Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Idaho Focused Program Integrity Desk Review

Medicaid Managed Care Oversight

May 2025

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 Idaho's program integrity oversight efforts of its Medicaid managed care program for Fiscal Years (FY) 2020 – 2022. 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. 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 SMA.

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 three findings that create risk to the Idaho Medicaid program related to managed care program integrity oversight. In response to the findings, CMS identified **three** 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:** To come into compliance with § 438.66, Idaho should develop formal written policies and procedures documenting how the state will assess, monitor, and rate the performance of the MCOs relative to § 438.66, which requires the state to have in effect a monitoring system for all managed care programs that includes program integrity requirements.

MCO Contract Compliance

> **Recommendation #2**: To come into compliance with § 438.608(a)(5), Idaho should include language in its MCO contracts regarding MCO beneficiary verification activities and the application of such verification processes on a regular basis.

MCO Investigations of fraud, waste, and abuse

Recommendation #3: In accordance with § 438.608(a)(2), Idaho should enforce the contractual provision for prompt reporting of all overpayments identified or recovered, specifically overpayments due to potential fraud, to the state. Idaho should verify that identified and collected overpayments are fully reported by the MCOs and that these amounts are incorporated into the rate-setting process, as required in § 438.608(d)(4).

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 **eight** observations related to Idaho'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 Idaho to enhance its managed care oversight efforts by taking such actions as (a) utilizing outside contractors to provide additional resources for oversight efforts, (b) developing a corrective action plan process inclusive of all MCOs, (c) including announced and unannounced MCO onsite reviews as part of the monitoring process to verify compliance with its fraud and abuse contract requirements, and (d) developing and providing program integrity training to each MCO on a routine basis to enhance case referrals from the MCOs and provide education on conducting investigations.

Observation #2: CMS encourages Idaho to enhance its MCO general contract development process to include (a) formal written policies and procedures for the development of the MCO general contract to ensure all required elements are addressed in the MCO contracts and (b) a minimum staffing ratio requirement for all MCO Special Investigations Units (SIUs), including a requirement for at least one investigator to be physically located in Idaho.

MCO Contract Compliance

Observation #3: CMS encourages Idaho Department of Health and Welfare (IDHW) to develop formal policies and procedures for the annual review of MCO compliance plans and fraud, waste, and abuse plans. CMS further encourages Idaho to develop an effective monitoring tool for the annual submission, review, and approval of MCO compliance plans and fraud, waste, and abuse plans.

Observation #4: CMS encourages Idaho to establish a process for the state to monitor each MCO's beneficiary verification processes.

Observation #5: CMS encourages the IDHW to ensure all MCO contracts contain consistent

payment suspension language, requiring the *reporting* of potential payment suspensions and/or fraud referrals, based on credible allegations of fraud to the state. According to regulatory requirements at § 455.23 and Idaho's verbal statement during this review, the state would determine creditable allegations of fraud for which MCOs must suspend payment. In addition, CMS encourages the IDHW to provide training to its contracted MCOs on the required reporting elements for potential payment suspensions and/or fraud referrals based on credible allegations of fraud.

Interagency and MCO Program Integrity Coordination

Observation #6: CMS encourages Idaho to establish regular, required collaborative sessions on program integrity issues relating to the Idaho Medicaid managed care program with all MCOs.

MCO Investigations of fraud, waste, and abuse

Observation #7: CMS encourages Idaho to develop a standardized case referral form to ensure all elements of the fraud referral are properly addressed and all MCOs have been provided guidance on the elements IDHW would like to see in a fraud referral. CMS also encourages Idaho to consider including a timeframe in the contract for MCOs to refer a suspected fraud case to the Medicaid Program Integrity Unit (MPIU).

Encounter Data

Observation #8: CMS encourages Idaho to continue efforts to improve their ability to analyze encounter data and perform data mining activities to identify fraud, waste, and abuse issues with MCO network providers, and develop formal policy related to the data mining process.

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 on-site 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 Idaho Managed Care Program and the Focused Program Integrity Review

The IDHW, Division of Medicaid (DOM) is responsible for the administration of the Idaho Medicaid program, Healthy Connections. Within IDHW, MPIU is the organizational unit tasked with oversight of program integrity-related functions for the managed care program. During the review period, Idaho contracted with four MCOs to provide health services to the Medicaid population: Blue Cross of Idaho, Managed Care of North America (MCNA) Dental, Molina Healthcare of Idaho (Molina), and United Behavioral Health doing business as Optum Idaho (Optum). As part of this review, all four MCOs were interviewed. Appendix C provides enrollment and expenditure data for each of the selected MCOs.

In April 2023, CMS conducted a focused program integrity review of Idaho's managed care program. This review assessed the state's compliance with CMS regulatory requirements at 42

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

CFR Part 438, Subpart H. As a part of this review, CMS evaluated program integrity activities performed by selected MCOs under contract with the SMA . CMS also evaluated the status of Idaho's previous corrective action plan that was developed in response to a previous focused program integrity review of Idaho's managed care program conducted by CMS in 2018. Idaho did not implement measures addressing the programmatic vulnerabilities identified in the 2018 program integrity review. This lack of oversight relative to the managed care program is evidenced by the continued low number of investigations referred to the state by the MCOs, as well as the limited overpayments identified and recovered, that were identified in this review. These prior recommendations and any actions taken to remediate are detailed in Appendix A.

SMA oversight of MCOs represents the initial line of defense against fraud, waste, and abuse within the Medicaid managed care program. Strengthening program integrity operations within this area serves to prevent inappropriate use of taxpayer dollars and improve program effectiveness. CMS encourages the state to proactively address the findings within this report to ensure the appropriate safeguard of the program.

During this review, CMS identified a total of **three** recommendations and **eight** 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 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.

The DOM is responsible for programmatic oversight, but program integrity-related functions are delegated to the MCOs and the MPIU for all fraud, waste, and abuse activities. Overall, CMS noted a general lack of oversight of the MCOs, which resulted in low to no referrals of potential fraud and low reported overpayments, as noted throughout this report. **Specifically, Idaho does not have formal policies and procedures that document how the state assesses, monitors, and rates the performance of Optum and MCNA relative to § 438.66.**

In addition, CMS identified several areas that CMS believes Idaho could enhance to further strengthen its oversight efforts. Specifically, the IDHW does not contract with any external entities to conduct program integrity activities, which could provide additional resources to oversight of its managed care program. Idaho also does not have a corrective action plan process in place for Optum or MCNA, nor does IDHW conduct any announced or unannounced onsite reviews. Finally, Idaho did not provide any fraud, waste, and abuse training to its MCOs during the review period to enhance case referrals from the MCOs or provide education on conducting investigations. These oversight efforts would provide Idaho with additional opportunities to assess MCO performance and ensure necessary corrective actions are implemented. In addition, IDHW did not perform any investigations of the contracted MCOs during the review period. CMS also identified several concerns with Idaho's MCO general contract process and requirements. Specifically, IDHW does not have formal written policies and procedures for the development of the MCO general contract. In addition, IDHW currently only requires Optum to maintain one designated SIU staff person and does not contractually require any designated SIU staff for MCNA, Blue Cross of Idaho, or Molina. While not a CMS requirement, establishing a

SIU staffing ratio for each MCO and requiring at least one investigator to be physically located in the state, Idaho would ensure that the MCOs have sufficient resources dedicated to maintaining oversight of their network providers and payments.

Recommendation #1: To come into compliance with § 438.66, Idaho should develop formal written policies and procedures documenting how the state will assess, monitor, and rate the performance of the MCOs relative to § 438.66, which requires the state to have in effect a monitoring system for all managed care programs that includes program integrity requirements.

Observation #1: CMS encourages Idaho to enhance its managed care oversight efforts by taking such actions as (a) utilizing outside contractors to provide additional resources for oversight efforts, (b) developing a corrective action plan process inclusive of all MCOs, (c) including announced and unannounced MCO onsite reviews as part of the monitoring process to verify compliance with its fraud and abuse contract requirements, and (d) developing and providing program integrity training to each MCO on a routine basis to enhance case referrals from the MCOs and provide education on conducting investigations.

Observation #2: CMS encourages Idaho to enhance its MCO general contract development process to include (a) formal written policies and procedures for the development of the MCO general contract to ensure all required elements are addressed in the MCO contracts and (b) a minimum staffing ratio requirement for all MCO SIUs, including a requirement for at least one investigator to be physically located in Idaho.

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, each of the unique MCO contracts were evaluated for compliance with several of these requirements, which are described in greater detail below.

The MCO contracts for Idaho are developed by IDHW's DOM Bureau of Long-Term Care and the Bureau of Care Management. These divisions are responsible for oversight of contractual requirements and working directly with the MPIU on program integrity topics.

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.

All four of the IDHW MCO contracts were reviewed and determined to explicitly address the requirement that all seven compliance plan elements listed above be addressed. A review of the MCOs' compliance plans and programs found that each MCO had a compliance plan with the required plan elements. However, the state did not provide formal policies and procedures related to the review of the MCO's compliance plan and fraud, waste, and abuse plan. Relatedly, IDHW does not use a tool or template for the compliance plan/fraud, waste, and abuse plan review process. While not a CMS requirement, utilizing such a tool could enhance consistency in the state's review and ensure that all requirements are met by including a template or checklist outlining the required compliance plan requirements under CMS regulations and the Idaho MCO contracts.

> **Observation #3:** CMS encourages IDHW to develop formal policies and procedures for the annual review of MCO compliance plans and fraud, waste, and abuse plans. CMS further encourages Idaho 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 Idaho, this requirement is not met because the state does not contractually-require the MCOs to have a beneficiary verification process in place. However, while not contractually-required, each MCO did have such a process in place. In addition, while not a CMS requirement,

Idaho does not have a process in place to monitor the MCOs' beneficiary verification policies, which would ensure that MCOs are remaining compliant with CMS requirements.

> **Recommendation #2**: To come into compliance with § 438.608(a)(5), Idaho should include language in its MCO contracts regarding MCO beneficiary verification activities and the application of such verification processes on a regular basis.
>
> **Observation #4**: CMS encourages Idaho to establish a process for the state to monitor each MCO's beneficiary verification 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 Act, including information about rights of employees to be protected as whistleblowers.

The state is compliant with this requirement. A review of the state's policy found that the state requires false claims education and has written policies in place as described in § 438.608(a)(6). The state confirmed that contract monitoring staff review MCO training materials for the inclusion of False Claims Act education.

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.

Idaho Medicaid MCOs are contractually-required to suspend payments to providers, but only at the state's direction. The MCO general contract requires 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, IDHW reported no credible allegations of fraud during the review period, and subsequently no payment suspensions. Although IDHW reported zero payment suspensions during the review period, Molina reported one in 2022, ten in 2021, and five in 2020. Blue Cross of Idaho reported several providers placed on pay hold in lieu of suspension and stated they do not have a payment suspension process or policy. CMS was unable to resolve the discrepant reporting between the state and its MCOs related to payment suspensions implemented during the review period. The state does not monitor or review MCO fraud referral activity, which could potentially result in a payment suspension due to creditable allegation of fraud. By not having a state oversight and monitoring process of implemented payment suspensions, Idaho is not able to ensure effective oversight of its managed care program.

Observation #5: CMS encourages Idaho to ensure that all MCO contracts contain consistent payment suspension language and require the reporting of potential payment suspensions and/or fraud referrals based on credible allegations of fraud to the state. According to regulatory requirements at § 455.23 and Idaho's verbal statement during this review, the state would determine creditable allegations of fraud for which MCOs must suspend payment. In addition, CMS encourages the IDHW to provide training to its contracted MCOs on the required reporting elements for potential payment suspensions and/or fraud referrals based on credible allegations of fraud.

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). The IDHW's MCO general contract requires the MCOs to report overpayment recoveries resulting from MCO program integrity activities on a quarterly basis. The MCO contracts with the IDHW also require all MCOs to maintain policies and procedures for treatment of recoveries made by the MCO of overpayments to providers in accordance with § 438.606. The contract stipulates that the MCO has twelve months from the date a service is billed to audit the service. After twelve months, the IDHW has the right to audit and recover identified overpayments, and once the provider agrees to the findings or exhausts all appeal rights, overpayments will be recovered from the MCO. The MCO general contract also stipulates that the MCO is to require any network provider to report when it has received an overpayment, return the overpayment within 60 calendar days after the date on which the overpayment was identified, and notify the MCO in writing of the reason for the overpayment. Excess capitation payments must be reported to the state within 30 calendar days.

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. Idaho 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 meets quarterly with the MFCU to discuss case referrals. The MOU between the MFCU and IDHW states that all referrals of potential fraud from the MCOs will be sent to the IDHW, who will then determine if the referral should be sent to the MFCU.

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 SMA does hold quarterly collaborative sessions with two of its MCOs to discuss program integrity issues, such as case referrals, leads, and administrative actions. However, the state did not hold regular meetings with Blue Cross of Idaho or Molina during the review period. CMS noted that the IDHW began meeting with Molina in February 2023.

> **Observation #6:** CMS encourages Idaho to establish regular, required collaborative sessions on program integrity issues relating to the Idaho Medicaid managed care program with all MCOs.

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.

Idaho has such a process in accordance with §§ 455.13-17 and 438.608(a)(7). Idaho requires MCOs to report credible allegations of provider fraud to the MPIU for referral to the MFCU through the state's SharePoint system. The IDHW will refer instances of fraud that are determined to be credible after the MCOs have completed a preliminary investigation. All

investigative records that support the allegation must be submitted with the referral. The MCOs are to refer credible allegations of fraud to the MPIU. The MPIU reviews the referrals and if there are credible allegations of fraud, refers the cases to the MFCU.

While not a CMS requirement, t

MCNA stated that the MPIU did not provide any guidance on the elements it would like to see in referred cases. In addition, t

> **Observation #7:** CMS encourages Idaho to develop a standardized case referral form to ensure all elements of the fraud referral are properly addressed and all MCOs have been provided guidance on the elements IDHW would like to see in a fraud referral. CMS also encourages Idaho to consider including a timeframe in the contract for MCOs to refer a suspected fraud case to the MPIU.

MCO Oversight of Network Providers

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

Overall, CMS found the reported MCO processes for the investigation of suspected fraud, waste, and abuse to adequately meet CMS requirements and state contract requirements. All three MCOs reported the use of an internal or contracted SIU tasked with identifying and conducting investigations of potential fraud, waste, and abuse. Indicators of potential issues were identified through data analytics, hotline tips, referrals from subcontractors, and data mining. Potential fraud cases are documented and reported to the IDHW MPIU and if determined credible, are sent to the MFCU.

Figure 1 below describes the number of investigations referred to Idaho by each MCO. As illustrated, the number of Medicaid provider referrals is low compared to the size of the MCOs, with two MCOs having no referrals over the 3-year period.

Figure 1. Number of Investigations Referred to Idaho by each MCO

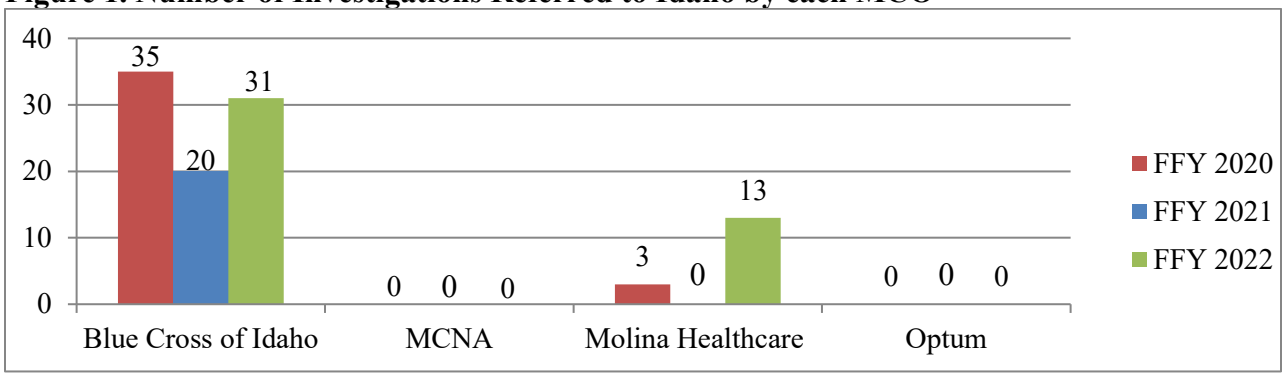


Table 1, below, describes each MCO's recoveries from program integrity activities. The state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process (§ 438.608(d)(4)). Without these adjustments, MCOs could be receiving inflated rates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

Table 1: MCO Recoveries from Program Integrity Activities

Blue Cross of Idaho's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered**
2020	69	3	*	$849,943
2021	59	8	*	$569,765
2022	50	9	*	$522,852

* Blue Cross of Idaho does not track identified overpayments.
** Blue Cross of Idaho stated that overpayment recoveries are not reported to the state because all recoveries are applied back to the claims.

MCNA's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations*	Total Overpayments Identified	Total Overpayments Recovered
2020	6	0	$5,725	$5,775
2021	2	0	$6,305	$6,305
2022	5	0	$3,545	$3,545

* MCNA referred no cases of suspected provider fraud or abuse to the MPIU during the review period.

Molina Healthcare's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	11	9	$98,434	$1,639
2021	11	2	$6,408	$17,084
2022	22	10	$104,544	$73,880

Optum's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	13	18	$ 17,985	$ 68,924
2021	27	29	$ 86,881	$ 3,298
2022	44	51	$ 685,324	$ 51,873

As noted above, the amount of overpayments identified and recovered by the MCOs appears to be low for a managed care program of Idaho's size. In addition, CMS noted that the amount of overpayments identified and recovered reported by the MCOs was drastically different from what was reported by the state. Although MCOs are not required to return overpayments from their network providers to IDHW, it is important that the IDHW obtain a clear accounting of any recoupments because these dollars are factored into establishing annual rates**.** Blue Cross of Idaho does not track identified overpayments and stated that overpayment recoveries are not reported to the state because all recoveries are applied back to the claims. Without these adjustments, the rates paid to the MCOs per member per month, may be inflated.

> **Recommendation #3:** In accordance with § 438.608(a)(2), Idaho should enforce the contractual provision for prompt reporting of all overpayments identified or recovered, specifically overpayments due to potential fraud, to the state. Idaho should verify that identified and collected overpayments are fully reported by the MCOs and that these amounts are incorporated into the rate-setting process, as required in § 438.608(d)(4).

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 Idaho MCO contracts and interviews with each of the MCOs, CMS determined that Idaho was in compliance with § 438.242. Specifically, the contract language states the MCOs' data submission requirements include encounter data, care management data, appeals and grievances data, utilization management data, third party liability data, and primary care provider data.

In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every three 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. Idaho was in compliance with § 438.602(e). Specifically, independent audits were conducted during the 3-year review period on encounter data by the contractor, Myers and Stauffer.

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. Idaho does not have a process to regularly analyze MCO encounter data for program integrity purposes. Specifically, Idaho's MPIU contracts with IBM Solution's JSURS for encounter data mining for FFS claims. However, it was not until February of 2023 that the MCO's encounter data was first uploaded to the state's data warehouse for data mining purposes. Prior to February 2023, all encounter data mining was conducted by the MCOs. For the review period, the state's MPIU requested claims data from the MCOs when investigations were conducted for specific codes identified as being of potential concern, or a claims history for a specific provider. Additionally, Idaho does not have a formal policy related to the data mining process.

> **Observation #8:** CMS encourages Idaho to continue efforts to improve their ability to analyze encounter data and perform data mining activities to identify fraud, waste, and abuse issues with MCO network providers, and develop formal policy related to the data mining process.

IV. Conclusion

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

V. Appendices

Appendix A: Status of Prior Review

Idaho's last CMS program integrity review was in July 2018, and the report for that review was issued in January 2019. The report contained ten recommendations. Although no follow-up or closure letter was sent to the state in response to the 2018 program integrity review CAP, the 2023 CMS review team attempted to evaluate the state's responses to the findings below.

Findings

1. ***The state should consider conducting onsite announced and unannounced visits at the MCOs to verify compliance with its fraud and abuse contract requirements.***
   Status at time of the review: Not Corrected

2. ***The state should ensure that policies and procedures are in place to ensure that the MCOs are verifying beneficiary services.***
   Status at time of the review: Not Corrected

3. ***The state should work with the MCOs to develop specific program integrity training to develop and enhance the quality of case referrals from the MCOs; provide more frequent feedback to the plans on the cases they refer to the state; and ensure that all SIU staff receive appropriate training in identifying and investigating potential fraudulent billing practices by providers.***
   Status at time of the review: Not Corrected

4. ***The state should ensure MCOs are in compliance with contractual requirements for submitting their audit work plan.***
   Status at time of the review: Not Corrected

5. ***The state should ensure all MCOs submit a compliance plan and be reviewed by the state on an annual basis in accordance with federal regulation 42 CFR 438.608.***
   Status at time of the review: Not Corrected

6. ***The state should continue efforts to improve their ability to analyze encounter data and perform data mining activities to identify fraud, waste, and abuse issues with MCO network providers.***
   Status at time of the review: Not Corrected

7. ***The state should verify that identified and collected overpayments are fully reported by the MCOs and that these amounts are incorporated into the rate-setting process.***
   Status at time of the review: Not Corrected

8. ***The state should work with MCOs to develop policies consistent with the payment suspension requirements in the federal regulation at 42 CFR 455.23. The state should provide training to its contracted MCOs on the circumstances in which payment***

suspensions are appropriate pursuant to 42 CFR 455.23 and should further require the reporting of plan-initiated payment suspensions based on credible allegations of fraud.
Status at time of the review: Not Corrected

9. ***The state should ensure all MCO contracts contain payment suspension language.***
Status at time of the review: Not Corrected (Partial compliance noted)

10. ***The state should monitor the MCOs' compliance with contractual requirements for conducting monthly checks on the SSA-DMF, upon enrollment and reenrollment.***
Status at time of the review: CMS was unable to determine if corrective action had been implemented as this was outside the scope of the current focused review.

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 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. https://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.

Table C-1. Summary Data for Idaho MCOs

Idaho MCO Data	Blue Cross of Idaho	MCNA	Molina Healthcare	Optum
Beneficiary enrollment total	14,237	426,491	MMCP - 4,875 IMP - 6,293	384,515
Provider enrollment total	12,328	453	22,355 total providers across all lines of business	2,715
Year originally contracted	MMCP*: 2014 IMP**: 2018	2018	2018	2013
Size and composition of SIU	1 Manager 1 Supervisor 1 Coordinator 4 Investigators	24***	110****	14 behavioral health investigators, with one investigator dedicated to Idaho
National/local plan	National/Local	National/Local	National/Local	National/Local

* Medicare-Medicaid Coordinated Plan
** Idaho Medicaid Plus Program
*** The local SIU is supported by the corporate SIU Team which consists of 1 Vice President of Program Integrity (PI), 1 PI Director, 1 PI/SIU Director, 1 PI Officer, 2 PI/SIU Managers, 1 PI/SIU Quality Assurance Lead, 2 PI/SIU Senior Investigators, 4 PI/SIU Investigators, 2 PI/SIU Junior Investigators, 1 PI/SIU Senior Fraud Analyst, 4 PI/SIU Fraud Analyst, 2 PI/SIU Intake Coordinators, 1 PI/SIU Records Coordinator, and 1 Senior Reporting Lead.
**** Molina is supported by the corporate SIU with one SIU investigator dedicated to the Idaho MMCP/IMP line of business.

Table C-2. Medicaid Expenditure Data for Idaho MCOs

MCOs	FY 2020	FY 2021	FY 2022
Blue Cross of Idaho	$197,964,933	$296,741,865	$341,695,005
MCNA	$51,771,062	$60,254,221	$66,086,451
Molina	$128,492,852	$161,901,212	$178,682,880
Optum	$146,812,012	$193,275,633	$220,526,703
Total MCO Expenditures	$525,040,859	$712,172,931	$806,991,039

Appendix D: State Response

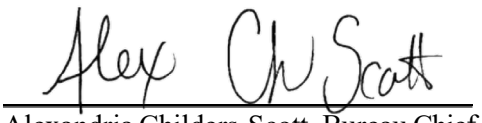
State PI Review Response Form

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	To come into compliance with § 438.66, Idaho should develop formal written policies and procedures documenting how the state will assess, monitor, and rate the performance of the MCOs relative to § 438.66, which requires the state to have in effect a monitoring system for all managed care programs that includes program integrity requirements.	**X**	
Recommendation #2	To come into compliance with § 438.608(a)(5), Idaho should include language in its MCO contracts regarding MCO beneficiary verification activities and the application of such verification processes on a regular basis.	**X**	
Recommendation #3	In accordance with § 438.608(a)(2), Idaho should enforce the contractual provision for prompt reporting of all overpayments identified or recovered, specifically overpayments due to potential fraud, to the state. Idaho should verify that identified and collected overpayments are fully reported by the MCOs and that these amounts are incorporated into the rate-setting process, as required in § 438.608(d)(4).	**X**	

Acknowledged by:



Alexandria Childers-Scott, Bureau Chief

07/25/2025

Date (MM/DD/YYYY)