Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

District of Columbia Focused Program Integrity 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 focused program integrity review of the District of Columbia's (the District's) Medicaid managed care program for Fiscal Years (FYs) 2019-2021 to assess the District's program integrity oversight efforts. This focused review specifically assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid managed care.

To meet the objectives of this focused review, CMS reviewed information and documents provided in response to the CMS managed care review tool provided at the initiation of the review, and conducted in-depth interviews with the District Medicaid agency, as well as evaluated program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency (SMA). The MCOs participating in this review are AmeriHealth Caritas District of Columbia (AmeriHealth Caritas), CareFirst Community Health Plan District of Columbia (CareFirst), and MedStar Family Choice District of Columbia (MedStar).

This report includes CMS' findings and the resulting recommendation, 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 two findings that create risk to the District of Columbia Medicaid program related to managed care program integrity oversight. In response to the findings, CMS identified **two** recommendations that will enable the District 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:** CMS recommends that the District improve oversight procedures to ensure that all MCO compliance plans meet the seven core elements outlined in § 438.608(a)(1)(i)-(vii).

MCO Contract Compliance

> **Recommendation #2:** CMS recommends that the District ensure the MCO general

contract includes language that requires MCOs to have a mechanism for a network provider to report and return an overpayment to the plan within 60 days of identification, consistent with § 438.608(d)(2). The District should also verify that identified and collected overpayments are fully reported by the MCOs and that these amounts are incorporated in the rate-setting process.

Observations

Observations represent operational or policy suggestions that may be useful to the District in the oversight of its Medicaid managed care program. CMS identified **seven** observations related to the District'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 the District to consider the inclusion of MCO general contract language addressing investigative unannounced provider site visits. In addition, CMS encourages the District to revise their MCO general contract to include language that specifies staffing requirements, including experience and physical location within the District of Columbia.

MCO Contract Compliance

Observation #2: CMS encourages the District to enhance its oversight of FWA plans. While the District requires each MCO to submit an annual FWA plan that addresses measures to detect and prevent fraud, waste, and abuse, CMS noted that several essential program integrity elements were excluded from at least one MCO's FWA plan.

Observation #3: CMS encourages the District to ensure that MCOs have sufficient corrective action plan (CAP) procedures in place and utilize them appropriately to address non-compliant Medicaid providers. Additionally, CMS encourages the District to ensure the full requirements of the CAP are completely satisfied by the providers.

Observation #4: CMS encourages the District to develop and distribute detailed guidance for standard, appropriate verification procedures and supporting this guidance with modified MCO general contract language.

MCO Investigations of fraud, waste, and abuse

Observation #5: CMS encourages the District to review the overpayment procedures of all MCOs and ensure the MCOs make recovering overpayments a program integrity priority to promote the recoveries of all improperly paid managed care Medicaid

payments.

Observation #6: CMS encourages the District to work with the MCOs to develop and routinely provide specific program integrity training related to enhancing the quantity of case referrals from the MCOs. This could include providing more frequent feedback to the MCOs regarding the quality and quantity of MCO case referrals forwarded to the District. In addition, CMS encourages the District to ensure that MCO staff are receiving adequate training in identifying, investigating, and referring potential fraudulent billing practices by providers.

Observation #7: CMS encourages the District to ensure that the MCOs have a prepayment review process in place, including collaborating to strengthen parameters regarding prepayment rules, policies, and requirements.

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 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 District of Columbia Managed Care Program and the Focused Program Integrity Review

The Department of Health Care Finance (DHCF) is responsible for the administration of the District of Columbia Medicaid program. Within DHCF, the Program Integrity Unit (PIU) is the organizational unit tasked with oversight of program integrity-related functions for the managed care program. During the review period, the District reported contracting with three MCOs to provide health services to the Medicaid population. As part of this review, the three MCOs interviewed were: AmeriHealth Caritas, CareFirst, and MedStar. Appendix C provides enrollment and expenditure data for each of the selected MCOs.

In June 2022, CMS conducted a virtual focused program integrity review of the District's managed care program. This focused review assessed the District's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. As a part of this review, CMS also

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

evaluated program integrity activities performed by selected MCOs under contract with the SMA. CMS interviewed key staff and may review 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 the District's previous corrective action plan that was developed in response to a previous Focused Program Integrity Review of the District of Columbia'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 **two** recommendations and **seven** observations. CMS also included technical assistance and educational resources for the District, which can be found in Appendix B. The District's response to CMS' draft report can be found in Appendix D, and the final report reflects changes CMS made based on the District'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 District, 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 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 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 District 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

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 the District of Columbia, CMS determined that the oversight and monitoring requirements set forth at §§ 438.66 and 438.602 were addressed within the MCO general contract. However, although these requirements are addressed within contract language, CMS observed inconsistent program integrity practices being performed by the MCOs, which could potentially allude to a lack of oversight activities being performed by the District despite their provision within the MCO general contracting. For example, MCOs varied on the number of beneficiary verifications being performed and were not issued specific guidance on certain components of the investigative process, such as when to perform unannounced provider site visits. Additionally, CMS noted that the MCO general contract did not have language addressing the organizational structure or geographical location of the MCO PIUs, nor did it provide any guidance or requirements for maintaining appropriate staffing levels within these units.

CMS observed that the District's MCO general contract did not include specific language related to professional experience of staff and the number of staff assigned to perform program integrity activities, as well as the staff being physically located in the proximity of the District of Columbia. It is critical that MCOs maintain sufficient program integrity resources and staffing levels to conduct a full range of program integrity functions, including but not limited to the review, investigation, auditing of provider types where Medicaid dollars are most at risk, and recovery of monies overpaid.

> **Observation #1**: CMS encourages the District to consider the inclusion of MCO general contract language addressing investigative unannounced provider site visits. In addition, CMS encourages the District to revise their MCO general contract to include language that specifies staffing requirements, including experience and physical location within the District of Columbia.

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 the District of Columbia is developed through a collaborative effort between the Health Care Delivery and Management Administration (HCDMA) and the District's Division of Program Integrity.

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 C.5.33.3.1 to C.5.33.3.7 of the District of Columbia'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 CareFirst and MedStar met the contract requirements; **however, CMS noted that AmeriHealth Caritas did not have language in their compliance plan addressing requirements for the establishment of a compliance officer and compliance committee.**

The SMA reported that MCOs are contractually required to develop a Fraud, Waste, and Abuse (FWA) plan to be submitted for annual review. However, CMS noted that MCO MedStar's FWA plan omitted elements including, but not limited to, overpayments, payment suspensions, meetings and/or interactions with the MFCU, and SIU onsite visits. CMS

identified no compliance concerns with the FWA plans for AmeriHealth Caritas and CareFirst.

CMS observed that the District's MCO general contract does address the use of corrective action plans (CAP). However, AmeriHealth Caritas reported that the MCO did not place any providers on a CAP within the review period. CareFirst placed sixteen providers on a CAP, and MedStar placed four providers on a CAP within the review period.

Recommendation #1: CMS recommends that the District improve oversight procedures to ensure that all MCO compliance plans meet the seven core elements outlined in § 438.608(a)(1)(i)-(vii).

Observation #2: CMS encourages the District to enhance its oversight of FWA plans. While the District requires each MCO to submit an annual FWA plan that addresses measures to detect and prevent fraud, waste, and abuse, CMS noted that several essential program integrity elements were excluded from at least one MCO's FWA plan.

Observation #3: CMS encourages the District to ensure that MCOs have sufficient CAP procedures in place and utilize them appropriately to address non-compliant Medicaid providers. Additionally, CMS encourages the District to implement mechanisms to ensure the full requirements of the CAP are completely satisfied by the providers.

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 the District of Columbia, this requirement is met for the review period. The District of Columbia's MCO general contract Section C.5.36.2.6 states "…the contractor shall verify that reimbursed services were actually provided to enrollees by providers and independent contractors." The three MCOs each reported following the requirements to verify that services billed by providers were received by beneficiaries. The MCOs are not required to submit a report of all beneficiary verifications that were conducted to the District. However, the MCOs are required to report to the District any suspected fraud and abuse identified from the beneficiary verifications. All three MCOs have tracking mechanisms in place for beneficiary verifications during the review period. However, CMS observed that the number of beneficiary verifications varied by MCO.

Observation #4: CMS encourages the District to develop and distribute detailed guidance for standard, appropriate verification procedures and supporting this guidance with modified MCO general contract language.

False Claims Act Information

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

The District is compliant with this requirement. CMS noted that each of the 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.

The District of Columbia Medicaid MCOs are contractually required to suspend payments to providers at the District's request. DHCF conducts a Payment Suspension Committee meeting with the relevant stakeholders to review allegations of fraud and to determine their credibility. If the committee determines that the allegations are credible, it is reviewed for a good cause exception found in § 455.23(e) and (f) to determine if any apply. If a payment suspension is determined, the MCO is notified via email with the results of the finding. The case is also discussed during the monthly meeting between DHCF DPI and the MCOs.

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 District. 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 District 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 District 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 District largely addressed the requirements at §§ 438.608(a)(2) and (d) in the MCO general contract adequately. Section C.5.33.1.7 states "…the contractor shall have retention policies for the treatment of recoveries of all overpayments from the contractor to a provider, including specifically a retention policy for the treatment of recoveries of overpayments due to fraud, waste, or abuse in accordance with § 438.608(d). Retention policies shall include the process, timeframes, and documentation required for reporting the recovery of all overpayments." **However, § 438.608(d)(2) requires MCOs to have a mechanism for a network provider to report and return an overpayment to the plan within 60 days of identification. The MCO general contract did not meet this regulatory requirement during the review period**.

> **Recommendation #2:** CMS recommends that the District ensure the MCO general contract includes language that requires MCOs to have a mechanism for a network provider to report and return an overpayment to the plan within 60 days of identification, consistent with § 438.608(d)(2). The District should also verify that identified and collected overpayments are fully reported by the MCOs and that these amounts are incorporated in the rate-setting process, consistent with § 438.608(d)(4).

C. Interagency and MCO Program Integrity Coordination

Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the District 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 District MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA. The District has a Memorandum of Understanding (MOU) in place with the MFCU that meets the regulatory criteria. Specifically, there is a MOU that contains procedures by which the MFCU will receive referrals of potential fraud from MCOs as required by 455.21(c)(3)(iv). Additionally, the District meets with the MFCU monthly to discuss case referrals.

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 monthly collaborative sessions with its MCOs to discuss program integrity issues, such as case referrals, leads, and administrative actions. These meetings are also attended by the MFCU and other relevant stakeholders. The MCOs are required to work cooperatively with

DHCF, the MFCU, the OIG, CMS, and any other law enforcement agencies, as appropriate, to administer effective program integrity practices and participate in any subsequent legal actions, and to participate in meetings with the District Program Integrity, Investigations, or Fraud Control personnel, the District Recovery Audit Contractor, and with other MCO compliance staff. These meetings are facilitated by the District and the MFCU.

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 District PIU or any potential fraud directly to the District'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.

The District of Columbia has such a process in accordance with §§ 455.13-17 and 438.608(a)(7). Section C.5.33.3.6.1 of the MCO general contract outlines the process in which MCOs are to refer to suspected fraud, and abuse to the District. The contract states, "Contractor shall be responsible for referring potential fraud, reporting violation of the terms of the Contract, taking prompt corrective action, and cooperating with DHCF in its investigation of the matter(s). Additionally, the Contractor shall promptly report to the DHCF if it discovers that any of its Providers have been excluded, suspended, or debarred from any District, or federal health care benefit program within three (3) Business days. Reporting on waste, abuse, and complaints or tips will be provided in monthly reports to the DHCF." The three MCOs each reported following the above requirements regarding referring suspected fraud and abuse to the District.

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

MCO Oversight of Network Providers

CMS verified whether each District of Columbia MCO had an established process for conducting investigations and making referrals to the District, consistent with CMS requirements and the District's MCO general 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 DHCF DPI. All referrals are initially triaged and validated through a preliminary investigation before moving forward with a full investigation. This process generally includes an intake of the complaint and review of the evidence presented. Preliminary investigation also 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.

The MCO general contract requires reporting of suspected credible allegations of fraud after investigation to the DHCF within 24 hours of the MCO completing the related investigation. All three MCOs reported that investigations are reported to DHCF DPI within five business days using an online complaint referral form.

Overall, CMS found the reported MCO processes for the investigation of suspected fraud, waste, and abuse to meet CMS requirements and the District's contract requirements.

In addition, CMS observed that the number of overpayments identified and recovered by the MCOs is low for a managed care program of the District of Columbia's size.

Figure 1 below describes the number of investigations referred to the District of Columbia by each MCO. CMS notes that there were a limited number of provider investigations being conducted by the MCOs.

Figure 1: Number of Investigations Referred to the District of Columbia by each MCO

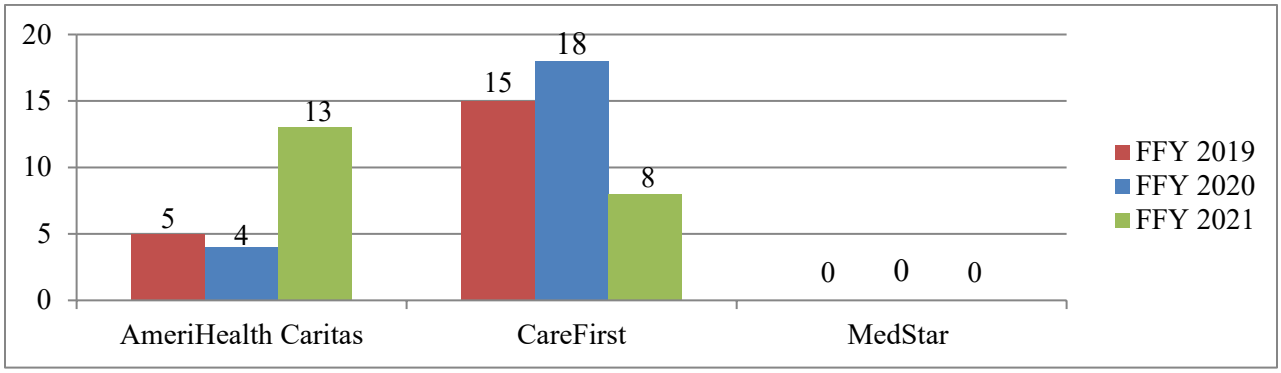

Table 1, below, describes each MCO's recoveries from program integrity activities. The District must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process (§ 438.608(d)(4)). Without these adjustments, MCOs could be receiving inflated rates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

Table 1: MCO Recoveries from Program Integrity Activities

AmeriHealth Caritas Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	26	11	$116,704.18	$138,677.96
2020	16	11	$30,054.18	$26,194.31
2021	19	24	$145,569.10	$46,703.70

CareFirst Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	8	0	$1,207,486	$11,790
2020	69	0	$2,623,452	$353,324
2021	67	0	$540,927	$364,069

MedStar Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	0	0	$0	$0
2020	0	0	$0	$0
2021	139	81	$90,054	$0

Observation #5: CMS encourages the District to review the overpayment procedures of all MCOs and ensure the MCOs make recovering overpayments a program integrity priority to promote the recoveries of all improperly paid managed care Medicaid payments.

Observation #6: CMS encourages the District to work with the MCOs to develop and routinely provide specific program integrity training related to enhancing the quantity of case referrals from the MCOs. This could include providing more frequent feedback to the MCOs regarding the quality and quantity of MCO case referrals forwarded to the District. In addition, CMS encourages the District to ensure that MCO staff are receiving adequate training in identifying, investigating, and referring potential fraudulent billing practices by providers.

Observation #7: CMS encourages the District to ensure that the MCOs have a prepayment review process in place, including collaborating to strengthen parameters regarding

prepayment rules, policies, and requirements.

E. Encounter Data

In accordance with § 438.242, the District must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. Additionally, § 438.242 further states that MCO contracts must specify the frequency and level of detail of beneficiary encounter data, including allowed amount and paid amount, that the District 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 District of Columbia MCO general contract and interviews with each of the MCOs, CMS determined that the District of Columbia was in compliance with § 438.242. Specifically, the contract language states the 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.

In addition, in accordance with § 438.602(e), the District 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. The District of Columbia was in compliance with § 438.602(e) .

In addition, while it is not a requirement, regularly analyzing the encounter data submitted by MCOs enables SMAs to conduct additional program integrity activities, such as identifying outlier billing patterns, payments for non-covered services, and fraudulent billing. The District of Columbia has a process to regularly analyze MCO encounter data for program integrity purposes. Specifically, the contracts with the MCOs require all encounter data be submitted within thirty days after reimbursement of the claim or capitation payment. Per the contract, upon request by DHCF, the contractor shall provide all provider claims, both denied and paid, to DHCF based on requested reporting requirements.

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

IV. Conclusion

CMS supports the District of Columbia's efforts and encourages the District to look for additional opportunities to improve overall program integrity. CMS' focused review identified two recommendations and seven observations that require the District's attention.

We require the District 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 District 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

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

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

CMS looks forward to working with the District of Columbia to build an effective and strengthened program integrity function.

V. Appendices

Appendix A: Status of Prior Review

The District of Columbia'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. The findings from the 2017 District of Columbia focused PI review report were considered by CMS to be corrected by the District.

Appendix B: Technical Resources

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

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

Appendix C: Enrollment and Expenditure Data

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

Table C-1. Medicaid Enrollment Summary Data for District of Columbia MCOs

District of Columbia MCO Data	AmeriHealth	CareFirst	MedStar
Beneficiary enrollment total	99,980	61,127	60,512
Provider enrollment total	10,861	5,689	3,761
Year originally contracted	2013	2013	2020
Size and composition of SIU	3	FY19: 3 FY20 – FY21: 5	3
National/local plan	National	Local	Local

Table C-2. Medicaid Expenditure Data for District of Columbia MCOs

MCOs	FY 2019	FY 2020	FY 2021
AmeriHealth Caritas	$567,044,945.74	$631,905,087.49	$658,149,156.01
CareFirst	$146,559,318.94	$133,230,345.52	$392,717,096.60
MedStar	$66,787.29	$0	$381,262,929.33
Total MCO Expenditures	$713,671,051.97	$765,135,433.01	$1,432,129,181.94

Appendix D: State Response

State PI Review Response Form

INSTRUCTIONS:

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

Classification	Issue Description	Agree	Disagree
Recommendation #1	CMS recommends that the District improve oversight procedures to ensure that all MCO compliance plans meet the seven core elements outlined in § 438.608(a)(1)(i)-(vii).		
Recommendation #2	CMS recommends that the District ensure the MCO general contract includes language that requires MCOs to have a mechanism for a network provider to report and return an overpayment to the plan within 60 days of identification, consistent with § 438.608(d)(2). The District should also verify that identified and collected overpayments are fully reported by the MCOs and that these amounts are incorporated in the rate-setting process.		

Acknowledged by:

_____
[Name], [Title]

_____
Date (MM/DD/YYYY)