# Department of Health and Human Services

# Centers for Medicare & Medicaid Services

# Center for Program Integrity

# Louisiana Program Integrity Desk Review:

# Medicaid Managed Care Oversight

# August 2023

# Final Report

# Table of Contents

# I. Executive Summary

## Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a program integrity desk review to assess Louisiana's program integrity oversight efforts of its Medicaid managed care program for Fiscal Years (FYs) 2019-2021. This desk 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 desk 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 and evaluated program integrity activities performed by selected managed care organizations (MCOs) under contract with the State Medicaid Agency (SMA).

This report includes CMS' findings and resulting recommendations, as well as observations, that were identified during the desk 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 **one** finding that creates risk to the Louisiana 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 is:

*MCO Contract Compliance*

> **Recommendation #1:** Louisiana should revise procedures that direct MCOs to suspend payments to providers due to a credible allegation of fraud, in accordance with § 455.23. The SMA must ensure that MCOs cannot opt out of suspending payments to providers when directed by the agency unless a good cause exception under § 455.23 applies. The SMA should also ensure that MCOs do not take other administrative or network actions at their own discretion in lieu of an agency-directed payment suspension due to a credible allegation of fraud. CMS also encourages Louisiana to clarify terms and responsibilities for good cause exceptions and other MCO actions relating to payment suspensions to ensure full compliance with § 455.23 and avoid inconsistencies in fraud investigation efforts.

## Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid managed care program. CMS did not identify any observations related to Louisiana'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.

# II. Background

## Program Integrity Desk 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 Program Integrity Desk 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 document review and program evaluation 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 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 Louisiana Managed Care Program and the Program Integrity Desk Review

The Louisiana Department of Health (LDH) is the entity responsible for the administration of the Louisiana Medicaid program, titled Healthy Louisiana. Within LDH, the Program Integrity section (LDH-PI) is the organizational unit tasked with oversight of program integrity-related functions for the managed care program. The LDH-PI operates under the Office of the Secretary, outside of the Louisiana Medicaid program. During the review period, Louisiana contracted with five MCOs to provide health services to the Medicaid population.[2] As part of this review, three

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf
[2] https://ldh.la.gov/assets/medicaid/EQRO/2021/Medicaid-Managed-Care-QualityStrategyEvaluation-FY21_8321.pdf

of these MCOs were interviewed: AmeriHealth, Anthem, and Centene. Appendix C provides enrollment and expenditure data for each of the selected MCOs.

Louisiana's total Medicaid expenditures in FY 2021 totaled approximately $10.55 billion. During FY 2021, Louisiana's Federal Medical Assistance Percentage (FMAP) was 67.42 percent and was increased to 73.62 percent in January 2020 due to the COVID-19 public health emergency. Louisiana's Medicaid program served 2,011,232 beneficiaries in FY 2021. Of that total, approximately 86 percent, or 1,730,013 beneficiaries, were enrolled in managed care.[3] Louisiana managed care includes physical and behavioral health services, as well as non-emergency medical transportation (NEMT) and dental benefits. The state contracts with two dental benefit prepaid ambulatory health plans (PAHP), DentaQuest and Managed Care of North America (MCNA). Louisiana Medicaid also contracts with Magellan for specialized behavioral health services for children.

In September 2022, CMS conducted a Program Integrity Desk Review of Louisiana's managed care program. This desk review assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. As a part of this review, CMS also evaluated program integrity activities performed by selected MCOs under contract with the state Medicaid agency. CMS reviewed a sample of program integrity cases investigated by the MCOs Special Investigations Units (SIUs), as well as other primary data. CMS also evaluated the status of Louisiana's previous corrective action plan that was developed in response to a previous Focused Program Integrity Review of Louisiana'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. 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.

[3] Medicare-Medicaid dual beneficiaries and long-term care recipients are covered through the state's fee-for-service (FFS) program.

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. 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 Louisiana, these oversight and monitoring requirements were met during the review period. The state reported that oversight of the managed care system in Louisiana is a shared effort between the Managed Care Oversight unit within LDH-PI, the Health Plan Management team, and other subject matter experts involved in contract monitoring. The Managed Care Oversight unit consists of five full-time employees and covers fraud, waste, and abuse oversight; network provider audits; and other contract monitoring activities. The SMA confirmed that it does not have interagency agreements between LDH-PI, which operates under the Office of the Secretary, and LDH outlining specific managed care oversight and program integrity responsibilities. Louisiana contracts with Gainwell Technologies (Gainwell), the state's fiscal intermediary, to conduct provider investigations and recover overpayments. The Gainwell unit is contractually required to support LDH-PI staff and conduct a minimum of 600 investigations annually. All investigatory activities and complaints received through the Gainwell fraud, waste, and abuse complaint hotline are documented through case tracking. The Gainwell unit also conducts FFS claims review and managed care encounter data review with subcontractor IBM Watson Health.

Gainwell submits monthly summary reports to LDH-PI, including cases opened and closed, overpayments identified and recovered, complaints received, MFCU referrals, and beneficiary verifications conducted.

The LDH-PI Managed Care Oversight team has conducted onsite and virtual reviews of MCOs to verify compliance with fraud and abuse contract requirements. The Managed Care Oversight team selects an area of focus for the review, which can include SIU case evaluation, annual training plan completion rate, compliance plan review, and coder verification review. Reviews are documented through written work papers that outline any discrepancies or contract violations. For case evaluation reviews, a final report is published, including details of the virtual interview with the MCO and any recommendations for improvement.

Louisiana's MCO contract at Section 15.1.14. Fraud, Abuse, and Waste Prevention General Requirements states that, "[a]t a minimum, the MCO shall have one full-time investigator physically located within Louisiana for every 50,000 members or fraction thereof. This full-time position is in addition to the Program Integrity Officer and must be located in-state.". CMS observed that all three MCOs followed these staffing ratio requirements during the review period.

In accordance with § 438.66, the state's external quality review organization (EQRO), IPRO, conducts annual compliance reviews of each MCO, including quality of care and medical records reviews. According to Section 14.3 of the Louisiana MCO general contract, MCOs are also contractually required to provide a description of "performance improvement goals, objectives, and activities developed and implemented in response to the EQRO findings." LDH-PI monitors program integrity performance through quarterly fraud, waste, and abuse reporting from each MCO and quarterly meetings with all MCOs. The MCO manager at LDH-PI documents perceived risks and proposed solutions for each MCO to keep a running log of potential issues that may reveal patterns of noncompliance or low performance.

A review of the state's MCO contracts showed compliance with §§ 438.48 and 438.602(h) regarding conflict-of-interest safeguards. The state's MCO master contracts and amendments are also posted publicly on the SMA's website, in accordance with § 438.602(g)(1).

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

## 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 Louisiana is developed by all business owners who have material related to their sections in the MCO request for proposal (RFP). LDH-PI staff assists in

developing contract language on fraud and abuse during RFP development. Outside of the development process, LDH-PI can submit contract language revisions and justifications to the Program Operations and Compliance unit to be approved by the Medicaid Director. The Health Plan Management team, within the Program Operations and Compliance unit, is responsible for monitoring managed care general contract compliance and collaborates with the LDH-PI manager to oversee MCO compliance with fraud, waste, and abuse program requirements.

***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 15.2.6 of Louisiana's MCO general contract explicitly addresses the requirement that all seven compliance plan elements listed above be addressed. As required by § 438.608, the Managed Care Oversight unit reviews MCO compliance plans annually using an internal Annual Compliance Assessment Tool, documents the status of the review internally, and provides written feedback to the MCOs before implementation. LDH-PI may require MCOs to revise and resubmit their compliance plan if major elements are missing.

Louisiana does not require MCOs to have a separate fraud, waste, and abuse plan; instead, fraud, waste, and abuse activities are required to be included within MCO compliance plans. CMS observed that the necessary regulatory requirements were met in Section 15.2 of the MCO general contract, including provisions for annual fraud, waste, and abuse training; internal monitoring; site visits; and development of corrective action initiatives. A review of the MCOs' compliance plans and programs found that they are in compliance with the requirements at §

438.608.

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 Louisiana, this requirement is met through MCO general contract Section 15.2.6.11, which stipulates that MCOs have "procedures to verify, by sampling or other methods, whether services that have been represented have been delivered… and the application of such verification on a regular basis." LDH-PI provides additional guidance on recipient explanation of medical benefits (REOMBs) in Section 4.3 of the Program Integrity Managed Care Monitoring Training Manual. MCOs are required to send survey letters to a two-percent representative sample every month, investigate all instances of services not rendered, and provide quarterly survey results to LDH. CMS observed that all of the MCOs follow the requirement to verify that services billed were received by beneficiaries as prescribed, and submit a quarterly report of all verifications to the state.

***False Claims Act Information***

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

The state is compliant with this requirement. A review of that state's policy found that section 15.2.6.16 of the Louisiana MCO general contract includes language that requires false claims education as described in § 438.608(a)(6).

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.

Louisiana Medicaid MCOs are contractually required to suspend payments to providers for whom a credible allegation of fraud was identified, according to Section 15.1.18.10 of the MCO general contract. However, while Louisiana has the appropriate contractual provisions, CMS found the state to be non-compliant with § 455.23 in practice. The LDH-PI provider payment

suspension notices provide MCOs with alternatives to payment suspensions due to credible allegations of fraud, including allowing the MCO to not initiate a payment suspension under § 455.23. When the SMA sends notification of payment suspension due to credible allegation of fraud, Louisiana MCOs can choose to suspend payments as directed or provide the rationale explaining that a good cause exception under § 455.23 applies. However, the notice also allows MCOs to not initiate a payment suspension and instead take any other type of administrative action, up to and including immediate termination, if it so chooses, which is not permissible under § 455.23. MCOs must inform LDH-PI of their selected action within one business day. All three MCOs reported that payment suspensions are initiated only if directed in writing by LDH. The state requested that the MCOs suspend payments to two providers due to a credible allegation of fraud in FY 2019 and one provider in FY 2020. However, AmeriHealth and Anthem did not report implementing any payment suspensions during the review period.

CMS determined that allowing MCOs to not initiate a payment suspension and instead take any other type of administrative action it so chooses is not consistent with federal regulations at § 455.23 because MCOs must suspend all payments to a provider for which there is a credible allegation of fraud unless a good cause exception applies, as outlined in § 455.23.

> **Recommendation #1:** Louisiana should revise procedures that direct MCOs to suspend payments to providers due to a credible allegation of fraud, in accordance with § 455.23. The SMA must ensure that MCOs cannot opt out of suspending payments to providers when directed by the agency unless a good cause exception under § 455.23 applies. The SMA should also ensure that MCOs do not take other administrative or network actions at their own discretion in lieu of an agency-directed payment suspension due to a credible allegation of fraud. CMS also encourages Louisiana to clarify terms and responsibilities for good cause exceptions and other MCO actions relating to payment suspensions to ensure full compliance with § 455.23 and avoid inconsistencies in fraud investigation efforts.

***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). Section 15.5.3 of

the MCO general contract states that the MCO shall "…report to LDH Program Integrity at least quarterly all audits performed, and overpayments identified and recovered by the MCO and all of its subcontractors." Section 15.7 also includes the state's recovery retention policies in accordance with § 438.608(d). MCOs must report identified overpayments and recoveries to LDH-PI on a quarterly basis through financial statements and required fraud, waste, and abuse activity reporting. Annual reporting of fraud and abuse recoveries is required as part of the MCOs' annual financial statement submission to LDH, as required by § 438.608(d)(3). Fraud and abuse recovery amounts are removed from total medical expenditures for rate setting. The state confirmed that MCO financial reports include validated recovery information, and LDH-PI Managed Care Oversight periodically audits encounter data and case files to verify any adjustments to recovery amounts.

During the three FYs reviewed, there were no returned overpayments from the MCOs to the state. LDH confirmed that the state does not require MCOs to return overpayments recovered from providers. LDH's retention policy in Section 15.7 stipulates that the MCO can retain recoveries for all provider overpayments they have identified. If the MCO does not collect the identified recovery after one year from approval of the recoupment, then LDH can pursue and retain the overpayment amount. Section 15.2.7 of the general contract also requires that MCOs have a process for network providers to report and return overpayments to the MCO within 60 days of identification, in accordance with § 438.608(d)(2).

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. Section 15.5.1 of the MCO general contract requires MCOs to report suspected fraud to both LDH and the MFCU within three days of discovery, in accordance with § 455.21(c)(3)(iv). Additionally, the MCOs, LDH-PI, and the MFCU must meet "…quarterly and at LDH's request, to discuss fraud, abuse, waste, neglect, and overpayment issues," as directed in Section 15.1.2 of the MCO general contract.

In Louisiana, MCOs are contractually required to immediately report provider fraud concurrently to LDH-PI and the MFCU. Only referrals submitted on the SMA-provided fraud referral template are considered official; allegations received in any other format are considered tips. After the case is referred, LDH-PI is responsible for reviewing the MCO's investigation activity

and determining whether the referral is accepted or denied. In cases where credible allegation of fraud is found, LDH-PI follows up with the MFCU with a separate fraud referral processing memo. The MFCU then reviews the case information and provides written confirmation to LDH-PI as to whether the MCO can proceed with the investigation. The state reported that the MFCU also sends official written notice to LDH-PI of formal acceptance or rejection of the case within six months of referral. However, LDH-PI confirmed that all referrals submitted to the MFCU over the last three FYs were denied. Denied cases are returned to the MCOs for administrative action.

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 its MCOs to discuss program integrity issues, such as case referrals, leads, and administrative actions. LDH-PI's Managed Care Specialist also leads a monthly call with MCO SIUs, Gainwell staff, LDH-PI investigators, and MFCU staff for investigators to discuss cases and leads. The MCOs confirmed meeting with LDH-PI and the MFCU quarterly; AmeriHealth reported that their SIU also meets with LDH-PI and the MFCU monthly.

The state provides program integrity training to the MCOs during their quarterly meetings with the LDH-PI and the MFCU, in addition to annual SIU training sessions. MCOs are also contractually responsible for providing program integrity training to their staff, according to Section 15.2.6. Fraud, Waste, and Abuse Compliance Plan, of the state general contract.

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

## D. MCO Investigations of Fraud, Waste, and Abuse

***State Oversight of MCOs***

Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state PIU and 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.

Louisiana has such a process in in accordance with §§ 455.13-17 and 438.608(a)(7). Louisiana requires, in section 15.5.1 of the MCO contract, that "[t]he MCO and its subcontractors shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect information to the state's MFCU and LDH within three business days of discovery." AmeriHealth and Anthem reported subcontracting with vendors for some program integrity-related functions. AmeriHealth works with its subcontractors for potential fraud, waste, and abuse case identification and pharmacy site visits and reviews. Subcontractors undergo annual fraud training and periodic claims reviews by AmeriHealth. AmeriHealth's compliance office also tracks any corrective

actions placed on vendors on a monthly basis until the corrective action is closed. Anthem works with multiple vendors for data mining, prepayment review, and overpayment collections. Vendor contract compliance for program integrity requirements is managed by the corporate Program Integrity Vendor Compliance team. Centene's subcontractors handle dental, pharmacy, vision, and NEMT fraud, waste, and abuse audits or reviews. Centene's Delegated Vendor Oversight team identifies any subcontractors who receive fraud, waste, and abuse complaints or tips and collaborates with the SIU Manager to conduct investigations and track activities. CMS determined that the MCOs implemented adequate policies and procedures for oversight of subcontractors during the review period.

MCOs are also contractually required to report all internal and external tips, provide updates during the triage process, and conduct and provide results of preliminary investigations of potential fraud to LDH, as directed in Section 15.1.18 of the MCO general contract. If the MCO confirms provider fraud or abuse through preliminary investigation, they are required to submit a standardized fraud referral form to LDH-PI and the MFCU concurrently. If LDH-PI determines that a full investigation is appropriate, LDH-PI directs the MCO in writing to continue their investigation, collaborate with other entities, or stand down. Sections 15.5.4 and 15.1.18.4.1 of the MCO general contract require all MCOs to submit monthly tips reports and quarterly reports of fraud, waste, and abuse activity, including case and provider referral information, to LDH-PI for review. Each of the three MCOs confirmed adhering to this process using SMA-provided reporting templates. LDH-PI staff review each submitted referral and provide applicable feedback to the MCO. LDH-PI also uses MCO encounter data and claims data mining to conduct case investigations. The state informed CMS that all quarterly MCO fraud, waste, and abuse reports are reviewed during quarterly meetings with MCO SIUs, LDH-PI staff, and the MFCU. Overpayment recovery efforts by the three MCOs are only initiated upon LDH approval. The state considers most of the reporting and cases referred by the MCOs to be of adequate quality and in line with CMS referral standards. LDH-PI reported that some referrals receive written feedback for areas of improvement, including proper case tracking and supporting documentation. If an MCO is not submitting an adequate number of referrals based on previous quarters, LDH-PI provides additional guidance for referral submission during quarterly program integrity meetings.

CMS did not identify any findings or observations related to state oversight of the MCOs.

***MCO Oversight of Network Providers***

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

All three MCOs reported use of an internal or contracted SIU or similar unit tasked with identifying and reporting instances of potential fraud, waste, and abuse to the SMA. The MCO SIU is responsible for initiating and conducting a preliminary investigation based on a referral or through data mining. All referrals are initially triaged and validated through a preliminary investigation before moving forward with a full investigation. Preliminary investigation includes, but is not limited to, review of claims data, data analytics, due

diligence, and applicable guidelines/regulations. Once the preliminary investigation has been completed, cases may be escalated to a full investigation, if necessary. A full investigation provides more detailed examination of the complaint or allegation; full investigation activities can include, but are not limited to, on-site visits, interviews, medical record review, identification of overpayments, additional investigative outcomes, and referrals to external agencies.

Each MCO reported that the SIU notifies LDH and the MFCU of any suspected fraud, waste, or abuse within three business days of discovery, in accordance with contract requirements. The SIU also reports the results of all investigations and case tracking on a quarterly basis. Once LDH-PI has sent formal approval on overpayment recovery, collection is coordinated by the MCO.

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. CMS did not identify any findings or observations related to MCO provider oversight.

Figure 1 below describes the number of investigations referred to Louisiana by each MCO, as reported by LDH-PI. While reviewing MCO documentation, CMS observed that the number of cases referred to the state reported by AmeriHealth did not match the number reported by the state.

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

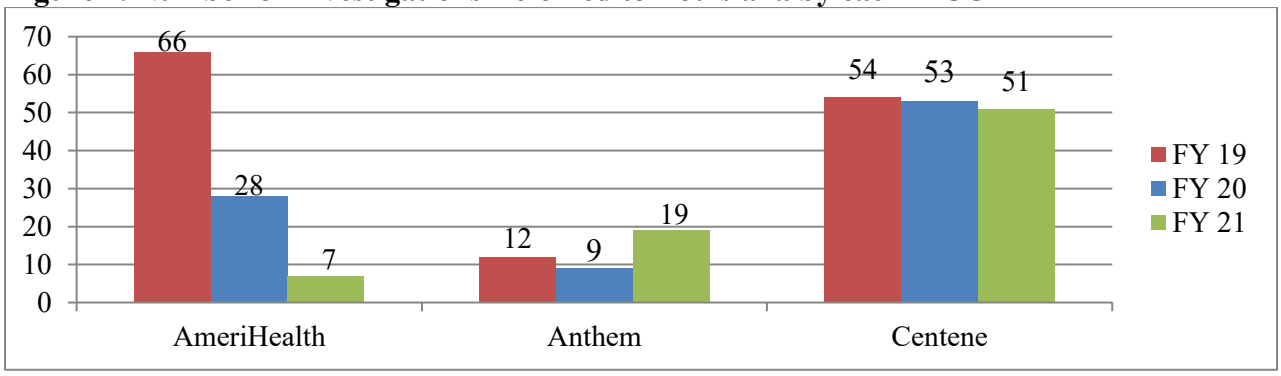


Table 1, below, describes each MCO's recoveries from program integrity activities. The state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the

annual rate-setting process (§ 438.608(d)(4)). Without these adjustments, MCOs could be receiving inflated rates per member per month. The state reported that rate setting is based on paid encounter claims and adjusted total medical expenditures that account for overpayment recoveries. LDH-PI confirmed that the MCOs submit any corrections for invalid encounters to ensure the appropriate claims were adjusted.

**Table 1: MCO Recoveries from Program Integrity Activities**

**AmeriHealth's Recoveries from Program Integrity Activities**

| FY | Preliminary Investigations | Full Investigations | Total Overpayments Identified | Total Overpayments Recovered |
|---|---|---|---|---|
| 2019 | 439 | 236* | $2,690,851 | $1,008,245 |
| 2020 | 476 | 312 | $3,314,270 | $781,541 |
| 2021 | 381 | 247 | $2,075,918 | $1,746,516 |

**Anthem's Recoveries from Program Integrity Activities**

| FY | Preliminary Investigations | Full Investigations | Total Overpayments Identified | Total Overpayments Recovered |
|---|---|---|---|---|
| 2019 | 503 | 209* | $1,890,500 | $833,557 |
| 2020 | 805 | 301 | $2,348,842 | $1,407,449 |
| 2021 | 623 | 308 | $5,329,735 | $2,647,359 |

**Centene's Recoveries from Program Integrity Activities**

| FY | Preliminary Investigations | Full Investigations | Total Overpayments Identified | Total Overpayments Recovered |
|---|---|---|---|---|
| 2019 | 957 | 305* | $6,670,346 | $326,492 |
| 2020 | 1,245 | 521 | $1,323,379 | $473,949 |
| 2021 | 931 | 406 | $1,661,029 | $435,688 |

*LDH-PI tracking of MCO SIU cases unavailable before July 2020

## 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 stipulates 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 Louisiana MCO general contract and MCO submissions, CMS determined that Louisiana was in compliance with § 438.242. Specifically, the contract language in Section 18.0 Reporting includes all the necessary provisions in accordance with § 438.242. MCO submissions revealed that the state provides systems companion guides to standardize encounter data submissions. MCOs are contractually required to submit encounter data and attestation weekly. CMS determined during the review that all MCOs were in compliance with this requirement. The MCOs reported receiving accepted and denied encounters on a weekly and monthly basis from the state's fiscal intermediary. AmeriHealth reported that LDH-PI also provides regular feedback on encounter data submissions during bimonthly touchpoints. LDH contracts with Myers and Stauffer to verify MCO encounter completeness and payment accuracy. The state also works with vendor Gainwell to run algorithms for provider income spikes and conduct ad-hoc data mining.

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. Louisiana was in compliance with § 438.602(e) during the review period. Specifically, Section 14.3.2. External Independent Review, states, "[t]he MCO shall cooperate with the EQRO during the review (including medical records review), which will be done at least one time per contract year." MCOs are required to provide a written description of performance improvement goals and activities developed in response to EQRO findings, according to Section 14.3.4. of the MCO general contract.

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. CMS observed that Louisiana has a process to regularly analyze MCO encounter data for program integrity purposes. Specifically, the Surveillance & Utilization Review Subsystem (SURS) unit within LDH-PI conducts regular and ad-hoc data mining runs on managed care encounters to identify outlier billing patterns and potentially fraudulent billing.

CMS did not identify any findings or observations related to state oversight of the MCOs.

# IV. Conclusion

CMS supports Louisiana's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' desk review identified one recommendation that requires the state's attention.

We require the state to provide a corrective action plan for the recommendation 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 recommendation has 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.

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

# V. Appendices

## Appendix A: Status of Prior Review

Louisiana's last CMS program integrity review was in March 2017, and the report for that review was issued in August 2017. The report contained seven recommendations for improvement. During the desk review in September 2022, CMS conducted a thorough review of the corrective actions taken by Louisiana to address all recommendations reported in calendar year 2017. Six of the seven recommendations had been corrected. The only recommendation that was not corrected is described below.

### Findings

1. ***The state should develop written policies and procedures, or an interagency agreement that outlines which state unit will be responsible for the various program integrity-related oversight functions.***

   **Status at time of the review:** Partially Corrected

   LDH-PI reported that the program integrity unit operates under the Office of the Secretary, outside of Medicaid; there is currently no interagency agreement between LDH-PI and Medicaid for managed care oversight. However, CMS observed that the state has some procedural requirements for contract monitoring, compliance notification protocols, and utilizing a reporting site to verify acceptance of fraud, waste, and abuse related deliverables.

**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 Louisiana MCOs as of January 1, 2021**

| Louisiana MCO Data | AmeriHealth | Anthem | Centene |
|---|---|---|---|
| **Beneficiary enrollment total** | 225,146 | 349,148 | 531,324 |
| **Provider enrollment total** | 17,038 | 29,438 | 7,859 |
| **Year originally contracted** | 2012 | 2012 | 2012 |
| **Size and composition of SIU** | 6 FTEs | 11 FTEs | 11 FTEs |
| **National/local plan** | National | National | National |

**Table C-2. Medicaid Expenditure Data for Louisiana MCOs**

| MCOs | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|
| **AmeriHealth** | $1,135,977,641 | $1,250,760,637 | $1,373,638,554 |
| **Anthem** | $1,473,841,528 | $1,739,322,737 | $2,068,830,481 |
| **Centene** | $2,350,455,854 | $2,583,188,064 | $2,891,529,905 |
| **Total MCO Expenditures** | $4,960,275,023 | $5,573,271,438 | $6,333,998,940 |

**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 | Louisiana should revise procedures that direct MCOs to suspend payments to providers due to a credible allegation of fraud, in accordance with § 455.23. The SMA must ensure that MCOs cannot opt out of suspending payments to providers when directed by the agency unless a good cause exception under § 455.23 applies. The SMA should also ensure that MCOs do not take other administrative or network actions at their own discretion in lieu of an agency-directed payment suspension due to a credible allegation of fraud. CMS also encourages Louisiana to clarify terms and responsibilities for good cause exceptions and other MCO actions relating to payment suspensions to ensure full compliance with § 455.23 and avoid inconsistencies in fraud investigation efforts. | | |

Acknowledged by:

_____
[Name], [Title]

_____
Date (MM/DD/YYYY)