Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

California Focused Program Integrity Review:

Medicaid Managed Care Oversight

September 2023

Final Report

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I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a focused program integrity review to assess California's program integrity oversight efforts for the Fiscal Years (FY) 2019-2021. This focused review specifically assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid managed care.

To meet the objectives of this focused review, CMS reviewed information and documents provided in response to the CMS managed care review tool provided at the initiation of the review, and conducted in-depth interviews with the state Medicaid agency, as well as evaluated program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency.

This report includes CMS' findings and resulting recommendations, as well as observations, that were identified during the focused review.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified 3 findings that create risk to the California Medicaid program related to managed care program integrity oversight. In response to the findings, CMS identified **3** recommendations that will enable the state to come into compliance with federal and/or state Medicaid requirements related to managed care program integrity oversight. These recommendations include the following:

State Oversight of Managed Care Program Integrity Activities

> **Recommendation #1:** CMS recommends that California ensure its MCOs provide timely and complete access to documentation for purposes of inspection and auditing, as required under § 438.3(h). This may include establishing a routine process to ensure a timely and complete response to requests for documentation from CMS in the future.

MCO Contract Compliance

> **Recommendation #2:** California should strengthen its MCO general contract language regarding MCO beneficiary verification activities and the verification of the application of such processes on a regular basis, consistent with the requirements of § 438.608(a)(5). In addition, CMS encourages California to ensure that all MCOs have consistent beneficiary verification policies and procedures that comply with the contractual requirement, and a process in place for the state to monitor these processes.

Recommendation #3: California should establish a documented process that shows how it determines MCOs have written policies that provide detailed information about the False Claims Act and other federal and state laws described in Section 1902(a)(68) of the Act, including information about the right of employees to be protected as whistleblowers, to ensure MCOs are compliant with the requirements of § 438.608(a)(6).

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid managed care program. CMS identified **7** observations related to California's managed care program integrity oversight. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observations identified during this review include the following:

State Oversight of Managed Care Program Integrity Activities

Observation #1: CMS encourages California to include a staffing ratio requirement in the MCO general contract.

MCO Contract Compliance

Observation #2: CMS encourages California to develop an effective monitoring tool for the annual submission, review, and approval of MCO compliance plans and fraud, waste, and abuse plans.

Observation #3: CMS encourages California to either amend its MCO general contract or provide sub-regulatory guidance specific to describing the payment suspension process and requirements. In addition, CMS encourages California to conduct routine oversight to ensure MCOs are meeting the payment suspension requirements.

MCO Investigations of fraud, waste, and abuse

Observation #4: CMS encourages California to develop a mechanism to track all cases and identify the reporting MCO for cases referred to the state and/or MFCU to ensure the MCOs are aware of each case disposition.

Observation #5: CMS encourages California to enhance existing MCO case referral policies and procedures to include specific guidelines and metrics by collaborating with the MCOs to increase the number of quality referrals and recovery of overpayments.

Observation #6: CMS encourages California to consider the inclusion of MCO general contract language to address conducting investigative announced/unannounced provider site visits for more effective oversight of network providers.

Observation #7: CMS encourages California to consider obtaining evidence from its MCOs

in support of any statements attributing a decline in overpayments to the direct result of cost avoidance activities or proactive measures that were in place. Some examples of cost avoidance include a walk-through of the Management Information System edits; written policies and procedures specifically addressing cost avoidance activities; documentation from MCOs regarding measures instituted and resulting from cost avoidance; screenshots, documentation, tracking spreadsheets, or samples from systems that demonstrate cost avoidance measures; and an explanation of any methodology employed that has resulted in deterring overpayments to providers.

II. Background

Focused Program Integrity Reviews

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[1] This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

As a part of these efforts, CMS conducts Focused Program Integrity Reviews on high-risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and personal care services. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

Medicaid Managed Care

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that receive a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

Overview of the California Managed Care Program and the Focused Program Integrity Review

The California Department of Health Care Services (DHCS) is responsible for the administration of the California Medicaid program, titled Medi-Cal. Within DHCS, the Audits and Investigations (A&I) division, which serves as Medi-Cal's primary anti-fraud division and

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

designated Medicaid Program Integrity Unit (PIU), is the organizational unit tasked with oversight of program integrity-related functions for the managed care program. During the review period, California contracted with 25 managed care plans, hereinafter referred to as MCOs to provide health services to the Medicaid population. As part of this review, three of these MCOs were interviewed: CalOptima Health (CalOptima), Kaiser Permanente (Kaiser), and Molina Healthcare (Molina). Appendix C provides enrollment and expenditure data for each of the selected MCOs.

In October 2022, CMS conducted a focused program integrity review of California's managed care program. This focused review assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. As a part of this review, CMS also evaluated program integrity activities performed by selected MCOs under contract with the state Medicaid agency. CMS interviewed key staff and reviewed other primary data. CMS also evaluated the status of California's previous corrective action plan that was developed in response to a previous Focused Program Integrity Review of California's managed care program conducted by CMS in 2014, the results of which can be found in Appendix A.

During this review, CMS identified a total of **3** recommendations and **7** observations. CMS also included technical assistance and educational resources for the state, which can be found in Appendix B. The state's response to CMS' draft report can be found in Appendix D, and the final report reflects changes CMS made based on the state's response.

This review encompasses the following five areas:

A. **State Oversight of Managed Care Program Integrity Activities** - CMS established requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas. These areas include, but are not limited to: data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under §438.608.
B. **MCO Contract Compliance** - Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, such as implementing compliance plans, payment suspensions based on credible allegations of fraud, and overpayment reporting.
C. **Interagency and MCO Program Integrity Coordination** - Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state Medicaid Fraud Control Unit (MFCU) play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars. Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA.
D. **MCO Investigations of Fraud, Waste, and Abuse** - Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse

that the MCO identifies to the state Program Integrity Unit (PIU) or any potential fraud directly to the state's MFCU. Similarly, as required by § 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

E. **Encounter Data** - In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO.

III. Results of the Review

A. State Oversight of Managed Care Program Integrity Activities

State oversight of managed care program integrity activities is critical to ensuring that MCOs are meeting all CMS requirements and state contractual requirements. CMS established state monitoring requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas, including but not limited to, data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under §§ 438.608.

Pursuant to § 438.3(h), CMS may, at any time, inspect an audit any records or documents of a state's MCO. **When performing this review of California's oversight of its managed care program, CMS encountered significant delays as a result of the state's and MCOs' failure to provide timely and complete documentation.** This lack of documentation delayed the start of the review by two months and impacted CMS' requests for additional documentation during the review process. While the state and MCOs often requested extensions, both the state and its MCOs failed to meet the new deadlines or provide complete documentation. In addition, CMS scheduled bi-weekly meetings with California before the review began to discuss any issues or concerns prior to the review; however, the state failed to utilize these meetings.

Once the necessary documentation was received, CMS conducted a review of the documentation to ensure compliance with federal rules and requirements. In California, these oversight and monitoring requirements are met. The DHCS monitoring of MCOs includes assessment of utilization management, case management and coordination of care, access and availability, member rights, quality improvement, and administrative and organizational capacity to ensure timely and appropriate delivery of health care to Medi-Cal members. Program integrity oversight and monitoring requirements are met by the DHCS A&I division. The A&I serves as Medi-Cal's primary anti-fraud division and is the federally-designated Medicaid PIU for California. The A&I is primarily responsible for performing audits and investigative activities as well as fraud and abuse oversight. The scope of these audits is assessing the extent to which the MCO remains compliant with fraud and abuse contract requirements. Audit findings and recommendations for each annual audit are documented and published on the DHCS website. The A&I division coordinates with other DHCS divisions, federal and state partners, and MCOs in maintaining the

integrity of all Medi-Cal programs.

In addition, if warranted, focused audits are performed when DHCS determines good cause for an additional review or audit exists. Focused audits are ad-hoc, have no set frequency, and examine specific areas of concern. The MCOs are required to provide a corrective action plan (CAP) upon completion of the audit or any other monitoring activity where findings are identified. The DHCS evaluates the CAP submission and provides technical assistance to ensure compliance.

The DHCS has several enforcement levers available in the event the MCO fails to meet the requirement of the contract. These include the imposition of any or a combination of financial and non-financial enforcement actions consisting of CAPs, financial sanctions, payment withholds, auto-assignment withholds for new enrollment, and/or liquidated damages.

The DHCS Medi-Cal Behavioral Health Division (MCBHD) administers, oversees, and monitors specialty behavioral health care services covered under the Medi-Cal program. These services are provided through a carve-out managed care delivery system. The MCBHD works collaboratively with the A&I division to investigate suspicion or reports of Medi-Cal fraud, waste, and abuse within the specialty behavioral health care services covered under the Medi-Cal program. These reviews include performing onsite and virtual audits and investigative activities of suspected fraud, waste, and abuse.

The state has not included a provision in the MCO general contract that specifies SIU staffing ratios for its MCOs. During the review period, Molina only had one dedicated investigator. While not a federal requirement, specifying SIU staffing ratios would allow MCOs to build SIUs with sufficient resources and staffing commensurate with the size of the managed care program and conduct the full range of program integrity functions, including the review, investigation, referral, and auditing of provider types where Medicaid dollars are most at risk. Based on the quantity and quality of cases investigated during the review period, CMS believes the state could benefit from including a staffing ratio requirement in the MCO general contract.

> **Recommendation #1:** CMS recommends that California ensure its MCOs provide timely and complete access to documentation for purposes of inspection and auditing, as required under § 438.3(h). This may include establishing a routine process to ensure a timely and complete response to requests for documentation from CMS in the future.
>
> **Observation #1:** CMS encourages California to include a staffing ratio requirement in the MCO general contract.

B. MCO Contract Compliance

Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. These requirements extend to any subcontractor that is delegated responsibility for coverage of services and payment of claims under the contract between the state and the MCO. As part of this review, the MCO general contract was evaluated

for compliance with several of these requirements, which are described in greater detail below.

The MCO general contract for California is developed by DHCS. Health Care Delivery Systems (HCDS) is responsible for managed care contract oversight and monitoring. The Managed Care Operations Division oversees operational and program activities of the MCOs. The Medical Review Branch within the A&I performs medical audits of MCOs on an annual basis.

Compliance Plans

In accordance with §§ 438.608(a)(1)(i)-(vii), states must require MCOs to implement compliance programs that meet certain minimal standards, which include the following:

1. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements
2. Designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors
3. Establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program and its compliance with the requirements under the contract
4. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the contract
5. Effective lines of communication between the compliance officer and employees
6. Enforcement of standards through well-publicized disciplinary guidelines
7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract

In California, this requirement is met. California's MCO general contracts, Exhibit E, Attachment 2 – Fraud and Abuse, explicitly address the requirement that all seven compliance plan elements listed above be included. A review of the MCOs' compliance plans and programs found that each of the MCOs included in the review had compliance plans in place that met the requirements of §§ 438.608(a)(1)(i)-(vii). However, while not a federal requirement, the state does not review and approve the compliance plan or the fraud, waste, and abuse plan.

> **Observation #2:** CMS encourages California to develop an effective monitoring tool for the annual submission, review, and approval of MCO compliance plans and fraud, waste, and abuse plans.

Beneficiary Verification of Services

In accordance with § 438.608(a)(5), the state, through its contract with the MCO, must require a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

In California, this requirement is met through the MCO contract, Exhibit E, Attachment 2 – Fraud and Abuse, which requires the MCOs to have a method to verify on a regular basis, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by the beneficiary. The MCOs employ a variety of verification mechanisms ranging from mailer surveys to beneficiary direct calls**. However, CMS noted the state was not verifying whether the MCOs were performing beneficiary verification of services in accordance with contract requirements.** The DHCS stated that they perform annual MCO medical audits to test for compliance in this area; however, based on a review of the MCO medical audits performed during the review period, CMS was unable to verify that the topic of MCO processes to verify beneficiary services under § 438.608(a)(5) was included in MCO audits.

For fraud, waste, and abuse investigations, CalOptima performs a proactive data analysis to determine to whom to send beneficiary verifications. They select 25 members to review for services match, and medical records are requested, and services are validated. If no medical records are received from the provider, an overpayment recovery request is issued to the provider for failure to corroborate paid claims. They also send out a random number of service verification surveys and conduct phone interviews as additional methods to corroborate services rendered. **CMS noted that CalOptima does not have a formal policy that addresses this process.**

Kaiser network providers are employed by Kaiser; therefore, there is no billing or payments to providers for services rendered. Kaiser Foundation Health Plan, Inc. (Health Plan), Kaiser Foundation Hospitals and, regionally, The Permanente Medical Group (TPMG) and Southern California Permanente Medical Group (SCPMG) offer an integrated healthcare delivery model. Most health care services are provided by TPMG and SCPMG primary care physicians, specialists, and non-physician providers. When services cannot be furnished by TPMG or SCPMG providers, Kaiser refers beneficiaries to its contracted and credentialed network providers and, on occasion, to out-of-network providers. Kaiser only tracks and monitors outside referrals. Kaiser tracks non-network beneficiary inquiries and concerns, and documents the reasons for each inquiry or complaint, including if any of these inquiries are related to the non-receipt of services that are billed in the explanation of benefits (EOBs). **Kaiser reported that they send EOBs to 100% of beneficiaries; however, they do not send EOBs for services provided by their network providers, which constitutes the majority of services provided under their plan.**

Molina did not institute the beneficiary verification process until November 2020. Molina sends 100 beneficiary verifications per quarter. Should a beneficiary communicate to member services that services noted in the beneficiary verification letter were not received, this call is categorized

as a fraud, waste, or abuse complaint and would subsequently create a referral. The referral would be assigned to the SIU for triage and potential investigation. **However, Molina does not have a policy detailing this process.**

> **Recommendation #2:** California should strengthen its MCO general contract language regarding MCO beneficiary verification activities and the verification of the application of such processes on a regular basis, consistent with the requirements of § 438.608(a)(5). In addition, CMS encourages California to ensure that all MCOs have consistent beneficiary verification policies and procedures that comply with the contractual requirement, and a process in place for the state to monitor these processes.

False Claims Act Information

In accordance with § 438.608(a)(6), the state, through its contract with the MCO, must require that, in the case of MCOs that make or receive annual payments under the contract of at least $5,000,000, there are written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Social Security Act (the Act), including information about rights of employees to be protected as whistleblowers.

The state is not compliant with this requirement. In the MCO contracts, Exhibit E, Attachment 2, addresses this requirement. **However, the state failed to provide formal policies and procedures that address how the state ensures this requirement is being met by the MCOs.** These policies and procedures were requested by CMS as a deliverable, but the state failed to provide documentation of this process.

> **Recommendation #3:** California should establish a documented process that shows how it determines MCOs have written policies that provide detailed information about the False Claims Act and other federal and state laws described in Section 1902(a)(68) of the Act, including information about the right of employees to be protected as whistleblowers, to ensure MCOs are compliant with the requirements of § 438.608(a)(6).

Payment Suspensions Based on Credible Allegations of Fraud

Pursuant to § 438.608(a)(8), states must ensure that MCOs suspend payments to a network provider for which the state determines there is a credible allegation of fraud in accordance with § 455.23.

California includes MCO general contract language requiring MCOs to suspend payments to network providers for which the state determines there is a credible allegation of fraud, consistent with § 438.608(a)(8). However, California does not specify in contract language or sub-regulatory guidance how MCOs should operationalize such a process. The state indicated that when a provider is placed on payment suspension as a result of a credible allegation of fraud, DHCS A&I updates the Restricted Provider Database (RPD) to denote the effective date of the payment suspension, and MCOs are required to take action to suspend managed care payments. Plans are required to check the RPD on a monthly basis for provider enrollment purposes, as instructed in All Plan Letter (APL) 19-004, dated June 12, 2019. The DHCS expects MCOs to

review the RPD and take appropriate action; however, this process is not described in contract language or sub-regulatory guidance, limiting the effectiveness of such a general contract requirement.

As of the review period, the reviewed MCOs all had developed payment suspension policies; however, CalOptima's policy was not effective until March 4, 2021, during the review period.

> **Observation #3:** CMS encourages California to either amend its MCO general contract or provide sub-regulatory guidance specific to describing the payment suspension process and requirements. In addition, CMS encourages California to conduct routine oversight to ensure MCOs are meeting the payment suspension requirements.

Overpayments

Regulations at §§ 438.608(a)(2) and (d) require states to maintain oversight of MCOs' overpayment recoveries. Specifically, § 438.608(a)(2) requires states to ensure that MCOs promptly report all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. In addition, § 438.608(d) requires states to specify in MCOs' contracts how the MCOs should treat overpayment recoveries. This must include retention policies for recoveries of all overpayments, including overpayments due to fraud, waste, and abuse; the process, timeframes, and documentation requirements for reporting the recovery of all overpayments; and the process, timeframes, and documentation requirements for payment of recoveries to the state in situations where the MCO is not permitted to retain some or all of the recoveries. States must also ensure that MCOs have a process for network providers to report to the MCO when it has received an overpayment (including the reason for the overpayment), and to return the overpayment to the MCO within 60 calendar days. Each MCO must report annually to the state on their recoveries of overpayments, and the state must use the results of the information in setting actuarially sound capitation rates, consistent with the requirements in § 438.4.

The state adequately addressed the requirements at §§ 438.608(a)(2) and (d). In accordance with the DHCS All Plan Letter 17-003, dated March 30, 2017, and the MCO contract Exhibit E – Attachment 2, each MCO must create an internal retention and documentation process for recovery of all overpayments. The MCO must retain all recoveries of less than $25 million. If the MCO recovers an overpayment to a provider of $25 million or more, DHCS and the MCO share the recovery amount equally. Within 60 days of the date the overpayment was identified, the MCO must report the overpayment to DHCS, including the overpayment amount that was recovered, the provider information, and the steps taken to correct future occurrences.

Each MCO must report annually to DHCS on recoveries of overpayments, including those made to a network provider that was otherwise excluded from participation in the Medicaid program and payments made to a network provider due to fraud, waste, or abuse. Each MCO must require network providers to report to the MCO when it has received an overpayment, to return the overpayment to the MCO within 60 days after the date on which the overpayment was identified, and to notify the MCO in writing of the reason for the overpayment.

While not operational during the review period, the DHCS informed CMS that since this review, a new case reference system was implemented to track overpayments that are the result of a credible allegation of fraud investigation, and then a recoupment is initiated and the entity for recovery is determined. During the review period, Kaiser did not track overpayments identified for the Medicaid program. However, since this review, Kaiser has initiated procedures to capture the total Medicaid overpayment amounts identified starting in 2022.

CMS did not identify any findings or observations related to these requirements.

C. Interagency and MCO Program Integrity Coordination

Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars and beneficiaries. Each of these entities performs unique functions that are critical to providing effective oversight of the Medicaid program. The ability to reduce fraud in Medicaid managed care will be greatly enhanced as these entities develop methods and strategies to coordinate efforts. Ineffective collaboration can adversely affect oversight efforts, putting taxpayer dollars and beneficiaries at risk.

Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA. The state has a Memorandum of Understanding (MOU) in place with the Department of Justice, Office of the Attorney General, Bureau of Medi-Cal Fraud and Elder Abuse, which serves as the state's MFCU. The DHCS A&I meets monthly with the MFCU to discuss case referrals. However, the MOU in place during the review period did not meet the required regulatory criteria. Specifically, during the review period, the MOU did not contain procedures by which the MFCU would receive referrals of potential fraud from MCOs as required by § 455.21(c)(3)(iv), even though in practice the MFCU received referrals directly from both DHCS and the MCOs. Since this review, California adopted a new MOU that was effective on November 18, 2022, and that contained the appropriate language required by § 455.21(c)(3)(iv).

While there is no requirement for an SMA to meet on a regular basis with its MCOs for collaborative sessions to discuss pertinent program integrity issues regarding fraud, waste, and abuse and relevant contractual concerns, such collaborative sessions are an effective and important process to ensure open communication and strong partnerships. The California SMA, in conjunction with the MFCU, holds quarterly collaborative sessions with its MCOs to discuss program integrity issues, such as case referrals, leads, and administrative actions. During the review period, the MFCU conducted training for the MCOs on program integrity during quarterly two-hour anti-fraud meetings/training sessions. Attendees included DHCS program integrity staff, MFCU staff, and MCO program integrity and compliance staff. These sessions included discussions about new fraud trends, and tools/best practices for detecting and preventing fraud, waste, and abuse in health care. The sessions also serve as a forum for the state and/or the MFCU to respond to questions from the MCOs regarding the fraud referral process or specific ongoing investigations. These anti-fraud training sessions have historically been hosted

by the MFCU. However, in the November 2022 MOU, DHCS and MFCU agreed to jointly host this meeting series. In addition to the scheduled training sessions, the state will meet with MCOs on an ad hoc basis as requested.

CMS did not identify any findings or observations related to these requirements.

D. MCO Investigations of Fraud, Waste, and Abuse

State Oversight of MCOs

Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state PIU or any potential fraud directly to the state's MFCU. Similarly, as required by §§ 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

California has such a process in accordance with §§ 455.13-17 and 438.608(a)(7). California, in the MCO contract (Exhibit E, Attachment 2, under Fraud and Abuse Reporting), requires prompt referral of any potential fraud, waste, and abuse the MCO identifies to the A&I. The contract requires the MCO to conduct, complete, and report to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within ten working days of the date the MCO first became aware of such activity. The report must be submitted on a Confidential Medi-Cal Complaint Report (MC 609). The MCOs are required to report case outcomes to the state upon completion of their investigation. The state reviews and assesses the MCO case disposition details, complaints received from all sources, and self-generated leads from data analytics to determine whether a credible allegation of fraud exists. However, the state did not track the MCO associated with each case. As a result, the state was not notifying the MCOs of the case disposition or when a case was closed.

> **Observation #4:** CMS encourages California to develop a mechanism to track all cases and identify the reporting MCO for cases referred to the state and/or MFCU to ensure the MCOs are aware of each case disposition.

MCO Oversight of Network Providers

CMS verified whether each California MCO had an established process for conducting investigations and making referrals to the state, consistent with CMS requirements and the state's MCO general contract requirements.

Overall, CMS found the reported MCO processes for the investigation of suspected fraud, waste, and abuse to meet CMS requirements and state MCO general contract requirements at Exhibit E, Attachment 2, which requires the MCO to implement and maintain procedures that are designed to detect and prevent fraud, waste, and abuse.

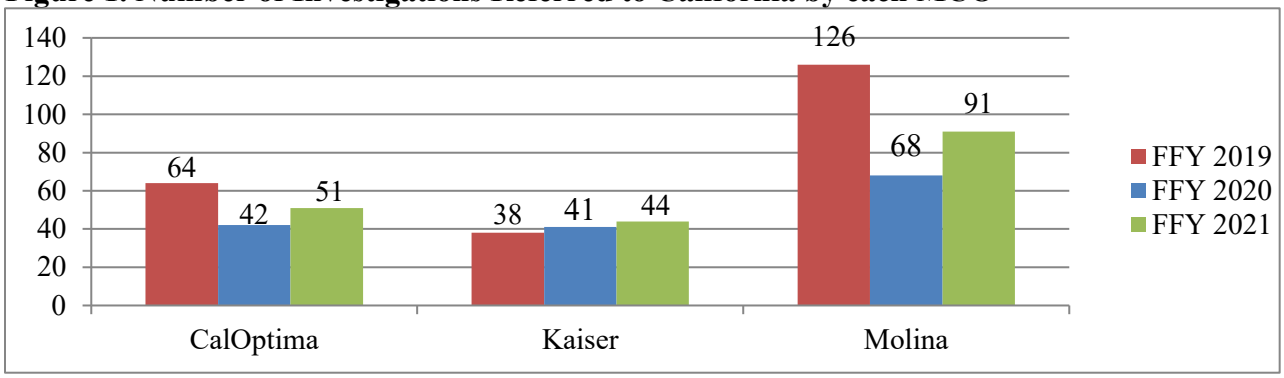
All three MCOs reported use of an internal or contracted SIU or similar unit tasked with

identifying and conducting investigations of potential fraud, waste, and abuse. In addition, each of the MCOs reported that these units are supported by third-party fraud detection data analytics contractors, which provide reporting and identify aberrant billing patterns that may require investigation. When an outlier is identified, either through data analytics or other sources, a preliminary investigation is initiated by the SIU to review the referral details and the evidence provided to assess the validity of the allegation. If this preliminary investigation determines there is a credible allegation of possible fraud, waste, or abuse, a full investigation is initiated, including review of a sample of the provider's claims related to the case. Once the sample to be reviewed, medical records and encounter data may be requested when appropriate. All investigations are reported to DHCS using the MC 609 Form within ten business days of the MCO receiving the potential fraud allegation, or when the investigation began.

In addition to post-payment investigations of provider behavior, each of the three MCOs reported use of prepayment edits and tools intended to flag claim codes prior to adjudication of the claim. However, CalOptima, Kaiser, and Molina's SIUs did not perform any investigative provider site visits, announced or unannounced, during the review period. Investigative provider site visits are an effective tool in the detection of fraud, waste, and abuse within the Medicaid program.

Figure 1 below describes the number of investigations referred to California by each MCO. The MCOs and DHCS reported differing data when specifying the number of investigations referred. The state does not track credible allegations of fraud based on referrals for MCOs, so we were unable to determine the actual number. As such, Figure 1 reflects the data submitted by DHCS. CMS believes the number of investigations referred to DHCS is low for a Medicaid program of this size.

Figure 1. Number of Investigations Referred to California by each MCO*



** CMS notes that the number of investigations reported by the MCOs to have been referred to the SMA varied widely from the number of investigations reported by the SMA to have been referred during the review period.*

Table 1, below, describes each MCO's recoveries from program integrity activities. The state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process (§ 438.608(d)(4)). Without these adjustments, MCOs could be receiving inflated rates per member per month.

Table 1: MCO Recoveries from Program Integrity Activities

CalOptima's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	106	64	$526,721.90	$457,900.17
2020	241	42	$751,368.70	$643,105.28
2021	255	51	$196,587.52	$151,830.01

Kaiser's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	38	38	*	$996,307.00
2020	41	41	*	$269,815.00
2021	44	44	*	$6,478,067.00

*During the review period, Kaiser did not track overpayments identified for the Medicaid program. Kaiser has recently initiated procedures to capture the total Medicaid overpayment amounts identified starting in 2022.

Molina's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	126	126	$5,951,298.89	$3,380,082.85
2020	68	68	$2,731,689.07	$331,300.70
2021	91	91	$1,641,984.43	$2,693,159.35

Overpayments in Table 1 show a decline for CalOptima and Molina during the review period. CMS received statements from these MCOs attributing the decline in overpayments as the direct result of cost avoidance activities or proactive measures that were in place. However, CMS did not receive supporting information from the MCOs regarding such cost avoidance activities.

Observation #5: CMS encourages California to enhance existing MCO case referral policies and procedures to include specific guidelines and metrics by collaborating with the MCOs to increase the number of quality referrals and recovery of overpayments.

Observation #6: CMS encourages California to consider the inclusion of MCO general contract language to address conducting investigative announced/unannounced provider site visits to more effectively oversee network providers.

Observation #7: CMS encourages California to consider obtaining evidence from its MCOs in support of any statements attributing a decline in overpayments to the direct result of cost avoidance activities or proactive measures that were in place. Some examples of cost avoidance include a walk-through of the Management Information System edits; written policies and procedures specifically addressing cost avoidance activities; documentation from MCOs regarding measures instituted and resulting from cost avoidance; screenshots, documentation, tracking spreadsheets, or samples from systems that demonstrate cost avoidance measures; and an explanation of any methodology employed that has resulted in deterring overpayments to providers.

E. Encounter Data

In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. Additionally, § 438.242 further states that state MCO contracts must specify the frequency and level of detail of beneficiary encounter data, including allowed amount and paid amount, that the state is required to report to CMS under § 438.818. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

Through a review of the California MCO general contract and interviews with each of the MCOs, CMS determined that California was in compliance with § 438.242. Specifically, the contract language in Exhibit A - Attachment 3, Exhibit A - Attachment 7, Exhibit A – Attachment 16, and Exhibit E – Attachment 3 addresses these requirements.

The DHCS Enterprise Data and Information Management (EDIM) division is responsible for establishing data collection and reporting processes, collecting encounter data, and monitoring data quality. The MCOs are required to submit encounter data using the X12 837 and National Council for Prescription Drug Programs standards. The DHCS receives claim and service line level information. The MCOs are required to submit encounters at least monthly to DHCS.

For network adequacy, DHCS' data teams use encounter data to analyze utilization trends for specific providers and services to determine if there are access to care issues on a routine and ad hoc basis. The DHCS uses encounter data, as appropriate, to perform the review of medical loss ratio calculations and the development of actuarially sound capitated rates. The DHCS provides this data to its actuarial contractor, Mercer, following completion of edits and validations.

In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO. California was in compliance with § 438.602(e). Specifically, Exhibit E, Attachment 3 – Duties of the State, Section 8.D. of the contract states that periodically, but no less frequently than once every three years, the state will conduct, or contract for the conduct of, an independent audit of the encounter data and financial data submitted by the MCOs. The DHCS contracts with Mercer to perform these audits. This process includes testing of the MCO fee-for-service (FFS) claims payments, global, and sub-capitated provider per member per month payments. If this

audit finds material errors in reporting or processes by the MCO, DHCS has the authority to sanction the MCO.

In addition, while it is not a requirement, regularly analyzing the encounter data submitted by MCOs will allow the state to conduct additional program integrity activities, such as identifying outlier billing patterns, payments for non-covered services, and fraudulent billing. California has a process to regularly analyze MCO encounter data for program integrity purposes. Specifically, program and data teams within DHCS use encounter data in various ways to monitor and evaluate program performance and MCO plan compliance. This process includes production of large analytical datasets to share with internal and external data users in the evaluation of the program and to fulfill routine and ad hoc data requests, and the creation of business intelligence solutions to monitor utilization and produce program monitoring reports. In addition, program and data teams within DHCS use standardized and peer reviewed algorithms of varying complexity to pull record level data and summarize data into analytic datasets and summary totals. The methodology and logic vary in complexity and is specific to analytical program needs. This includes algorithms to accurately produce datasets and determine utilization totals for various study periods, study populations, and services rendered. The DHCS' programs and data teams access encounter data from the Management Information System/Decision Support System (MIS/DSS) data warehouse utilizing software tools such a Statistical Analysis System (SAS), Teradata Structured Query Language (SQL) Assistant, and Business Objects. Other analytical teams use Business Intelligence Solutions to gather summary totals derived from encounter data stored in the data warehouse.

The DHCS' PIU reviews encounter data for anomalies and questionable billing patterns. Claims data is also used in conjunction for carve-out services paid through the FFS delivery system. Fraud, waste, and abuse analytics and research findings may lead to administrative or investigative audits and/or preliminary criminal investigations.

CMS did not identify any findings or observations related to these requirements.

IV. Conclusion

CMS supports California's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified 3 recommendations and 7 observations that require the state's attention.

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

to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

The state is not required to develop a corrective action plan for any observations included in this report. However, CMS encourages the state to take the observations into account when evaluating its program integrity operations going forward.

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

V. Appendices

Appendix A: Status of Prior Review

California's last CMS program integrity review was in August 2014, and the report for that review was issued in March 2016. The report contained 6 recommendations. During the virtual review in October 2022, CMS conducted a review of the corrective actions taken by California to address all recommendations reported in calendar year 2016. The findings from the 2016 California focused program integrity review report have not been satisfied by the state. Additionally, on September 6, 2017, the state was requested to complete the corrective action plan updates. CMS sent a follow up request on November 8, 2017, to which the state never responded.

Appendix B: Technical Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access COVID-19 Program Integrity educational materials at the following links:
  - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf
  - Risk Assessment Template (DOCX) July 2021: HI_22_Focused_PI_Final.docx
  - Risk Assessment Template (XLSX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.xlsx
- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCUs.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address overpayment and recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. http://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Appendix C: Enrollment and Expenditure Data

Table C-1 and Table C-2 below provide enrollment and expenditure data for each of the selected MCOs. Unless otherwise noted, totals are as of January 1, 2021.

Table C-1. Summary Data for California MCOs Data

California MCO Data	CalOptima	Kaiser	Molina
Beneficiary enrollment total	805,735	829,464	3,160,555
Provider enrollment total	8,015	63,641	20,339
Year originally contracted	1993	Sacramento 2008; San Diego 2010	1996
Size and composition of SIU	7	25*	104**
National/local plan	Local	Local/National*	Local/National **

* Kaiser is supported by Kaiser Permanente's National Special Investigations Unit (NSIU).
** Molina of California is a local plan providing services to beneficiaries in California. Molina is a subsidiary of Molina Health Inc., and is supported by the National Plan SIU.

Table C-2. Medicaid Expenditure Data for California MCOs

MCOs	FY 2019	FY 2020	FY 2021
CalOptima	$3,816,077,967.00	$3,955,781,971.00	$4,571,538,013.00
Kaiser	$638,886,170.00	$623,583,110.00	$779,245,744.00
Molina	$1,971,306,481.00	$1,976,017,590.00	$2,270,753,457.00
Total MCO Expenditures	$6,426,270,618.00	$6,555,382,671.00	$7,621,537,214.00

Appendix D: State Response

State PI Review Response Form

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
Recommendation #1	CMS recommends that California ensure its MCOs provide timely and complete access to documentation for purposes of inspection and auditing, as required under § 438.3(h). This may include establishing a routine process to ensure a timely and complete response to requests for documentation from CMS in the future.	**X**	
Recommendation #2	California should strengthen its MCO general contract language regarding MCO beneficiary verification activities and the verification of the application of such processes on a regular basis, consistent with the requirements of § 438.608(a)(5). In addition, CMS encourages California to ensure that all MCOs have consistent beneficiary verification policies and procedures that comply with the contractual requirement, and a process in place for the state to monitor these processes.		**X** DHCS remains compliant with this requirement. The annual medical managed care audits review the overall health system, including utilization management, care coordination, and the grievance system. The audit program includes test procedures on the verification of beneficiary services as part of this system review. The reports are available for public review on the DHCS website. https://www.dhcs.ca.gov/services/Pages/M

Classification	Issue Description	Agree	Disagree
			edRevAuditsCAP.aspx. Each report has a scope and audit procedures section which outlines the records selected for review. For example, pages 4 and 5 of the 2022 CalOptima report, show the number of beneficiary records sampled for that year's audit. These records were examined for compliance to several different requirements. Here is the link to the report: https://www.dhcs.ca.gov/services/Documents/MCQMD/Compliance%20Unit-CAP/2022-CalOptima-Audit-Report.pdf A&I meets annually with Program to discuss program risks and to make scope adjustments as needed. If additional test work is warranted in any area of the audit work, it is evaluated for inclusion.
Recommendation #3	California should establish a documented process that shows how it determines MCOs have written		**X** DHCS disagrees with this statement.

Classification	Issue Description	Agree	Disagree
	policies that provide detailed information about the False Claims Act and other federal and state laws described in Section 1902(a)(68) of the Act, including information about the right of employees to be protected as whistleblowers, to ensure MCOs are compliant with the requirements of § 438.608(a)(6).		DHCS remains compliant with this requirement. This area of focus is addressed in DHCS' audit program (and working paper templates) for its annual medical managed care audits. The attachment titled "2022 CalOptima 6.2 Fraud and Abuse Working Paper" is an example of a previous fraud and abuse working paper for the 2022 CalOptima audit. Within the attachment the yellow highlighted area shows where requirements of 42 CFR 438.608 are identified along with necessary audit work. As part of DHCS' annual risk assessment of managed care plans, Audits & Investigations (A&I) meets with Program to discuss current program risks and to make audit scope/program adjustments as needed. If the prior year audit results warrant re-inclusion of test procedures

Classification	Issue Description	Agree	Disagree
			specific to MCO compliance with False Claims Act and other federal and state laws, DHCS will augment the audit program as needed. The objective of this approach is to ensure existing personnel resources are focusing their attention on the areas of greatest exposure and risk to non-compliance, fraud, waste, or abuse.

Acknowledged by:

_____
[Name], [Title]

_____
Date (MM/DD/YYYY)