Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Indiana Focused Program Integrity Review:

Medicaid Managed Care Oversight

September 2023

Final Report

I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a focused program integrity review to assess Indiana'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 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 fourteen findings that create risk to the Indiana Medicaid program related to managed care program integrity oversight. In response to the findings, CMS identified **one** recommendation that will enable the state to come into compliance with federal and/or state Medicaid requirements related to managed care program integrity oversight. This recommendation includes the following:

State Oversight of Managed Care Program Integrity Activities

> **Recommendation #1:** Indiana should ensure all MCOs comply with the beneficiary verification of services requirements in § 438.608(a)(5) and included in Section 4.7.8 of the Indiana MCO general contract. Indiana could consider providing additional guidance to MCOs and requiring regular reporting of beneficiary verification data to the state to assist the state with overseeing this contract requirement.

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 Indiana'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 Indiana to have policies in place to verify that MCOs are in compliance with all program integrity contract requirements on a regular (e.g., annual) basis.

MCO Investigations of fraud, waste, and abuse

Observation #2: CMS encourages Indiana to implement an effective overpayment verification method to provide comprehensive oversight of the MCO overpayment recovery process to ensure the information is accurate.

MCO Oversight of Network Providers

Observation #3: CMS encourages Indiana to work with the MCOs to develop more quality case referrals and routinely provide specific program integrity training related to enhancing the quality of case referrals from the MCOs. CMS also encourages Indiana to provide more frequent feedback to the plans regarding the quality and quantity of MCO case referrals forwarded to the state. This work could include detailed guidance on all investigative elements the MFCU requires for a quality referral of suspected fraud, as well as training in identifying, investigating, and referring potential fraudulent billing practices by providers.

Observation #4: CMS encourages Indiana to consider enhancing policies and training to ensure MCOs appropriately recover provider overpayments so that recoveries are comparable to the size of this program.

Observation #5: CMS encourages Indiana to ensure MCOs are actively engaged in conducting unannounced investigative site visits that do not conflict with any PHE protocols, to ensure effective oversight of the provider networks. This could include amending the MCO general contract to specify the guidelines for conducting investigative announced and unannounced site visits.

Encounter Data

Observation #6: CMS encourages Indiana to consider methods to ensure all MCOs submit encounter data weekly, as required.

Observation #7: CMS encourages Indiana to regularly analyze the encounter data submitted by MCOs to allow the state to conduct additional program integrity activities, such as identifying outlier billing patterns, payments for non-covered services, and fraudulent billing

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 to 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 Indiana Managed Care Program and the Focused Program Integrity Review

The Indiana Office of Medicaid Policy and Planning (OMPP), within the Family and Social Services Administration (FSSA), is the division responsible for the administration of the Indiana Medicaid program. Within OMPP, the PIU is the organizational unit tasked with oversight of program integrity-related functions for the managed care program. During the review period, Indiana contracted with five MCOs to provide health services to the Medicaid population. As part of this review, four of these MCOs were interviewed: Anthem, CareSource, MDWise, and MHS. Appendix C provides enrollment and expenditure data for each of the selected MCOs.

In July 2022, CMS conducted a virtual focused program integrity review of Indiana'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

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

program integrity activities performed by selected MCOs under contract with the SMA. CMS interviewed key staff and reviewed other primary data. CMS also evaluated the status of Indiana's previous corrective action plan that was developed in response to a previous Focused Program Integrity Review of Indiana's managed care program conducted by CMS in 2017, the results of which can be found in Appendix A.

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

This review encompasses the following five areas:

A. **State Oversight of Managed Care Program Integrity Activities** - CMS established requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas. These areas include, but are not limited to: data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under §§ 438.608.
B. **MCO Contract Compliance** - Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, such as implementing compliance plans, payment suspensions based on credible allegations of fraud, and overpayment reporting.
C. **Interagency and MCO Program Integrity Coordination** - Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state Medicaid Fraud Control Unit (MFCU) play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars. Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA.
D. **MCO Investigations of Fraud, Waste, and Abuse** - Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state Program Integrity Unit (PIU) or any potential fraud directly to the state's MFCU. Similarly, as required by § 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.
E. **Encounter Data** - In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO.

III. Results of the Review

A. State Oversight of Managed Care Program Integrity Activities

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

In Indiana, these oversight and monitoring requirements are met by the MCO general contract. However, CMS also observed inconsistent program integrity practices being performed by the MCOs, which could allude to a lack of oversight activities being performed by the state in regard to the application of these practices.

In Indiana, managed care oversight is performed by two divisions within OMPP: the division of Quality and Outcomes, and the PIU. Quality and Outcomes oversees compliance with all contractual requirements, while the PIU oversees program integrity-related functions for the managed care program. The PIU primarily performs these duties through oversight MCO SIU activities.

With the assistance of the Program Integrity division, the Quality and Outcomes division within the SMA monitors MCO performance through monthly and quarterly reports, and check-ins/interviews. CMS noted that the state reviewed reports submitted by the MCOs to verify compliance with applicable contractual requirements and performed follow up interviews as needed. However, the SMA did not conduct any virtual or on-site compliance visits with the MCOs during the review period. The absence of virtual or on-site compliance visits prevented the complete verification of compliance with fraud, waste, and abuse-related contract requirements for the review period.

Section 2.10.3 of the MCO general contract requires that each MCO designate an SIU to, "help review and investigate the Contractor's providers and members that are engaging in wasteful, abusive, or fraudulent billing or service utilization." In addition, the contract requires that the SIU shall have, "at a minimum, one full-time, dedicated staff member for every 100,000 members, excluding the SIU Manager." CMS confirmed that all four MCOs were compliant with this requirement.

> **Observation #1:** CMS encourages Indiana to have policies in place to verify that MCOs are in compliance with all program integrity contract requirements on a regular (e.g., annual) basis.

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 Indiana is developed by the FSSA and all of the contract is overseen within OMPP. The program integrity provisions of the contract are overseen by the PIU.

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

Section 7.4.1 of Indiana's MCO general contract explicitly addresses 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's compliance plan contained the required elements in accordance with §§ 438.608(a)(1)(i)-(vii). Each of the four MCOs submitted a compliance plan to OMPP annually for the three FYs reviewed.

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 Indiana, the MCOs are contractually required to meet this provision. CMS verified that Section 4.7.8 of the MCO general contract requires the MCO to detail their processes and procedures for beneficiary verification of services in their annual Program Integrity Plan. However, this requirement was not fully satisfied for the review period. Indiana did not provide comprehensive guidance to the MCOs concerning § 438.608(a)(5), limiting the state's ability to ensure compliance with the regulation. **CMS found that at least one MCO was performing beneficiary service verifications on an ad hoc basis, and not at regular intervals as required by § 438.608(a)(5).** This resulted in MCO MDWise completing just 14 beneficiary service verifications during the review period. Indiana also does not require the MCOs to submit reporting or data from the beneficiary verifications conducted to the state. All four MCOs had a tracking system in place for identifying conducted beneficiary verifications but were not submitting reports of this information to the state because it was not contractually-required. Without such data being reported to the state, Indiana cannot ensure that MCOs are meeting the contractual requirements for beneficiary verifications.

Additionally, MCO MHS offered only online service verification for their Medicaid beneficiaries, limiting the ability of all members to verify services. CMS did not identify concerns related to beneficiary verification for Anthem or CareSource during the review period.

> **Recommendation #1:** Indiana should ensure all MCOs comply with the beneficiary verification of services requirements in § 438.608(a)(5) and included in Section 4.7.8 of the Indiana MCO general contract. Indiana could consider providing additional guidance to MCOs and requiring regular reporting of beneficiary verification data to the state to assist the state with overseeing this contract requirement.

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 the requirements at 438.608(a)(6).

The state is compliant with this requirement. Each of the four MCOs had 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.

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.

Indiana Medicaid MCOs are contractually required to suspend payments to providers at the state's request. The MCO contract requires, at Section 7.4.3, that "[t]he Contractor shall suspend all payments to a provider after OMPP determines that there is a credible allegation of fraud and has provided the Contractor with a written notice of a payment suspension." The state provides all MCO SIU staff detailed information on the provider being placed on payment suspension, and request confirmation by each MCO that the suspension has been put in place.

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

Overpayments

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

The Indiana MCO general contract included requirements regarding the reporting and returning of identified overpayments consistent with §§ 438.608(a)(2) and (d) during the review period. The general MCO contract section 7.4.4 states, "[c]ontractor has primary responsibility for the identification of all potential waste, fraud and abuse associated with services and billings generated as a result of this Contract. In cases involving wasteful or abusive provider billing or service practices, including overpayments, identified and recovered by Contractor, the Contractor will have policies and procedures in place to fully comply with 42 CFR 438.608."

The Indiana MCO general contract also specified the retention policies for overpayments related to fraud, waste, and abuse, including the rights of the SMA to make recoveries in cases identified by the OMPP PI Section, in accordance with § 438.608. Section 7.4.4 states, "OMPP may recover any identified overpayment directly from the provider or may require Contractor to recover the identified overpayment and repatriate the funds to the State Medicaid program as directed by the OMPP PI Section." Furthermore, this section required that MCOs submit quarterly and annual reporting of recoveries, in accordance with guidance provided in the state-issued Reporting Manual. However, CMS noted that information provided in this reporting was not subject to any state data validation processes.

> **Observation #2**: CMS encourages Indiana to implement an effective overpayment verification method to provide comprehensive oversight of the MCO overpayment recovery process to ensure the information is accurate.

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. Indiana has a Memorandum of Understanding (MOU) in place with the MFCU that meets the regulatory criteria. Specifically, there is an 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 with the MFCU monthly to discuss case referrals. The state reported that, during the review period, the MFCU did not notify the SMA of the outcomes of referred fraud, waste, and abuse cases. Rather, the SMA became aware of convictions or collections of payments via press releases. However, CMS noted that the SMA is now receiving this information directly from the MFCU. CMS encourages Indiana to continue improving the information sharing process between the SMA and law enforcement agencies.

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. In Indiana, the SMA holds monthly collaborative sessions with its MCOs to discuss program integrity issues, such as case referrals, leads, and administrative actions. CMS noted that the state holds two types of regular meetings between the state PIU and MCO staff. The state PIU and MCO SIU staff meet monthly to discuss pertinent issues relating to the specific MCOs

program integrity activities, including the status of current investigations. The state PIU also holds a monthly meeting with MCO and MFCU staff to share information regarding ongoing cases.

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.

Indiana has such a process, in accordance with §§ 455.13-17 and 438.608(a)(7). Indiana requires that, in section 7.4.3 of the MCO contract, "…the Contractor shall cooperate with all appropriate state and federal agencies, including the Indiana MFCU and the OMPP Program Integrity Section, in investigating fraud and abuse." The contract continues, "[t]he Contractor shall promptly report suspected or confirmed fraud and abuse to OMPP or another agency that has been designated by OMPP to receive the report. The Contractor shall promptly provide the results of its preliminary investigation to the OMPP Program Integrity Section or to another agency designated by the OMPP Program Integrity Section." Upon conclusion of an audit or investigation, the MCO is required to immediately report all suspected or confirmed instances of waste, fraud, and abuse to the OMPP and the OMPP Program Integrity Section.

MCOs are required to implement mechanisms to make referrals to the OMPP PI Section and accept referrals from a variety of sources including but not limited to: directly from providers (either provider self-referrals or from other providers), beneficiaries, law enforcement, and government agencies. When referring cases of confirmed fraud, the SMA requires all MCOs to complete a referral form, provide the investigatory materials, and present the referral for review by the state.

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

MCO Oversight of Network Providers

CMS verified whether each Indiana 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 meet CMS requirements and state MCO general contract requirements. All four MCOs reported use of an internal or contracted SIU tasked with identifying and conducting investigations of potential fraud, waste, and abuse. All four MCOs identify leads for preliminary investigation through multiple sources. When a lead is received, the MCO verifies with the state that the provider is not currently under another investigation, and then initiates a preliminary

investigation. A preliminary investigation includes the compilation of relevant data and documents, including claims records, and the review of all available information by fraud analysts or investigators to validate the legitimacy of the allegations. Additional activities performed during preliminary investigations include, but are not limited to; utilization analysis, researching state and federal billing and coding, obtaining a sample of medical records, interviewing relevant individuals to confirm findings, pursuing record review by clinical advisors/medical coding experts, creating and analyzing reports, and educating providers. If the case is determined to have a credible allegation of fraud present, it is escalated to a full investigation. Full investigations include, but are not limited, to: high-level data analytics, provider scope of practice and license research, business ownership research, internet/social media and in-depth personal background research, credentialing and provider contract review, medical/payment policy, medical industry standard research, lines of business rule and guideline research, phone or in-person interviews, statistically valid random sample medical request, expert clinical and coding review, onsite visit, and law enforcement collaboration. All four MCOs report suspected fraud, waste, and abuse to the Indiana OMPP Program Integrity Department, in accordance with contractual requirements.

Figure 1 below describes the number of investigations referred to Indiana by each MCO. As illustrated, MCOs CareSource, MDWise, and MHS reported low investigations/referrals during the review period.

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

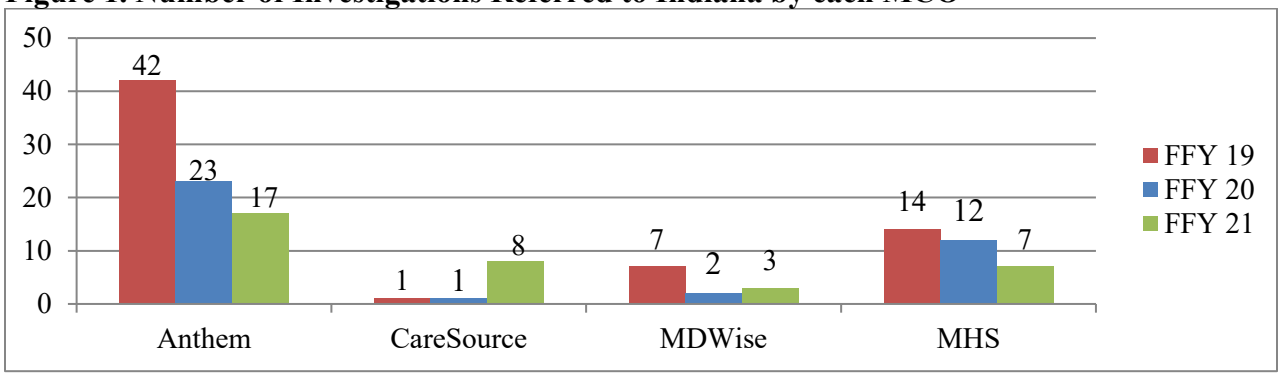

Table 1, below, describes each MCO's recoveries from program integrity activities. The state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process (§ 438.608(d)(4)). Without these adjustments, MCOs could be receiving inflated rates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

Table 1: MCO Recoveries from Program Integrity Activities

Anthem's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	289	149	$687,812.50	$121,136.46
2020	181	145	$16,068,036.54	$550,080.52
2021	195	134	$5,638,815.26	$320,196.12

CareSource's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	N/A	24	$1,451.09	$1,454.09
2020	N/A	24	$10,622,48	$10,622.18
2021	N/A	21	$58,493.34	$53,225.82

MDWise's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	N/A	17	$1,046,561.53	$254,706.49
2020	N/A	24	$1,287,462.48	$1,311,104.13
2021	N/A	34	$667,457.69	$187,441.14 (claim offsets) + $41,242.32 (settlements) = **$228,683.46**

MHS's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	67	26	$1,721,617.24	$165,562.20
2020	48	29	$738,757.96	$164,128.87
2021	36	82	$2,612,930.98	$436,766.99

As noted in Table 1, above, the reported overpayments identified and recovered by several of

the MCOs were low for a program of this size, indicating that the application of the related MCO general contract requirement may vary in efficacy and require more oversight. In total, MCOs recovered just 14% of the overpayments identified during the review period. These low recoveries are primarily attributable to three MCOs: Anthem, MDWise, and MHS. For the three years reviewed, Anthem identified $16,394,664.30 and recovered $991,413.10 in overpayments, MDWise identified $3,001,481.70 and recovered $1,539,787.59 in overpayments, and MHS identified $5,073,306.18 and recovered $766,458.06 in overpayments. There was no concern identified with CareSource during the review period, as the overpayments identified totaled $70,566.91 and overpayments recovered totaled $65,299.39.

Additionally, CMS observed that, although the review period coincided with the COVID-19 Public Health Emergency (PHE), which restricted MCOs' ability to perform unannounced investigative site visits, two of the four MCOs did not conduct any unannounced site visits prior to the start of the PHE. CareSource conducted zero unannounced site visits in FY 2019, one in FY 2020, and zero in FY 2021. MDWise conducted zero unannounced site visits for FY 2019 - FY 2021; MDWise clarified that the plan did not conduct unannounced site visits during the review period due to safety concerns. Additionally, the remaining two MCOs conducted very limited unannounced site visits prior to the start of the PHE. Anthem conducted four unannounced site visits in FY 2019, and zero in FY 2020 and FY 2021 due to PHE. MHS conducted four unannounced site visits in FY 2019, one in FY 2020, and three in FY 2021.

Observation #3:CMS encourages Indiana to work with the MCOs to develop more quality case referrals and routinely provide specific program integrity training related to enhancing the quality of case referrals from the MCOs. CMS also encourages Indiana to provide more frequent feedback to the plans regarding the quality and quantity of MCO case referrals forwarded to the state. This work could include detailed guidance on all investigative elements the MFCU requires for a quality referral of suspected fraud, as well as training in identifying, investigating, and referring potential fraudulent billing practices by providers.

Observation #4: CMS encourages Indiana to consider enhancing policies and training to ensure MCOs appropriately recover provider overpayments so that recoveries are comparable to the size of this program.

Observation #5: CMS encourages Indiana to ensure MCOs are actively engaged in conducting unannounced investigative site visits that do not conflict with any PHE protocols, to ensure effective oversight of the provider networks. This could include amending the MCO general contract to specify the guidelines for conducting investigative announced and unannounced site visits.

E. Encounter Data

In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. Additionally, § 438.242 further states that state MCO contracts must specify the frequency and level of detail of beneficiary encounter data, including allowed amount and paid amount, that

the state is required to report to CMS under § 438.818. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

Through a review of the Indiana MCO general contract and interviews with each of the MCOs, CMS determined that Indiana was in compliance with § 438.242. Specifically, the contract language states that MCOs shall have a system(s) that will provide information on areas including, but not limited to, utilization, claims, grievances, appeals, and disenrollment for other loss of Medicaid eligibility. Additionally, the MCO general contract specifies that 98% of claims must be submitted to the state within 14 calendar days of adjudication, and further requires that the MCO submit a complete batch of encounter data for all claims on a weekly basis. However, during the review, CMS noted that MDWise reported submitting its encounter data quarterly to the state. There was no concern found with Anthem, CareSource, or MHS, as these MCOs reported submitting encounter data weekly to the state.

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. Indiana was in compliance with § 438.602(e) for the review period.

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. Indiana does not have a process to regularly analyze MCO encounter data for program integrity purposes. Specifically, the state reviews encounter data using an Actuary (Milliman) contract as well as input from the state's fiscal agent. CMS also noted that the state does not use encounter data to conduct its own program integrity investigations unless the beneficiary is receiving services through both the managed care and Fee-for-Service programs.

> **Observation #6**: CMS encourages Indiana to consider methods to ensure all MCOs submit encounter data weekly, as required by the MCO general contract.
>
> **Observation #7**: CMS encourages Indiana to regularly analyze the encounter data submitted by MCOs to allow the state to conduct additional program integrity activities, such as identifying outlier billing patterns, payments for non-covered services, and fraudulent billing.

IV. Conclusion

CMS supports Indiana's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified one recommendation 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 Indiana to build an effective and strengthened program integrity function.

V. Appendices

Appendix A: Status of Prior Review

Indiana's last CMS program integrity review was in June 2017, and the report for that review was issued in November 2017. The report contained six recommendations. The findings from the 2017 Indiana focused program integrity review report have all been satisfied by the state.

Appendix B: Technical Resources

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

- Access COVID-19 Program Integrity educational materials at the following links:
  - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf
  - Risk Assessment Template (DOCX) July 2021: 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 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 Indiana MCOs

Indiana MCO Data	Anthem	CareSource	MDWise	MHS
Beneficiary enrollment total	677,132	121,459	350,481	311,676
Provider enrollment total	37,831	36,662	71,171	209,436
Year originally contracted	2007	2017	1996	1994
Size and composition of SIU (FTEs)	20	3	5	5
National/local plan	National	National	Local	National

Table C-2. Medicaid Expenditure Data for Indiana MCOs

MCOs	FY 2019	FY 2020	FY 2021
Anthem	$3,051,493,921.93	$3,898,754,779.93	$4,667,494,074.79
CareSource	$447,335,300.11	$501,498,881.71	$667,466,648.57
MDWise	$1,441,783,992.60	$1,472,703,287.51	$1,775,398,744.08
MHS	$1,500,555,213.20	$1,594,127,538.12	$1,986,034,245.04
Total MCO Expenditures	$6,441,168,427.84	$7,467,084,487.26	$9,096,393,712.48

Appendix D: State Response

State Program Integrity 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	Indiana should ensure all MCOs comply with the beneficiary verification of services requirements in § 438.608(a)(5) and included in Section 4.7.8 of the Indiana MCO general contract. Indiana could consider providing additional guidance to MCOs and requiring regular reporting of beneficiary verification data to the state to assist the state with overseeing this contract requirement.		

Acknowledged by:

_____
[Name], [Title]

_____
Date (MM/DD/YYYY)