 92.36(i)(11)	Records - Retention - retain records in accordance with 45 CFR Part 74 (3 years after final payment is made and all pending matters closed, or if an audit, litigation, or other legal action involving the records is started before or during the original 3-year period until all litigation, claims, or audit findings involving the records have been resolved and final action taken).	Yes (PHPs also)	Suggested	Suggested
42 CFR 455.1(a)(1)	Report - State must report fraud and abuse information to DHHS.	Suggested	Yes	Yes
42 CFR 455.17	Report - Require State to report the following to DHHS: number of complaints of fraud and abuse made to State that warrant preliminary investigation. For each instance, which warrants investigation, supply: C Name/id number C Source of complaint C Type of provider C Nature of complaint C Approximate dollars involved, and C Legal and administrative disposition of case	Suggested	Yes	Yes
	Report Frequency/Format - Specify in program/waiver; include maximum time allowed between detection and reporting	Suggested	Suggested	Suggested
42 CFR 438.606*	Report - MCO must report fraud and abuse information to State.	Yes (PHPs also)	Suggested	Suggested

Legal Citation (as applicable)	Subject	Included in Contract	Included in SPA	
	<p>Report - Require MCO to report the following to State: number of complaints of fraud and abuse made to State that warrant preliminary investigation. For each instance, which warrants investigation, supply:</p> <ul style="list-style-type: none"> C Name/id number C Source of complaint C Type of provider C Nature of complaint C Approximate dollars involved, and C Legal and administrative disposition of case 	Suggested	Suggested	Suggested
	<p>Report - Frequency/Format -Specify in MCO contract; include maximum time allowed between detection and reporting</p>	Suggested	Suggested	Suggested
42 CFR 434.67(b)	<p>Report - States must report recommendations of imposition of sanctions to HCFA</p>	Suggested	Yes	Yes
1903(m)(5)(B)(ii) 42 CFR 434.22 434.42, 434.67 SMM 2092.4	<p>Sanctions - Payment - Payments denied for new enrollees when, and for as long as, payment for those enrollees is denied by HCFA per 42 CFR 434.67(e), for one of the violations listed in next item (Note: This sanction is imposed in addition to any intermediate sanction imposed per next item) *Note: OIG can impose Federal sanction as authorized by Title XIX. See also, OIG CMP chart contained in Appendix 4.</p>	Yes (PHPs also)	Suggested	Suggested

Legal Citation (as applicable)	Subject	Included in Contract	Included in SPA	
1932(e)(1-2) BBA 4707(a) 42 CFR 438.700*, 438.702* SMD letter 2/20/98	<p>Sanctions - Intermediate - specify intermediate sanctions if contractor:</p> <ul style="list-style-type: none"> C fails substantially to provide medically necessary items and services that are required (under law or under contract with the State) to be provided to an enrollee covered under the contract, C impose premiums/charges in excess of those allowed by law (i.e., greater than FFS limits), C discriminates based on health status, C misrepresents/falsifies information, C fails to comply with Physician Incentive Plan requirements C may not distribute directly or indirectly marketing materials that contain false or materially misleading information C fails to provide abortion services if the contract requires that abortion services must be provided <p>(Note: It is up to States to determine type of sanction to use. Examples in statutes are civil monetary penalties, temporary management, notifying and allowing enrollees to terminate without cause, suspending enrollment, and suspending payment.) *Note: OIG can impose Federal sanctions as authorized by Title XIX. See also OIG CMP chart which is contained in Appendix 4.</p>	Suggested	Yes	Yes
42 CFR 455.1(a)(2)	Service Verification - State must have a method to verify services actually provided	Suggested	Yes	Yes
	Service Verification - MCO must have a method to verify services actually provided.	Suggested	Suggested	Suggested

Legal Citation (as applicable)	Subject	Included in Contract	Included in SPA	
1932(d)(3) BBA 4707(a) 42 CFR 438.58* SMD letter 12/30/97	State Conflict of Interest Safeguards - MCO may not contract with State unless the State has conflict of interest safeguards at least as effective as federal safeguards (41 USC 423, section 27).	Suggested	Yes	Yes
	State - Informing MCOs - inform MCOs of fraud and abuse requirements, e.g., internal plan, reporting, cooperation, etc.	Suggested	Suggested	Suggested
	State - FFS vs. Managed Care - comparison of fraud and abuse monitoring activities	Suggested	Suggested	Suggested
	State Monitoring - specific monitoring plan for managed care fraud and abuse, including the use of QI strategy	Suggested	Suggested	Suggested
	State Resources - identification of staff and other resources devoted to monitoring fraud and abuse for effective oversight of fraud and abuse in managed care; resource analysis could be included in waiver application	Suggested	Suggested	Suggested
	State Systems - capable of exchanging fraud and abuse data with MCO; summary of system could be included in waiver application	Suggested	Suggested	Suggested
1932(e)(3) & (4) 1932(e)(2)(B) and (C) BBA 4707(a) 42 CFR 438.718* SMD letter 2/20/98	Termination Criteria - State can terminate a contract if contractor fails to meet contract or BBA requirements. Where the State opts not to terminate a contract after repeat violations, continued egregious behavior, or if there is substantial risk to health of enrollees, the contract must allow the State to appoint temporary management to oversee the entity AND enrollees must be allowed to disenroll without cause and be notified of ability to do so.	Suggested	Yes	Yes

Legal Citation (as applicable)	Subject	Included in Contract	Included in SPA	
1932(d)(1) BBA 4707(a) SMD letter 2/20/98	Termination for Prohibited Affiliations - State may continue existing contract (unless Secretary directs otherwise) but may not extend or renew contract unless the Secretary provides to the State and Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.	Suggested	Yes	Yes
	Training - State training for MCOs on fraud and abuse prevention, detection, reporting, and investigation of fraud and abuse. Collaborate with MFCUs.	Suggested	Suggested	Suggested

Appendix 2

Sample Certification Form

This appendix includes the State of New York's proposed language for data submission certification for the New York Medicaid program.

CERTIFICATION

Provider certifies that the business entity named on this form _____ is a qualified provider enrolled with and authorized to participate in the New York State Medical Assistance Program as a managed care organization (MCO); this form has been reviewed; pursuant to its contract the MCO has assigned, has made good faith efforts to assign and will continue to make good faith efforts to assign a primary care physician to each Medicaid recipient listed hereon as well as arranged and will continue to arrange for all medically necessary care, services, and supplies to be provided to each Medicaid recipient listed hereon in accordance with the terms of the managed care contract with the State and that the amounts listed are due and, except as noted, no part thereof has been paid by, or to the best of my knowledge is payable from any source other than, the Medical Assistance Program; payment of fees made in accordance with established schedules is accepted as payment in full; other than a claim rejected or denied or one for adjustment, no previous claim for the care, services and supplies itemized has been submitted or paid; **ALL STATEMENTS MADE HEREON ARE TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE; NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM; I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL, STATE, AND LOCAL PUBLIC FUNDS AND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT;** taxes from which the State is exempt are excluded; all records pertaining to the care, services and supplies provided including all records which are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medical Assistance Program will be kept for a period of six years from the date of payment, and such records and information regarding this claim and payment, therefore, shall be promptly furnished upon request to the local or State Department of Social Services, the State Medicaid Fraud Control Unit or the Secretary of the Department of Health and Human Services; there has been compliance with the

Federal Civil Rights Act of 1964 and with section 504 of the Federal Rehabilitation Act of 1973, as amended, which forbid discrimination on the basis of race, color, national origin, disability, age, sex, religion; I agree (or the entity agrees) to comply with the requirement of 42 CFR Part 455 relating to disclosures by providers; the State of New York through its fiscal agent or otherwise is hereby authorized to (1) make administrative corrections to this claim to enable its automated processing, subject to reversal by provider, and (2) accept the claim data on this form as original evidence of care, services, and supplies furnished.

By making this claim, I understand and agree that MCO shall be subject to and bound by all rules, regulations, policies, standards, fee codes, and procedures of the New York State Department of Social Services as set forth in Title 18 and 10 of the Official Compilation of Codes, Rules and Regulations of New York State, and other publications of the Department, including Medicaid Management Information System Provider Manuals and other official bulletins of the Department, as adopted by the Commissioner of the Department of Health. I understand and agree that I (or the entity) shall be subject to and shall accept, subject to due process of law, any determinations pursuant to said rules, regulations, policies, standards, fee codes, and procedures, including, but not limited to, any duly made determination affecting the MCO's past, present, and future status in the Medicaid program and/or imposing any duly considered sanction or penalty.

I understand that my signature on the face hereof incorporates the above certifications and attests to their truth.

Appendix 3

LIST OF ACRONYMS

BBA	Balanced Budget Act
BHO	Behavioral Health Organization
DHHS	Department of Health and Human Services
DA	District Attorney
DSS	Decision Support System
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQRO	External Quality Review Organization
FFS	Fee-for-Service
HCFA	Health Care Financing Administration
HIV	Human Immunodeficiency Virus
HIO	Health Insuring Organization
HMO	Health Maintenance Organization
ID	Identification
*MCO	Managed Care Organization
MFCU	Medicaid Fraud Control Unit
MIS	Management Information System
MMIS	Medicaid Management Information System
OIG	Office of the Inspector General
PCCM	Primary Care Case Management

PCP	Primary Care Provider
**PHP	Prepaid Health Plan
PI	Program Integrity
QA	Quality Assurance
QI	Quality Improvement
QIS	Quality Improvement Strategy
QISMC	Quality Improvement System for Managed Care
RFP	Request for Proposal
SMA	State Medicaid Agency
SURS	Surveillance and Utilization Review Staff
UR	Utilization Review

*MCE - Managed Care Entity is a broader use of the term MCO and includes PCCM programs. Under the BBA this only pertains to the marketing and enrollment provisions.

**PHP - The principles of guarding against fraud and abuse that apply to MCOs outlined in this document are also meant to apply to PHPs.

Appendix 4

**Civil Monetary Penalty (CMP) Authorities Applicable to
Medicaid Managed Care Organizations (MCOs)**
(Enforceable by the Office of the Inspector General (OIG) and the States)

(Prepared and Presented by the OIG)

Program	Statutory Authority	Basis to Impose CMP
1. Failure to Provide Medically Necessary Services	Federal: §1903(m)(5)(A)(i) of the Social Security Act (the Act); 42 U.S.C. §1396b(m)(5)(A)(i) State: §1932(e)(1)(A)(i) of the Act; 42 U.S.C. §1396u-2(e)(1)(A)(i)	MCO fails to provide medically necessary services to beneficiaries.
2. Unauthorized Premiums	Federal: §1903(m)(5)(A)(ii) of the Act; 42 U.S.C. §1396b(m)(5)(A)(ii) State: §1932(e)(1)(A)(ii) of the Act; 42 U.S.C. §1396u-2(e)(1)(A)(ii)	Premiums imposed on enrollees by MCO exceed authorized amounts.
3. Improper Disenrollment Practices	Federal: §1903(m)(5)(A)(iii) of the Act; 42 U.S.C. §1396b(m)(5)(A)(iii) State: §1932(e)(1)(A)(iii) of the Act; 42 U.S.C. §1396u-2(e)(1)(A)(iii)	MCO expulsion/refusal to re-enroll individuals with medical conditions that may require substantial health care services.

<p>4. Misrepresentation</p>	<p>Federal: §1903(m)(5)(A)(iv) of the Act; 42 U.S.C. §1396b(m)(5)(A)(iv)</p> <p>State: §1932(e)(1)(A)(iv) of the Act; 42 U.S.C. §1396u-2(e)(1)(A)(iv)</p>	<p>MCO represents or falsifies information furnished to the Secretary, the State, an enrollee, a potential enrollee, or a health care provider.</p>
<p>5. Improper Physician Incentives</p>	<p>Federal: §1903(m)(5)(A)(v) of the Act; 42 U.S.C. §1396b(m)(5)(A)(v)</p> <p>State: §1932(e)(1)(A)(v) of the Act; 42 U.S.C. §1396u-2(e)(1)(A)(v)</p>	<p>MCO fails to comply with the requirements of a physician incentive plan as specified in §1876(i)(8) of the Act.</p>
<p>6. Improper Marketing Practices</p>	<p>State: §1932(e)(1)(A) of the Act; 42 U.S.C. §1396u-2(e)(1)(A)</p>	<p>MCO/primary care case manager distributes directly, or through any agent or independent contractor, marketing materials that contain false or misleading information.</p>

WORKGROUP MEMBERSHIP LIST

The following is a list of workgroup and contributing members who participated in the development of this document.

Barnes, Walter, Deputy Director
Audits & Investigations
Sacramento, California

Benson, William, Director
MFCU & Special Agent In-Charge
Tennessee Bureau of Investigation
Nashville, Tennessee

Boerschig, Janis, Management Analyst, Health
Care Financing Administration
Atlanta, Georgia

Brooks, Bill, Health Insurance Specialist
Health Care Financing Administration
Dallas, Texas

Buenting, John, Manager
SURS, Program Integrity
Iowa Department of Human Services
Des Moines, Iowa

Crimi, Carol, Health Insurance Specialist
Health Care Financing Administration
Seattle, Washington

Donovan, Sharon, Medicaid Managed
Care Specialist
Health Care Financing Administration
Seattle, Washington

Elwood, Scott, SURS Nurse
Missouri Department of Social Services Jefferson
City, Missouri

Fischer, Donna, Health Insurance Specialist
Health Care Financing Administration
Philadelphia, Pennsylvania

Francis, Pete, Director
Office of Program Integrity
Arizona Health Care Cost Containment System
Phoenix, Arizona

Gebhards, LouAnn, Manager
Utilization Review Systems
Program Integrity/Fraud
Kansas Department of Social Services
Topeka, Kansas

Guthrie, John, Director
Office of Attorney General
Division of Ohio MFCU
Columbus, Ohio

Hall, Rhonda, National Medicaid Fraud & Abuse
Coordinator
Health Care Financing Administration
Atlanta, Georgia

Hatten, Rose, Health Insurance Specialist
Health Care Financing Administration
Baltimore, Maryland

Heyman, Harvey
Health Insurance Specialist
Health Care Financing Administration
Baltimore, Maryland

Jackson, Brenda, Managed Care Specialist
Health Care Financing Administration
Kansas City, Missouri

Logsdon, Kris, Unit Manager
Program Integrity/SURS
Nebraska Dept. of Health & Human Services
Lincoln, Nebraska

McElroy, Carolyn, Director, MFCU
Office of the Attorney General
Baltimore, Maryland

Martin, Wayne R. (Workgroup Chair)
Health Insurance Specialist
Health Care Financing Administration
Kansas City, Missouri

Mays, Delorse, Quality Assurance Manager
Missouri Department of Social Services
Jefferson City, Missouri

Miner, Paul, Team Leader for National Medicaid
Fraud & Abuse Initiative
Health Care Financing Administration
Baltimore, Maryland

Moskovitz, Mark, Special Assistant
New York State Attorney General's Office
New York, New York

Oberman, Joe, Health Insurance Specialist
Health Care Financing Administration
Chicago, Illinois

Patterson, Sharon, Quality Assurance Specialist
Health Care Financing Administration
Kansas City, Missouri

Peters, J. P., National Medicaid Fraud & Abuse
Liaison
Health Care Financing Administration
Dallas, Texas

Schmidt, Donna
Health Insurance Specialist
Health Care Financing Administration

Baltimore, Maryland

Sharpe, Tim, Deputy Director
MFCU, Office of the Attorney General Baltimore,
Maryland

Shaub-Rimel, Alissa
Health Insurance Specialist
Health Care Financing Administration
Baltimore, Maryland

Simon, Sherry, Manager
SURS/Program Integrity Unit
Missouri Department of Social Services Jefferson
City, Missouri

Spahr, Stephen, Deputy Attorney General &
Director, MFCU
Office of the Attorney General
New York, New York

Svoboda, Pamela, Director
MFCU
Phoenix, Arizona

Zelner, Barbara, Counsel
National Association of MFCUs Washington, D.C.