Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Colorado Focused Program Integrity Review:

Medicaid Managed Care Oversight

May 2023

Final Report

Table of Contents

I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a focused program integrity review to assess Colorado's program integrity oversight efforts of its Medicaid managed care program for Fiscal Years (FYs) 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 by the state in response to questions posed by CMS in a managed care review tool provided at the initiation of the review. CMS also conducted in-depth interviews with the State Medicaid Agency (SMA) and 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 four findings that create risk to the Colorado Medicaid program related to managed care program integrity oversight. In response to the findings, CMS identified **two** 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:

MCO Contract Compliance

Recommendation #1: Colorado should work with the MCOs to develop policies consistent with the payment suspension requirements in § 455.23. In addition, the state should provide training to its contracted MCOs on the circumstances in which payment suspensions are appropriate.

Recommendation #2: In accordance with § 438.608(a)(2), the state should ensure that any identified or recovered overpayment be reported promptly to the state, not just those overpayments that are due to fraud, waste, or abuse. CMS also encourages the state to ensure MCOs have internal overpayment tracking systems to better account for and report overpayment information under § 438.608(a)(2). The state should also develop MCO general contract language that specifies the overpayment retention process, as specified by § 438.608(d)(1).

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 **seven** observations related to Colorado'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 Colorado to ensure that its MCOs have appropriate safeguards in place against conflicts of interest. CMS also encourages Colorado to ensure there is appropriate oversight of physician-owned MCOs that are receiving bonus payments from the Colorado Department of Health Care Policy and Financing (HCPF) to ensure there is no conflict of interest.

MCO Contract Compliance

Observation #2: CMS encourages Colorado to strengthen its contract language regarding the MCO's beneficiary verification processes, consistent with § 438.608(a)(5). In addition, Colorado should ensure that all MCOs have consistent beneficiary verification policies and procedures that comply with contractual requirements.

MCO Investigations of Fraud, Waste, and Abuse

Observation #3: Based on the quantity and quality of cases investigated and referred during the review period, CMS encourages Colorado to include a staffing ratio requirement in the MCO general contract to further support the existing requirement in Section 17.2.2. Specifically, CMS encourages the state to establish staffing requirements that are commensurate with the size of its managed care program.

Observation #4: CMS encourages Colorado to work with the MCOs to develop and provide program integrity training on a routine basis to enhance case referrals. This includes ensuring MCO staff are attending scheduled meetings and/or training and collaborating with the MCOs to develop and enhance suspected fraud case referrals.

Observation #5: CMS encourages Colorado to assess the quantity and quality of MCO referrals. This may include enhancing existing MCO case referral policies and procedures to include specific guidelines for referring cases, such as when a credible allegation of fraud exists.

Observation #6: CMS encourages Colorado to obtain supporting documentation from its MCOs to support MCO statements attributing a decline in overpayment recoveries to cost avoidance activities or proactive measures that MCO put in place. Supporting documentation

may include MMIS edits; written policies and procedures specifically addressing cost avoidance activities; documentation from contractors regarding measures instituted resulting in cost avoidance; screenshots, documentation, tracking spreadsheets, samples from systems that demonstrate cost avoidance measures; or an explanation of any methodology employed that has resulted in deterring overpayments to providers.

Observation #7: CMS encourages Colorado to increase monitoring, tracking, and reporting parameters for open cases where overpayments have been identified but no monies have been collected. Increased oversight of the investigative and overpayments processes improves the potential for recoveries for cases that have remained open over time extended periods with overpayments identified and not recouped.

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 Colorado Managed Care Program and the Focused Program Integrity Review

The HCPF is the department responsible for the administration of the Colorado Medicaid program, titled Health First Colorado. Within HCPF, the Fraud, Waste, and Abuse Division is the organizational unit tasked with oversight of program integrity-related functions for the managed care program. The state of Colorado administers Health First Colorado through its Accountable Care Collaborative (ACC). The ACC is a hybrid managed care program authorized through a Section 1915(b) waiver.

During the review period, Colorado contracted with seven Regional Accountable Entities (RAEs) and two MCOs to provide health services to the Medicaid population. The RAEs function as a Prepaid Inpatient Health Plan (PIHP) for the administration of all ACC members'

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

capitated mental health and substance abuse disorder services, as well as a Primary Care Case Management (PCCM) Entity responsible for the effective and coordinated utilization of fee-for-service medical/surgical Medicaid benefits. For simplicity purposes, RAEs will be addressed as MCOs within this report.

The state is divided into seven geographic regions with a single MCO operating the ACC in each region. As part of this review, three MCOs were interviewed:

- Denver Health Medical Plan (DHMP), which operates under a comprehensive risk-based contract and only enrolls members in the Denver metropolitan area.
- Northeast Health Partners (NHP), which is supported by Beacon Health Options (Beacon) in providing administrative service support, including data analytics and reporting.
- Rocky Mountain Health Plan (RMHP), which is part of UnitedHealthcare.

Appendix B provides enrollment and expenditure data for each of the selected MCOs.

In June 2022, CMS conducted a focused program integrity review of Colorado'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. Because Colorado did not have an open corrective action plan from a prior managed care review, there were no unimplemented corrective actions for CMS to review.

During this review, CMS identified a total of two recommendations and seven observations. CMS also included technical assistance and educational resources for the state, which can be found in Appendix A. The state's response to CMS' draft report can be found in Appendix C, 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.

In Colorado, these oversight and monitoring requirements are partially met through bi-weekly meetings with the MCOs to discuss topics including, but not limited to program and policy changes, contract expectations, and deliverable performance. The HCPF has identified four types of common MCO performance issues: single incidents of low acuity, patterns of behavior, substantive non-compliance, and systemic problems. Some contract performance management tools used by HCPF include informal performance feedback, an Action Monitoring Plan, and a Formal Corrective Action Plan.

In addition, the HCPF Quality Health Improvement Unit under the Cost Control and Quality Improvement Division conducts annual site reviews of all MCOs through the state's certified External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG). The reviews are on a 3-year rotating schedule to review the requirements under § 438.608. The HSAG annual site reviews cover several areas, such as provider participation and program integrity, credentialing and recredentialing, sub contractual relationships and delegation,

encounter data, and quality assessment and performance improvement. In addition, the state conducts operational readiness reviews that consist of a desk audit and a site review. The readiness review includes such topics as administrative staffing and resources; delegation and oversight responsibilities; provider communications; grievances and appeals; member communications, services, and outreach; provider network management; program integrity/compliance; utilization review; financial reporting and monitoring; claims management; quality improvement; and encounter data and enrollment information management. These requirements are addressed in the MCO general contract Section 3.10.3.1.4. In addition, Medical Loss Ratio reporting requirements are addressed in the MCO general contract Section 14.1.3.4. for RMHP and NHP, and Section 13.11.3. for DHMP. The MCO general contract also addresses other MCO operations requirements, including MCO marketing activities in Section 7.4 and network adequacy standards Section 9.5. for RMHP and NHP, and 9.13. for DHMP.

During the review, CMS noted that some of the MCOs are physician-owned entities. Specifically, as of January 1, 2020, the DHMP was a 501(c) not-for-profit privately held organization owned by Denver Health and Hospital Authority (DHHA). The NHP is jointly owned by four local Federal Qualified Health Centers and Community Mental Health Centers. The RMHP is a UnitedHealthcare company, and UnitedHealthcare has a joint operating agreement with Reunion Health, a coalition of providers that have a role in decision-making. The DHMP, NHP, and RMHP are responsible for ensuring Health First Colorado beneficiaries have access to primary care and behavioral health services, coordinating beneficiary care, and monitoring data to ensure beneficiaries are receiving quality care. These entities play a role in paying providers, including managing payments for behavioral health services, and using bonus payments to encourage primary care providers to improve care.

> **Observation #1:** CMS encourages the state to ensure that its MCOs have appropriate safeguards in place against conflicts of interest. CMS also encourages the state to ensure there is appropriate oversight of physician-owned MCOs that are receiving bonus payments from HCPF to ensure there is no conflict of interest.

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 Colorado is developed by HCPF. Within HCPF, the Fraud, Waste, and Abuse Program Integrity Division is the organizational unit tasked with oversight of program integrity-related functions for the managed care program.

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 Colorado, each MCO is required to have a compliance plan for the identification of fraud, waste, and abuse. The compliance plan is reviewed annually by Colorado, and Section 17.1.5. of the MCO general contract explicitly addresses the requirement that all seven compliance plan elements listed above be addressed. In addition, the MCOs are contractually-required to outline in the compliance plan the screening and audit activities related to fraud, waste, and abuse for the plan year. A review of the MCOs' compliance plans and programs found that each of the MCOs reviewed were compliant with the requirements of §§ 438.608(a)(1)(i)-(vii).

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

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 Colorado, this requirement is met through the MCO general contract, which requires all MCOs to have a process for verifying services. This process is also required to be outlined in the annual compliance plan. The MCOs randomly select a sample of paid claims/encounters and send members written correspondence that requests that members identify if the services did not occur as billed. The MCO general contracts require that MCOs send individual notices to all or a

statistically significant sample of members to verify services. The MCO beneficiary verification results are to be reported to the state on the semi-annual fraud, waste, and abuse report.

However, the NHP only sent 100 beneficiary verifications each year and reported a zero-return rate. The RMHP does not track return on investment and reported a less than 1 percent return on beneficiary verifications.

> **Observation #2:** Colorado should strengthen its contract language regarding the MCO's beneficiary verification processes, consistent with § 438.608(a)(5). In addition, Colorado should ensure that all MCOs have consistent beneficiary verification policies and procedures that comply with contractual requirements.

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 compliant with this requirement. A review of Colorado's policy found that the MCOs are required by MCO general contract Section 17.1.5.9. to have written policies addressing this requirement. In addition, a review of the EQRO HSAG 2021 review for each of the three MCOs included a step to verify that written policies exist for all employees, contractors, or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers.

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

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.

In Colorado, the MCOs are required by MCO general contract Section 17.7.1. to suspend payments due to a credible allegation of fraud, in full or in part, only at the direction of HCPF. The MCO general contract requires payment suspensions to be reported to the state on a monthly basis. When a referral is made to the MFCU based on a suspicion of fraud, the MFCU will review the case and decide whether to accept or decline the referral. If it is accepted, the MFCU notifies program integrity whether they are requesting a law enforcement exception. The MFCU notifies the state in writing if it requests the state to not suspend payments under the law enforcement exception. If a law enforcement exception is requested, the state will not suspend payments until the MFCU notifies them that the exception has been lifted. If the payment

suspension remains in place, HCPF will conduct a policy review to determine other possible exceptions to suspension. If none are determined, then program integrity notifies the provider that their payments are being suspended based on a credible allegation of fraud, and the MCO will also be notified. When a case is accepted, regardless of whether a suspension will be implemented, HCPF will notify the MCO that made the official referral. The MFCU provides a written request once it has finished its initial investigation and has decided to open a case.

Despite this process, the DHMP, NHP, and RMHP do not have formal payment suspension policies. Of note, the NHP provided a general payment suspension policy from Beacon Health Options that does not specifically address operations in Colorado.

> **Recommendation #1:** Colorado should work with the MCOs to develop policies consistent with the payment suspension requirements in § 455.23. In addition, the state should provide training to its contracted MCOs on the circumstances in which payment suspensions are appropriate.

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.

Colorado did not adequately address the requirements at §§ 438.608(a)(2) and (d). Regarding § 438.608(a)(2), instead of including MCO general contract language that requires any identified or recovered overpayments be reported to the state promptly, the MCOs are required to report recovered overpayments on a monthly basis and identified overpayments semi-annually. The only overpayments the state requires MCOs to report promptly (i.e., within five business days) are when overpayments due to fraud, waste, or abuse have been identified. Colorado requires the reports to be submitted to the HCPF program contract manager and include the provider's name and identification number, the issue that resulted in an overpayment, the date range of the claims involved, and the estimated dollar amount at issue. In addition, Colorado does not specify in MCOs' contracts how the MCOs should treat overpayment recoveries, as required by §§ 438.608(d)(1).

Overall, the number of overpayments identified and recovered by the MCOs is low for a managed care program of Colorado's size. Detailed information regarding the overpayments identified and recovered by the MCOs can be found in Tables 4-A through 4-C in section D of this report.

> **Recommendation #2:** In accordance with § 438.608(a)(2), the state should ensure that any identified or recovered overpayment be reported promptly to the state, not just those overpayments that are due to fraud, waste, or abuse. CMS also encourages the state to ensure MCOs have internal overpayment tracking systems to better account for and report overpayment information under § 438.608(a)(2). The state should also develop MCO general contract language that specifies the overpayment retention process, as specified by § 438.608(d)(1).

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 MFCU that meets the regulatory criteria. Specifically, there is a MOU that contains procedures by which the MFCU will receive referrals of potential fraud from MCOs as required by § 455.21(c)(3)(iv). Additionally, the state does meet with the MFCU monthly to discuss case referrals. The MOU between the HCPF and the MFCU states the MFCU must operate exclusively under the direction of the Attorney General of the state by and through the appointed MFCU Director. The MFCU, in conjunction with HCPF, conducts a statewide program for the investigation and prosecution of violations of all applicable federal and state laws regarding any and all aspects of fraud, false claims, and other violations of federal or state laws in connection with any aspects of the provision of medical assistance, the activities of providers of such assistance, and any other programs for which MFCU may have jurisdiction.

The HCPF and the MFCU have established procedures for the MCOs to refer suspected fraud directly to the MFCU. These procedures are contained in the MCO's contract and in guidance issued by the HCPF in Operational Memo (OM) 20-006 Updated Guidance to Contractors on Reporting Suspected Provider Fraud. Per OM 20-006, effective January 1, 2019, MCOs are required to refer all cases where there is reasonable cause to believe there is suspected Medicaid fraud, waste, or patient abuse, neglect, and exploitation directly to the MFCU. The MCOs, when reporting suspected provider fraud to the HCPF, must make a written report of suspected fraud as

required in the contract to both the contract manager and the MFCU. Using the Contractor Suspected Fraud Written Notice Form the MCO must include information pertaining to the provider involved, the suspected fraudulent activity, the time frame of the activity, the estimated amount at issue, and supporting documentation or records that led the MCO to suspect the fraudulent activity.

While there is no requirement for SMAs 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 HCPF Fraud, Waste, and Abuse Program Integrity Division holds meetings every other month with the MCOs and the MFCU where they discuss changes in plan requirements, policy updates, program integrity issues, such as case referrals, leads, and administrative actions, and conduct trainings.

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.

Colorado has such a process in accordance with §§ 438.608(a)(7) and 455.13-17. MCO general contract Section 17.1.3. requires the MCOs to have a fraud, waste, and abuse program that is documented in the annual compliance plan. In addition, all plans must have a fraud and abuse plan that is reviewed by the EQRO once every three years using tools created jointly with the EQRO and HCPF. This element was last reviewed in 2021. The HCPF requires an outline of screening and audit activities related to fraud, waste, and abuse for the plan year. The HCPF Fraud, Waste, and Abuse Program Integrity Division reviews the monthly reporting and semi-annual fraud, waste, and abuse report to monitor the MCOs fraud, waste, and abuse efforts. Colorado requires MCOs to report suspected provider fraud and abuse to the state and the MFCU within 3 days.

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

MCO Oversight of Network Providers

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

Denver Health Medical Plan: From September 2017 through April 30, 2020, the DHMP utilized an independent third-party vendor, LexisNexis, to perform the operations of the SIU, including conducting investigations of indicators for potential fraud, waste, and abuse. In December of 2020, DHMP conducted SIU operations in-house. The DHMP fraud, waste, and abuse identification tool is called Denver Health Detect. **During the review period, the in-house SIU consisted of one Fraud, Waste, and Abuse Analyst. A PI Manager was not hired until October 24, 2021.** The DHMP contracts with a Pharmacy Benefit Manager (PBM), MedImpact, which conducts surveillance and investigations to detect and prevent potential fraud specific to DHMP's prescription drug benefit. **During this review, it was noted that DHMP was unaware of the requirement to submit fraud referrals to the MFCU. They stated any referrals would be emailed directly to the contract managers.** The SIU Committee oversees fraud, waste, and abuse activities, including the execution of the annual fraud, waste, and abuse work plan and the performance of fraud, waste, and abuse audits and investigations. **The DHMP had not conducted announced or unannounced provider site visits during the review period.**

Rocky Mountain Health Plan: As a UnitedHealthcare company, RMHP has access to enterprise teams and tools, such as Optum's Payment Integrity, Fraud, Waste, and Abuse, and SIU resources. The Program Monitoring and Audit (PM&A) management is charged with the overall responsibility for administering the Fraud, Waste, and Abuse Deterrence Program and reporting cases to the HCPF and the MFCU. The PM&A staff will develop and conduct investigations designed to identify potential fraudulent situations, such as upcoding charges, unbundling charges, services charged but never rendered, fraudulent diagnosis, double billing, and assisting in falsification of information. Key detection structures and processes include routine risk monitoring, investigation of reported concerns, fraud, waste, and abuse data analytics, and education for staff and network providers. The RMHP compliance staff provide oversight and support for all audit activities.

The RMHP staff oversee both a program audit and quality assurance team that conduct routine and targeted audits. The Program Audit team consists of certified auditors who perform routine claims audits as well as fraud, waste, and abuse investigations. They also support internal audit activities of RMHP operations. The Quality Assurance team consists of licensed clinicians, nurses, and behavioral health clinicians, who conduct chart audits and quality-of-care reviews. The RMHP utilizes a third-party service, CGI, for post-payment review for incorrect payments and review of improper payments of durable medical equipment claims. The RMHP drafts a corrective action plan (CAP) based on the findings of an investigation. **The RMHP has not conducted provider site visits during the review period. They also have never performed any unannounced site visits.**

Northeast Health Partners: The NHP is supported by Beacon Health Options (Beacon), which provides administrative service support, including data analytics and reporting. The NHP's responsibilities for anti-fraud activities are limited to the behavioral health services for which it manages and pays claims. If NHP receives a report of potential fraud related to a provider, NHP will evaluate the report and determine whether it should be referred to HCPF and/or the MFCU. The NHP submits monthly and semi-annual fraud waste and abuse reports to HCPF. **The NHP**

has not conducted announced or unannounced provider site visits during the review period. Beacon's SIU conducts prepayment review of providers. A provider may remain on prepayment review until they have demonstrated they are documenting and billing services appropriately.

Overall, while the MCOs reviewed have program integrity structures in place, the number of fraud referrals and overpayment recoveries have largely remained low for a managed care program of Colorado's size. One of the MCOs interviewed, DHMP, did not report any cases of fraud, waste, and/or abuse to the HCPF/MFCU. In addition, RMHP and NHP reported a low number of fraud referrals to HCPF/MFCU. When asked whether the MFCU has expressed any concerns with the quantity and quality of case referrals from the MCOs, HCPF responded that the MFCU has shown some concern due to the low number of referrals that they have received from the MCOs. Several MCOs also stated the declining overpayment recoveries were due to cost avoidance measures that were implemented by the MCO. In addition, Section 17.2.2 of the MCO general contract requires adequate MCO staffing to fulfill its oversight duties and states, "The Contractor shall ensure adequate and dedicated staffing and resources needed in order to successfully implement the Compliance Plan and routinely monitor providers and clients to detect and prevent aberrant billing practices, potential Fraud, Waste, Program Abuse and promptly address potential compliance issues and problems."

Figure 1 below describes the number of investigations referred to Colorado MFCU by each MCO. As illustrated, overall, the number of Medicaid MCO provider referrals is low. In addition, the number of cases being reported to the MFCU differed from what the state indicated was reported by the MCOs to the MFCU.

Figure 1. Number of Investigations Referred to Colorado MFCU by each MCO

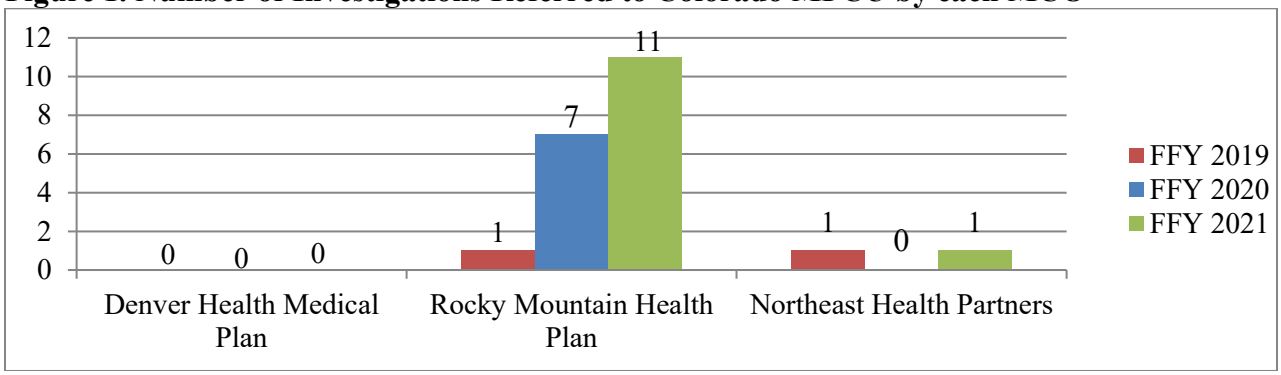

Table 1, below, describe each MCO's recoveries from program integrity activities. The state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process (§ 438.608(d)(4)). Without these adjustments, MCOs could be receiving inflated rates per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

Table: Denver Health Medical Plan's Recoveries from Program Integrity Activities

FFY	Preliminary Investigations	Full Investigations*	Total Overpayments Identified	Total Overpayments Recovered
2019	73	0	$45,337.43	$45,337.43
2020	2	0	$502.94	$502.94
2021	0	0	$0	$0

Table: Rocky Mountain Health Plan's Recoveries from Program Integrity Activities

FFY	Preliminary Investigations	Full Investigations*	Total Overpayments Identified	Total Overpayments Recovered
2019	22	0	$582,892.00	$548,941.00
2020	30	0	$139,719.00	$138,058.00
2021	10	0	$473,629.00	$244,024.00

Table: Northeast Health Partners' Recoveries from Program Integrity Activities

FFY	Preliminary Investigations	Full Investigations*	Total Overpayments Identified	Total Overpayments Recovered
2019	5	0	$0	$0
2020	5	0	$511.52	$511.52
2021	9	0	$48,680.69	$48,680.69

* - The state and the MCOs only conduct preliminary investigations for suspected fraud. If through the preliminary investigation it is verified that the allegation has an indicium of reliability, then it would be considered credible, and referred to the MFCU or law enforcement for the full investigation.

Observation #3: Based on the quantity and quality of cases investigated and referred during the review period, CMS encourages Colorado to include a staffing ratio requirement in the MCO general contract to further support the existing requirement in Section 17.2.2. Specifically, CMS encourages the state to establish staffing requirements that are commensurate with the size of its managed care program.

Observation #4: CMS encourages Colorado to work with the MCOs to develop and provide program integrity training on a routine basis to enhance case referrals. This includes ensuring MCO staff are attending scheduled meetings and/or training and collaborating with the MCOs to develop and enhance suspected fraud case referrals.

Observation #5: CMS encourages Colorado to assess the quantity and quality of MCO referrals. This may include enhancing existing MCO case referral policies and procedures to include specific guidelines for referring cases, such as when a credible

allegation of fraud exists.

Observation #6: CMS encourages Colorado to obtain supporting documentation from its MCOs to support MCO statements attributing a decline in overpayment recoveries to cost avoidance activities or proactive measures that MCO put in place. Some supporting documentation may include MMIS edits; written policies and procedures specifically addressing cost avoidance activities; documentation from contractors regarding measures instituted resulting in cost avoidance; screenshots, documentation, tracking spreadsheets, samples from systems that demonstrate cost avoidance measures; or an explanation of any methodology employed that has resulted in deterring overpayments to providers.

Observation #7: CMS encourages Colorado to increase monitoring, tracking, and reporting parameters for open cases where overpayments have been identified but no monies have been collected. Increased oversight of the investigative and overpayments processes improves the potential for recoveries for cases that have remained open over time extended periods with overpayments identified and not recouped.

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 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 Colorado MCO general contract and interviews with each of the MCOs, CMS determined that Colorado was in compliance with § 438.242. Specifically, the contract language states the MCOs must have a system in place that will provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility. The HCPF relies on flat file encounter data submissions to establish the capitation rates for individual managed care programs. The data are certified by the MCO's chief executive/financial officer or personnel that they have authorized and are reported to the HCPF in a flat file data submission. The MCOs are contractually required to submit all claims that are paid, denied, or adjusted.

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. Colorado was in compliance with § 438.602(e). Specifically, HCPF contracts with HSAG to complete encounter data validation (EDV) of MCO data on an annual basis. The EDV assesses the MCO's compliance with state standards regarding encounter data submission, as well as the consistency and accuracy with which each Medicaid MCO validated encounter data using medical record reviews.

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. Colorado has a process to regularly analyze MCO encounter data for program integrity purposes. Specifically, HCPF developed internal coding logic to test the reasonableness and accuracy of the submitted data. The aggregated amount reported by the data is also compared against the audited financials submitted by the MCOs. The encounter data paid amounts are checked against the claim payment filed within the medical loss ratio report for any discrepancies. In addition, the HCPF uses TOAD Data Point, RStudio, and Tableau to query, analyze, and visualize the data for review.

IV. Conclusion

CMS supports Colorado's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified two recommendations and seven 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 Colorado to build an effective and strengthened program integrity function.

V. Appendices

Appendix A: 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: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx
  - Risk Assessment Template (XLSX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.xlsx
- Access the 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 B: Enrollment and Expenditure Data

Table B-1 and Table B-2 below provide enrollment and expenditure data for each of the selected MCOs.

Table B- 1. Summary Data for Colorado MCOs

Colorado MCO Data	Denver Health Medical Plan	Rocky Mountain Health Plan	Northeast Health Partners
Beneficiary enrollment total	203,959	43,371	90,748
Provider enrollment total	23,698	6,214	3,777
Year originally contracted	Under the current ACC, contract was first executed in 2020*	Under the current ACC, contract was first executed in 2018	2018
Size and composition of SIU	1	3 Certified Auditors; 1 Director	22
National/local plan	Local	National (United Healthcare Company)	National/Local (Beacon)

* Until September 1, 2018, the Medicaid Choice contract with HCPF was held by DHHA and subcontracted to DHMP. In September of 2018, to align with the HCPF's new ACC, the Medicaid Choice contract was transitioned from DHHA to the new RAE 5 operated by Colorado Access and subcontracted to DHMP. Effective January 1, 2020, DHMP began contracting directly with HCPF and was no longer a subcontractor to Colorado Access RAE 5 or DHHA.

Table B-2. Medicaid Expenditure Data for Colorado MCOs

MCOs	FY 2019	FY 2020	FY 2021
Denver Health Medical Plan	$198,181,678	$257,674,921	$323,876,366
Rocky Mountain Health Plan	$195,391,792	$207,741,685	$233,290,843
Northeast Health Partners	$48,607,367	$50,300,419	$68,676,182
Total MCO Expenditures	$442,180,837	$515,717,025	$625,843,391

Appendix C:

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	Colorado should work with the MCOs to develop policies consistent with the payment suspension requirements in § 455.23. In addition, the state should provide training to its contracted MCOs on the circumstances in which payment suspensions are appropriate.		
Recommendation #2	In accordance with § 438.608(a)(2), the state should ensure that any identified or recovered overpayment be reported promptly to the state, not just those overpayments that are due to fraud, waste, or abuse. CMS also encourages the state to ensure MCOs have internal overpayment tracking systems to better account for and report overpayment information under § 438.608(a)(2). The state should also develop MCO general contract language that specifies the overpayment retention process, as specified by § 438.608(d)(1).		

Acknowledged by:

_____
[Name], [Title]

_____
Date (MM/DD/YYYY)