# Department of Health and Human Services

# Centers for Medicare & Medicaid Services

# Center for Program Integrity

# Louisiana Focused Program Integrity Review

# Final Report

# August 2017

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## Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of Louisiana to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency. The review also included a follow up on the state's progress in implementing corrective actions related to CMS's previous comprehensive program integrity review conducted in calendar year 2012.

## Background: State Medicaid Program Overview

The Louisiana Department of Health (LDH) is home to most of the state's human services and health care programs, including the Healthy Louisiana Plan (Medicaid), Aging and Adult Services, Behavior Health, Developmental Disabilities, and the Office of Public Health. Most of Louisiana's Medicaid and the Louisiana Children's Health Insurance Program recipients receive health care services through the Healthy Louisiana Plan, formerly known as Bayou Health. The LDH's Bureau of Health Services Financing (LDH-BHSF) is responsible for administering the Louisiana Medicaid program.

As of February 2017, the Louisiana Medicaid program served approximately 1.6 million beneficiaries; Medicaid expansion members comprised 415,778 of those beneficiaries. Approximately 7 percent of the total Medicaid population, or 111,176 beneficiaries, was served on a fee-for-service (FFS) basis and the remaining 93 percent, or approximately 1.5 million beneficiaries, was enrolled in one of the five MCOs. Louisiana's total Medicaid expenditures for federal fiscal year (FFY) 2016 totaled approximately $8.8 billion, which includes FFS expenditures of $4.2 billion, and MCO expenditures of $4.6 billion or 52 percent of total Medicaid expenditures. The Federal Medical Assistance Percentage for Louisiana for FFY 2016 was 62.21 percent. At the time of application for Medicaid, the beneficiary is requested to choose the MCO of preference. If the beneficiary does not select an MCO, the beneficiary will be automatically assigned to one.

The state has one dental benefit management program prepaid ambulatory health plan (PAHP) that covers dental benefits for all Louisiana Medicaid beneficiaries; this plan offers full dental coverage for children and denture services for adults. Louisiana Medicaid also contracts with Magellan, a prepaid inpatient health plan (PIHP), for specialized intensive behavioral health therapies that include home and community-based wraparound agencies intended to prevent inpatient stays for children at risk of institutionalization for mental health issues; this arrangement is called the Coordinated System of Care (CSoC). All Medicare-Medicaid dually eligible beneficiaries, long term care recipients, some waiver recipients, and all adult personal care services are covered by Legacy/FFS Medicaid.

## Methodology of the Review

In advance of the onsite visit, CMS requested that Louisiana and the MCOs selected for the focused review complete a review guide that provided the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. A

three-person review team has reviewed these responses and materials in advance of the onsite visit.

During the week of March 20, 2017, the CMS review team visited LDH-BHSF. It conducted interviews with numerous state staff involved in program integrity and managed care. The CMS review team also conducted interviews with three MCOs and their special investigations units (SIUs). In addition, the CMS review team conducted sampling of program integrity cases and other primary data to validate the state and the selected MCOs' program integrity practices.

## Results of the Review

The CMS review team identified areas of concern with the state's managed care program integrity oversight, thereby creating risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible, particularly those that remain from the earlier review. These issues and CMS's recommendations for improvement are described in detail in this report.

## Section 1: Managed Care Program Integrity

*Overview of the State's Managed Care Program*

As mentioned earlier, approximately 1.5 million beneficiaries, or 93 percent of the state's Medicaid population, were enrolled in five MCOs during FFY 2016. The state spent approximately $4.6 billion, or 52 percent of the total Medicaid expenditures, on managed care contracts in FFY 2016.

***Summary Information on the Plans Reviewed***

The CMS review team interviewed three MCOs as part of its review.

Aetna Better Health of Louisiana (ABH) is a subsidiary of Aetna, Inc. The national Medicaid SIU is comprised of 14 employees which include: a project manager, a project lead, investigators, and analysts. The SIU provides investigative services to Medicaid health plans in 16 markets nationwide and has been providing Medicaid managed care in Louisiana under the Healthy Louisiana Plan since February 2015. There are two SIU investigators fully-dedicated to Medicaid investigations in the Louisiana plan.

UnitedHealthcare (UHC) is an operating division of UnitedHealth Group, the largest single health carrier in the United States. The UHC operates in 24 markets nationwide and has been providing Medicaid managed care in Louisiana since February 2015. The UHC administers Medicaid managed care in Louisiana under the Healthy Louisiana Plan. The MCO's Louisiana program integrity unit (PIU) consists of a compliance officer, one compliance analyst, and four SIU investigators. The corporate SIU consists of an additional 28 staff members. Also, the Louisiana plan is supported by the resources of the parent company, UnitedHealth Group.

AmeriHealth Caritas Louisiana (ACLA) operates in 14 markets nationwide and has been operational in Louisiana since February 2012. The ACLA administers Medicaid managed care in Louisiana under the Healthy Louisiana Plan. The MCO's Louisiana PIU consists of a compliance director, two SIU investigators, and one SIU investigator vacancy. The SIU is supported by two additional units which are located at AmeriHealth Caritas corporate headquarters in Philadelphia, Pennsylvania. The Payment Integrity Unit, which consists of 34 full-time equivalents (FTEs), focuses on overpayment avoidance and recoveries. The SIU, which consists of 44 FTEs, focuses on identifying and developing cases that appear to be fraud or abuse-related. Both units provide support nationwide for the 14 markets in which AmeriHealth Caritas operates.

Enrollment information for each MCO as of February 2017 is summarized below:

**Table 1.**

| | **ABH** | **UHC** | **ACLA** |
|---|---|---|---|
| **Beneficiary enrollment total** | 107,314 | 408,841 | 210,601 |
| **Provider enrollment total** | 24,174 | 14,525 | 18,546 |
| **Year originally contracted** | 2015 | 2012* | 2012 |
| **Size and composition of the national SIU** | 14.0 FTEs | 34.0 FTEs | 44.0 FTEs |
| **Number of SIU FTEs fully-dedicated locally** | 2.0 FTEs | 6.0 FTEs | 4.0 FTEs** |
| **National/local plan** | National | National | National |

*The UHC started in Louisiana as a Medicaid Shared Savings Plan in 2012, but became an MCO in 2015.
**The total FTEs includes one SIU investigator position which was vacant at the time of the onsite review.

Total Medicaid expenditure information for each MCO as of February 2017 is summarized below:

**Table 2.**

| **MCOs** | **FFY 2014** | **FFY 2015** | **FFY 2016** |
|---|---|---|---|
| ABH | N/A* | $108.7 million | $318.8 million |
| UHC | N/A** | $282.1 million | $660.9 million |
| ACLA | $406.1 million | $562.0 million | $672.1 million |

*The UHC started in Louisiana as a Medicaid Shared Savings Plan in FFY 2012, but became a MCO in FFY 2015.
*****The MCO was not contracted to do business until FFY 2015.***

***State Oversight of MCO Program Integrity Activities***

The LDH-BHSF is responsible for ensuring Medicaid MCOs comply with the terms of their contract. General contract monitoring varies by contract type. The LDH-BHSF is responsible for the five MCOs and the dental PAHP. The Office of Behavioral Health (OBH) monitors the PIHP contract. The OBH and LDH-BHSF are jointly responsible, through an interagency agreement, for monitoring specialized behavioral health services provided by the MCOs. These services were carved into the MCO contracts during December 2015. Although, there is an interagency agreement between OBH and LDH-BHSF for the provision of MCO behavior health services, there is no interagency agreement between the Program Integrity Managed Care Unit and the Health Plan Management Unit outlining joint MCO responsibilities.

As a result a department-wide reorganization and realignment of the functions at LDH, MCO contract monitoring is now delegated by LDH's executive management to business owners, or subject matter experts, based upon the specific subject matter. If a person in LDH-BHSF is responsible for a specific issue in the FFS delivery system, that person is also responsible for that same issue in the managed care delivery system. Primary responsibility for general contract monitoring resides with the Health Plan Management Unit which is under the supervision of the MCO Deputy director; however, certain specialized sections such as the Finance Unit, Pharmacy Unit, the Medicaid Management Information System, and the PIU were heavily involved in contract monitoring prior to the formation of this division and continue to retain oversight ownership for those subject matter areas.

The PIU is responsible for fraud, waste, and abuse oversight of all managed care plans contracted with the state Medicaid agency. Currently, the PIU's Program Integrity Managed Care manager is fully-dedicated to fraud, waste, and abuse oversight, and contract monitoring. The LDH intends to increase the number of PIU staff dedicated to managed care oversight, as part of its department-wide reorganization.

During Spring 2017, the PIU also plans to begin audit reviews of MCO network providers utilizing its Surveillance and Utilization Review Systems (SURS) contract with Molina Healthcare, Inc. (Molina), its fiscal intermediary. The LDH contracts with Molina to conduct program integrity activities. The state's contract requires the Molina-SURS Department to close a minimum of 600 investigations per year. The Molina-SURS Department employs registered nurses, social workers, dental hygienists, and medical consultants to perform investigations and reviews of providers billing the Louisiana Medicaid program.

The Molina-SURS Department staff are contracted to detect, investigate, and recover overpayments resulting from fraud, waste, and abuse in the Louisiana Medicaid program. The contract staff conducts the investigatory activities from the beginning through completion, under the direction and approval of LDH's PIU staff. Each analyst reviews the claims or encounter data, medical records, policies, and the Current Procedural Terminology guidelines pertinent to their cases. All investigatory activities are documented in the case record. If an overpayment exists, those negative balances are forwarded to LDH's Finance Unit. All Molina-SURS Department cases are entered into a Microsoft Access database. This SURS database contains some of the following information: provider name, provider number, open date, closure date, case status code, assigned analyst, case disposition, recovered amount, and identified amount.

The Molina-SURS Department operates a Medicaid fraud, waste, and abuse complaint hotline. Complaints are received via telephone, internet, facsimile, and mail. These complaints are entered into a complaint database for tracking and reporting purposes; this database is known as FACTS. The SURS Department staff identifies aberrant billing patterns by utilizing the J-SURS Fraud and Abuse Detection System. The Molina-SURS Department subcontracts with Truven Health Analytics for the J-SURS solution software. All of the analysts have access to J-SURS to assist with investigations. J-SURS contains FFS claims data and managed care encounter data. A group of J-SURS power-users, who are individuals that utilize the advanced

features of the system, is responsible for performing regular and ad hoc data mining runs to isolate and identify suspicious providers and claims.

The Molina-SURS Department provides the Program Integrity Section chief with management summary reports. These reports include monthly statistics on cases such as number of cases opened and closed; amounts identified and recovered; number of hotline calls received; number of cases referred to the Medicaid Fraud Control Unit (MFCU); and the number of Recipient Explanation of Medical Benefits (REOMB) cases. Also, a report containing a list of open cases is forwarded monthly. During FFY 2016, the Molina-SURS Department referred approximately 100 cases to the MFCU; the MFCU accepted 83 of the referrals. The CMS review team did not include the fraud, waste, and abuse investigatory efforts of the Molina-SURS Department in this report, since their activities were outside of the scope of this MCO-focused review.

The Program Integrity Managed Care manager was responsible for fraud, waste, and abuse oversight prior to the MCO business owner reorganization, and has retained ownership of the fraud, waste, and abuse provisions of the MCO contracts. Also, the Program Integrity Provider Enrollment Unit is now responsible for monitoring provider exclusions, adverse actions, terminations, and prohibited affiliations; however, the contract monitor and final authority for all of the MCOs and the sole dental PAHP resides with the Medicaid director. The contract monitor of the PIHP is the Secretary of the Office of Behavioral Health.

During the CMS program integrity review conducted in 2012, it was noted that LDH was in violation of 42 CFR 455.20, which requires the state Medicaid agency to have a method for verifying whether services billed by providers in the Louisiana Medicaid program were received by the beneficiaries. However, LDH did create an REOMB attestation form, along with incorporating language requiring sampling of paid claims, into all managed care contracts in fulfillment of this requirement.

The Healthy Louisiana Plan's current request for proposal (RFP) requires a minimum representative sample of two percent of paid claims per month. The CSoC's RFP requires a minimum random sample of 65 members per month. The Dental Benefit PAHP's RFP requires a minimum sample of 200 claims per year. Surveys must be performed monthly and within 45 days of date of payment. All plans are required to report results to LDH on a quarterly basis.

Also, LDH requires MCOs to investigate all sampling responses indicating that services were not rendered; the results of these reviews must be reported to the PIU. Each plan completes a summary report and submits the *Sampling of Paid Claims Report* electronically through the established deliverable reporting processes for numbered reports. During the onsite review, the CMS review team determined that the 2012 CAP issue related to verification of services rendered was resolved; however, all three of the MCOs reported received either limited or no response from those beneficiaries surveyed. During the past three FFYs, ABH sent out approximately 2,128 REOMBs and received no response. The UHC sent out approximately 105,383 REOMBs and received 15 responses. The ACLA sent out approximately 102,992 REOMBs and received 152 responses. All three MCOs admitted that this was a low return on investment, when comparing the volume of surveys sent out to the number of responses received from beneficiaries. The ACLA acknowledged the low return rate of REOMBs and informed the

CMS review team that it was considering sending out REOMBs that would focus specifically on beneficiaries with known problematic procedural codes, in an effort to increase the probability of returns.

### *MCO Investigations of Fraud, Waste, and Abuse*

As required by 42 CFR 455.13, 455.14, 455.15, 455.16, and 455.17, the state does have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

Louisiana's MCO contract states that, "The MCO shall notify MFCU and LDH simultaneously and in a timely manner regarding all internal and external tips with potential implications to Louisiana Medicaid providers' billing anomalies and/or to safety of Medicaid enrollees that results in a full investigation (42CFR 455.15). Along with a notification, the MCO shall take steps to triage and/or substantiate these tips and provide simultaneous and timely updates to MFCU and LDH when the concerns and/or allegations of any tips are authenticated. The MCO should promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. The MCO shall promptly provide the results of its preliminary investigation to LDH or the agency to whom the incident was reported, or to another agency designated by the agency that received the report, unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse. The MCO shall not take any further actions as they specifically relate to Medicaid claims. All confirmed or suspected provider fraud and abuse shall immediately be reported to LDH and MFCU. The MCO shall utilize a *Fraud Reporting Form* deemed satisfactory by the agency to whom the report is to be made under the terms of the Contract."

The MCOs submit monthly reports of fraud, waste, and abuse activity to LDH-BHSF's PIU which is then sent to the Program Integrity Managed Care Unit director for review. The contract does includes language that requires the MCO to report suspected provider fraud, waste, or abuse to the Louisiana MFCU.

The ABH's data mining plan utilizes the Verisk Analytics' *Fraud Finder Pro* software tool to conduct peer-to-peer analysis, as well as targeted ad hoc reports, to identify outliers for known schemes; the results are forwarded to the SIU for prepayment review on a daily basis. During December 2016, ABH utilized IBM's *Fraud and Abuse Case Management* tool to proactively identify providers exhibiting billing behaviors which differ significantly from that of their peers. Providers are profiled by peer group, specialty, product, and geography. Currently, *SIU Lead Generation Tool* is used to view and evaluate leads provided by the Enterprise Analytics fraud team. The ABH referred one case of suspected fraud to LDH and MFCU in FFY 2016.

The UHC's SIU has four FTEs fully-dedicated to identifying and investigating fraud and abuse occurring within the Louisiana Medicaid program. In addition to the contractually required FTEs, UHC employs multiple vendors and resources to process claims, and identify fraud and abuse. OptumInsight, United Payment Integrity, OptumRx, and UHC's SIU operate jointly when conducting prospective and retrospective claim reviews. All claims are processed through

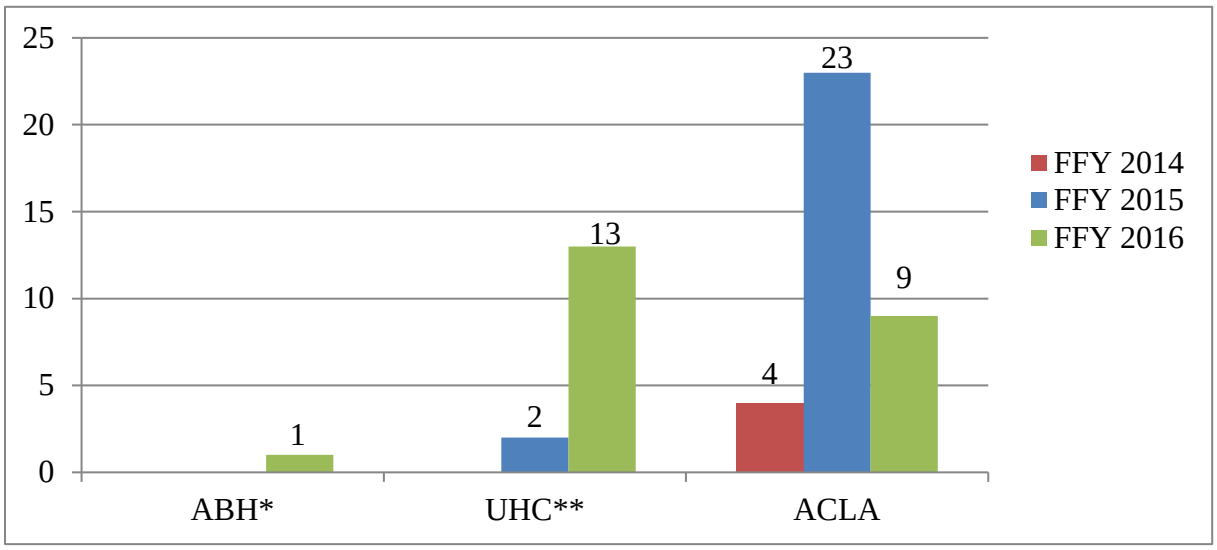
*Claims Editing System* (or iCES) and *Prospective 2.0* (P2). The P2 software tool includes: provider peer-to-peer profiling, claim-centric editing, and predictive modeling tools that uncover previously undetected aberrant behaviors. These software tools are applied to the plan's daily claim stream to identify fraud and abuse before the claim is paid. Once suspect claims are identified, medical records are requested using a system-generated letter that identifies the specific claim under review and the necessary documentation required to complete the review. OptumInsight and UHC jointly manage each prepayment investigation to ensure that claims are being processed within the applicable state prompt payment guidelines. The UHC utilizes an electronic case tracking system known as the Case Information Management System (or CIMS) to log and track all SIU investigations. Thirteen cases of suspected fraud were reported to LDH and MFCU in the last four quarters. One case was accepted as a referral by LDH or MFCU.

The ACLA has three SIU FTEs dedicated to identifying and investigating fraud and abuse within the Louisiana Medicaid program. The ACLA's Program Integrity Officer manages the compliance program; this includes associate fraud and abuse training, and coordination of referrals with law enforcement agencies. The local SIU investigators are responsible for performing onsite provider visits/audits as well as collaborating with state law enforcement agencies. In addition to the contractually required FTEs, ACLA employs multiple vendors and resources to process claims, and identify fraud and abuse. The HMS software tools and Cotiviti's *iHealth* provide data mining and claims editing support. The ACLA utilizes an electronic case tracking system known as the Commander Case Tracking System which is supported by General Dynamics Information Technology. Nine cases of suspected fraud were reported to LDH and MFCU in the last four quarters. None of these cases were accepted as a referral by LDH or MFCU.

The MCO model contract does include language that requires the MCO to report suspected provider fraud, waste, or abuse to the MFCU; however, the contract lacked policies and procedures requiring its MCOs to conduct unannounced and/or announced site visits for fraud and abuse.

Table 3 lists the number of referrals that ABH's SIU, UHC's SIU, and the ACLA's SIU made to the state in the last three FFYs. Overall, the number of Medicaid provider investigations and referrals by each of the MCOs is low, compared to the size of the plan. The level of investigative activity has not changed over time. During FFY 2015, ACLA's referrals increased due to increases in staffing levels and membership. During FFY 2016, ACLA's decreases in referrals were due to MCO contract changes requiring the referral of only cases where fraud has been substantiated.

Table 3.




*The ABH was not contracted to do business until FFY 2015.
**The UHC started in Louisiana as a Medicaid Shared Savings Plan in FFY 2012, but became a MCO in FFY 2015.

During FFYs 2014 through FFY 2016, ABH reported that 55 full investigations were conducted; however, only one case was referred to the state. The UHC reported 90 full investigations conducted; however, only 15 cases were referred to the LDH-BHSF. The ACLA reported 277 full investigations conducted; however, only 36 cases were referred to the state. According to LDH-BHSF staff, a total of two cases were accepted out of the total 23 cases referred to the LDH or MFCU by the three MCOs in the last four quarters.

***MCO Compliance Plans***

The state does require its MCOs to have a compliance plan to guard against fraud and abuse in accordance with the requirements at 42 CFR 438.608. The state does not have a process to review the compliance plans and programs. As required by 42 CFR 438.608, the state does review the MCO's compliance plan and communicates approval/disapproval with the MCOs.

The LDH-BHSF's Health Plan Management Unit and the Program Integrity Managed Care Unit are the state divisions responsible for oversight of the managed care program. Both divisions require the MCO contractors to have policies and procedures that comply with all state and federal statutes and regulations; this includes the requirements at 42 CFR 438.608 and Section 6032 of the federal Deficit Reduction Act of 2005 which governs fraud, waste, and abuse requirements. In accordance with their required program integrity plan, LDH-BHSF requires the MCOs' contractors to develop internal controls, policies, and procedures for preventing, identifying, and investigating enrollee and provider fraud, waste, and abuse. The LDH-BHSF also requires, in accordance with 42 CFR 438.608(b)(2), that the MCO designate a program integrity officer and program integrity committee that have the responsibility and authority for carrying out the provisions of the compliance program. The LDH-BHSF staff acknowledged that the MCOs submitted their compliance plans on time; however, the review of those compliance plans is currently incomplete. A review tool was being developed to document

completeness and compliance with federal regulation, but the review of the compliance plans was placed on hold, due to time constraints and conflicting priorities.

Additionally, LDH-BHSF required the MCOs to have provisions that comply with 42 CFR 438.610, and all relevant state and federal laws, regulations, policies, procedures, and guidance. The review of the compliance plan revealed no issues.

All of the MCOs provided the review team with a copy of their compliance plans that have been submitted to the state. A review of these plans revealed they were in compliance with 42 CFR 438.608.

***Encounter Data***

The LDH-BHSF requires MCOs to submit encounter data on HIPAA version 5010 form, and National Council for Prescription Drug Programs (NCPDP) compliant encounters in 837i, 837p, 837D, and NCPDP format. The MCOs have 30 days to submit 95 percent of their paid claims to the state. Regular and ad hoc data mining runs are generated through the Molina-SURS Department's J-SURS Fraud Detection System to isolate and identify suspicious providers and claims. With the addition of managed care encounters to the J-SURS data load, standard FFS algorithms that are applicable to managed care will be utilized to identify billing aberrancies with managed care network providers. The Molina-SURS Department has production runs that are performed routinely. Additionally, ad hoc runs are conducted based upon some of the following resources: research; referrals from within the Molina-SURS Department; LDH and external sources; issues found in current cases; complaints; local, state, and federal news.

Also, J-SURS contains both FFS claims data and managed care encounter data. In addition to J-SURS, the Molina-SURS Department staff may also request data archived in the LDH Data Warehouse via requests forwarded to statistical analysis system or structured query language users residing in the PIU, or through a request (LIFT request) that will be fulfilled by a Molina-SURS Department programmer.

The LDH-BHSF requires MCO certification of the truthfulness, completeness, and accuracy of all contract deliverables, including required encounter data. The state and its agents review encounter data for a number of purposes. The LDH-BHSF contracts with the accounting firm of Myers and Stauffer LC to verify MCO encounter completeness and payment accuracy. Myers and Stauffer LC compares the MCOs' cash disbursement journal to encounter claims submitted to the state to ensure completeness of encounter data and accuracy within a five percent error threshold, as contractually required. Myers and Stauffer LC also performs an examination of each MCOs' annual Medical Loss Ratio (MLR) report to ensure that medical and administrative expenses are properly reported. The LDH contracts with the actuarial firm Mercer which utilizes MCO encounter data in the development of actuarially sound capitation rates. Provider network staff use the MCO provider registry for reporting and to determine MCO network adequacy. To date, the Molina-SURS Department has not identified an overpayment to a provider using encounter data; however, encounter data is used in provider billing analysis, reporting, and data analytics. The quarterly *145 Fraud and Abuse Report* was revised effective July 2016 to require all overpayments and recoveries caused by provider error to be reported to the PIU.

***Overpayment Recoveries, Audit Activity, and Return on Investment***

The state does not require MCOs to return overpayments recovered to the state; however, the state does require the MCOs to report on overpayments recovered from providers as a result of MCO fraud and abuse investigations or audits.

The LDH contract requirements indicate overpayment recoveries are reported to LDH within 60 days via adjusted encounter submissions which are submitted on a daily basis. The MCOs may review and recover overpayments from providers, and retain those recoveries. The state may review and recover from providers after one year from claim's date of service. Also, the state may recover outright without delay, if no records review is necessary to determine that a payment was incorrect. The state retains recoveries which it identifies. If a provider fails to remit payment or enter into a payment plan with the state within 30 days, the state may require the plan to collect the overpayment from the provider and return the amount collected to the state.

Additionally, all overpayments and fraud and abuse recoveries are reported to LDH on quarterly financial statement reports. The effect of overpayment recoveries on rate setting is not addressed specifically in the contract language; according to LDH-BHSF staff, the MCOs must include fraud and abuse recoveries in their financial reports for MLR and rate setting.

The table below shows the respective amounts reported by ABH for the past three FFYs.

**Table 4-A.**

| FFY | Preliminary Investigations | Full Investigations | Total Overpayments Identified | Total Overpayments Recovered |
|---|---|---|---|---|
| 2014 | ** | ** | ** | ** |
| 2015 | 47 | 24 | $4,230 | $0 |
| 2016 | 59 | 31 | $40,830 | $26,344 |

*Table contains all Louisiana recoveries from program integrity activities conducted on both the local and national levels.
**The MCO was not contracted with the state until FFY 2015.

The ABH attributed the lack of SIU recoveries in FFY 2015 to becoming operational in February 2015. As a result, the SIU did not have an adequate claims history to review for identification of aberrant billing trends. Some of the overpayments identified for FFY 2015 were recovered in FFY 2016. The ABH identified $40,830 in overpayments for FFY 2016, but only recovered $26,344. The ABH states that the identified amount of overpayments for FY 2016 was reduced by approximately $10,000, after they completed their investigation; the remaining overpayments identified for that time period are still in the recovery process and are anticipated to be recovered in FFY 2017.

The table below shows the respective amounts reported by UHC for the past three FFYs.

**Table 4-B.**

| FFY | Preliminary Investigations | Full Investigations | Total Overpayments Identified | Total Overpayments Recovered |
|---|---|---|---|---|
| 2014 | ** | ** | ** | ** |
| 2015 | 6 | 0 | $6.8 million | $4.6 million |
| 2016 | 111 | 90 | $7.9 million | $4.9 million |

*Table contains all Louisiana recoveries from program integrity activities conducted on both the local and national levels.
**The UHC started in Louisiana as a Medicaid Shared Savings Plan in FFY 2012, but became a MCO in FFY 2015.

The UHC's local SIU team recovers overpayments related to fraud and abuse; the plan utilizes the resources of the parent company's national team to recover overpayments related to waste. During the onsite review, the UHC attributed the lack of any local SIU fraud and abuse recoveries in FFY 2015 and recoveries of $138,722 in FFY 2016 to becoming operational in February 2015. As a result of its newness to the state, the local SIU did not have an adequate claims history to review for identification of aberrant billing trends. However, UHC reported a large amount of recoveries resulting from all local and national program integrity-related activities cumulatively. The Payment Integrity Division of UHC contracts with several vendors to help support all UHC plans throughout the nation in these efforts. These vendors include OptumInsight and OptumRx which utilize prepayment billing review and retrospective claims analysis. According to quarterly reports submitted to LDH, UHC's corporate SIU had approximately $9.5 million in overpayments recovered for FFY 2015 and FFY 2016 from all program integrity-related activities.

The table below shows the respective amounts reported by ACLA for the past three FFYs.

**Table 4-C**.

| FFY | Preliminary Investigations | Full Investigations | Total Overpayments Identified | Total Overpayments Recovered |
|---|---|---|---|---|
| 2014 | 43 | 40 | $16.8 million | $14.1 million |
| 2015 | 69 | 63 | $4.9 million | $11.8 million |
| 2016 | 186 | 174 | $5.4 million | $9.8 million |

The ACLA did not recover any local overpayments during FFYs 2014 and 2015. During the onsite review, the MCO attributed the lack of FFY 2015 overpayment recoveries by its local SIU to unexpected delays in a number of program integrity system implementations. In addition, ACLA transitioned to a new program integrity post-payment clinical review vendor in FFY 2015. Overall, the ACLA's recoveries from all local and national program integrity-related activities were high. The ACLA utilizes the resources of its parent company, AmeriHealth Caritas Family of Companies (ACFC), to conduct program integrity activities. The corporate-based SIU has 44 FTEs and operates as an enterprise-wide unit in support of all plans at the national level. In addition, the ACFC operates a Payment Integrity Unit with 34 FTEs fully-

dedicated to overpayment avoidance and recoveries. The corporate-based SIU and Payment Integrity Unit recorded approximately $35.7 million in Louisiana Medicaid overpayment recoveries from all program integrity-related activities during the three FFYs reviewed. In addition, the CMS review team inquired why the amounts recovered in FFY 2015 and FFY 2016 were higher than the amounts identified during those same FFYs respectively; the ACLA staff attributed the higher recoveries to monies collected from recovery efforts related to prior years' overpayments. (Recoveries are often identified and collection efforts begin in one year, but the overpayments may not be recovered until the following year(s).)

***Waste Recoveries Retained by the MCOs***

As previously mentioned, LDH does not require its MCOs to return overpayments recovered from providers as a result of fraud and abuse investigations or audits to the state. Also, the Louisiana's MCO model contract does not require the MCOs to report on overpayments recovered from providers as a result of MCO program integrity activities. Also, the LDH generally allows the MCOs to collect and retain overpayments that are or are not potentially fraud-related. Although not contractually required, Louisiana directs the MCOs to report on overpayments recovered from providers as a result of MCO fraud and abuse investigations or audits. As a result of onsite interviews and overpayments reported by the MCOs, the CMS review team further evaluated the amount of recoveries attributed to either fraud and abuse, or waste.

The table below shows the specific recovery amounts attributed to waste and reported by UHC for the past three FFYs.

**Table 5-A.**

| FFY | Overpayments Recovered (Fraud and Abuse)* | Overpayments Recovered (Waste) | Total Overpayments Recovered (Fraud/Waste/Abuse) |
|---|---|---|---|
| 2014 | ** | ** | ** |
| 2015 | $0 | $4,617,687 | $4,617,687 |
| 2016 | $138,722 | $4,724,511 | $4,863,233 |

*Per the MCO, the fraud and abuse column contains only recoveries resulting from audits, and is reported on the *145 Fraud and Abuse Report*.

**The UHC started in Louisiana as a Medicaid Shared Savings Plan in FFY 2012, but became a MCO in FFY 2015.

The table below shows the specific recovery amounts attributed to waste and reported by ACLA for the past three FFYs.

**Table 5-B.**

| FFY | Overpayments Recovered (Fraud and Abuse) | Overpayments Recovered (Waste) | Total Overpayments Recovered (Fraud/Waste/Abuse) |
|---|---|---|---|
| 2014* | $42,556 | $14,045,010 | $14,087,566 |
| 2015** | $0 | $11,822,830 | $11,822,830 |
| 2016** | $0 | $9,849,781 | $9,849,781 |

*All fraud, waste, and abuse recoveries were conducted at the national level.
**All fraud and abuse recoveries for ACLA were conducted by local SIU associates. Waste recoveries were conducted by program integrity associates located in Philadelphia, Pennsylvania.

The ABH reported overall low recovery amounts resulting from fraud, waste, and abuse cases cumulatively; the majority of the recoveries for this plan was categorized as fraud and abuse-related. However, as seen in the two tables above, both UHC and ACLA's recoveries from program integrity activities demonstrated that the majority of the total overpayment monies recovered by both MCOs were attributed solely to waste. (Fraud and abuse activities comprised only a fractional margin of all program integrity-related recoveries.)

During the three FFYs reviewed, UHC reported cumulative program integrity-related recoveries of approximately $9.5 million; however, only $138,722 of these total recoveries was attributed to fraud and abuse. This amount is extremely low, in comparison to the plan's total waste recoveries of approximately $9.3 million. (As previously mentioned, fraud and abuse activities are conducted by the plan's local SIU. Waste recoveries are conducted by the parent company's national SIU.) The UHC's recoveries from fraud and abuse comprise 1.5 percent of all monies recovered for the three FFYs reviewed; recoveries attributed to waste accounted for 98.5 percent of the total recoveries for this timeframe.

In addition, over the same three FFYs reviewed, ACLA reported cumulative program integrity-related recoveries of approximately $35.7 million; however, only $42,556 of these total recoveries was attributed to fraud and abuse. This amount is extremely low, in comparison to the plan's total waste recoveries of approximately $35.3 million. The ACLA's recoveries from fraud and abuse comprise 0.1 percent of all monies recovered for the three FFYs reviewed; recoveries attributed to waste accounted for 99.9 percent for the same timeframe. Also, no recoveries were attributed to fraud and abuse-related activities during FFYs 2015 and 2016; waste comprised 100 percent of the recoveries during this time period. Table 5-B represents ACLA's recoveries initiated by associates physically located in Louisiana versus associates physically located elsewhere. The ACFC Program Integrity Department, which includes the SIU, performs fraud, waste, and abuse recoveries for ACLA. For FFY 2014, all fraud, waste, and abuse recoveries for ACLA were handled by ACFC program integrity associates located outside of Louisiana. For FFYs 2015 and 2016, all fraud and abuse recoveries for ACLA were handled by SIU associates located in Louisiana, and all waste recoveries for ACLA were handled by program integrity associates located in Philadelphia.

Overall, the amount of both UHC and ACLA's recoveries categorized as waste is significant, and the implications of identifying a case as waste potentially exempts suspect providers from being reported to the state or MFCU, payment suspensions, termination actions, and the other processes that are part of the fraud and abuse-related program integrity activities.

### *Payment Suspensions*

In Louisiana, Medicaid MCOs are contractually required to suspend payments to providers at the state's request. The state confirmed that there is contract language mirroring the payment suspension regulation at 42 CFR 455.23.

The LDH's suspension policy is captured in the following contract provision, "The MCO is to suspend payment to a network provider when the state determines there is a credible allegation of fraud, unless the state determines there is good cause for not suspending payments to the network provider pending the investigation. The MCO is responsible for sending the network provider the required notice and appeal rights as required by the code of federal regulations."

Although LDH requires that the MCOs suspend at the direction of LDH, there have been no payment suspensions enacted by any of the MCOs reviewed onsite. The LDH attributed the lack of providers suspended to the fact that none of the providers subject to payment suspensions were in the MCOs' networks. The MCOs indicated that they had suspension policies and procedures in place.

### *Terminated Providers and Adverse Action Reporting*

The state MCO contract states, "The MCOs are required to notify the state when they initiate a provider termination for cause, or if the termination results in a material change to the provider network." The state compiles a list of these providers and distributes a compilation from all of the MCOs, and distributes the compiled list monthly to the MCOs. However, the MCOs are not required to take any adverse administrative actions, based on another MCO's administrative finding or adverse action.

**Table 6.**

| MCOs | Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs | | Total # of Providers Terminated For Cause in Last 3 Completed FFYs | |
|---|---|---|---|---|
| ABH | 2014<br>2015<br>2016 | N/A*<br>22<br>8 | 2014<br>2015<br>2016 | N/A*<br>22<br>8 |
| UHC | 2014<br>2015<br>2016 | N/A**<br>10<br>14 | 2014<br>2015<br>2016 | N/A**<br>9<br>11 |
| ACLA | 2014<br>2015<br>2016 | 27<br>18<br>389 | 2014<br>2015<br>2016 | 15<br>2<br>3 |

*The MCO was not contracted with the state until FFY 2015.
**The UHC started in Louisiana as a Medicaid Shared Savings Plan in FFY 2012, but became a MCO in FFY 2015.

Overall, the number of providers terminated for cause by all of the plans appears to be low, compared to the number of providers in each of the MCOs' networks and compared to the number of providers disenrolled or terminated for any reason.

According to LDH-BHSF, MCOs do not terminate a provider's ability to participate in Louisiana Medicaid, but MCOs are permitted to terminate a provider's ability to participate in the MCO's provider network by terminating the contractual agreement between the provider and the MCO. When an MCO terminates a provider's network agreement for cause, the plan must report to LDH within seven days, as required in the MCO contracts. The MCOs must notify PIU when the plan denies a provider credentialing application, or disenrolls or limits a provider's ability to participate in the program for program integrity-related reasons. The plan must notify the provider and the provider's patients within 15 days. If the terminated provider was a member's primary care physician (PCP), the plan must notify its members to select another PCP within ten business days of the postmark of the termination notice.

Provider terminations and limitations for program integrity-related reasons are reported on the quarterly *145 Fraud and Abuse Report*. For cause terminations are defined on the *145 Fraud, and Abuse Report* template as terminations for reasons based upon fraud, integrity, or quality. For cause termination does not include closure due to billing or renewal inactivity, or voluntary action taken by the provider to end its participation in the program, except where action is taken by the provider specifically in order to avoid sanction. The plans are required to comply with all mandatory exclusions through the Office of the Inspector General's (OIG) exclusion database and state adverse actions. The OIG and state exclusion letters are shared with plans and the MCOs also are responsible for monthly exclusion database sweeps on providers, employees, and subcontractors. Federal financial participation is not available for services delivered by excluded providers.

***Federal Database Checks***

The regulation at 42 CFR 455.436 requires that the state Medicaid agency must check the exclusion status of the provider or persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE); the Excluded Parties List System (EPLS) on the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); the National Plan and Provider Enumeration System upon enrollment and reenrollment, and check the LEIE and EPLS no less frequently than monthly.

The MCOs are contractually required to screen all employees, subcontractors, and providers monthly for exclusions and prohibitions against the HHS-OIG's LEIE, SAM, National Practitioner Database, SSA-DMF, and Louisiana's *Adverse Actions List*. The plans confirm monthly that the screening was completed via the *Exclusion Database Attestation* form.

**Recommendations for Improvement**

- 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.
- The state should monitor the MCOs' REOMB processes for verifying beneficiary services rendered and the MCOs' efforts to improve the return on investment regarding the volume of surveys sent out in relation to the number of responses received from beneficiaries.
- The state should work with the MCOs to develop specific program integrity training to develop and enhance the quality of case referrals forwarded by the MCOs. In addition, the state should provide more frequent feedback to the plans regarding the cases that they refer to the state. Also, the state should ensure that all SIU staff are receiving adequate and appropriate training in identifying and investigating potential fraudulent billing practices by providers, to enhance the quantity and quality of referrals.
- The state should consider the inclusion of contract language requiring all MCOs to conduct unannounced and/or announced provider onsite visits for fraud and abuse. Regular onsite visits provide increased oversight by the state Medicaid agency, in addition to existing review tools.
- The state should develop a plan to review the MCOs compliance plans on a regular and timely basis.
- The state should verify that identified and collected overpayments are fully reported by the MCOs and that they are incorporated into the rate setting process along with the overpayments determined by state-initiated reviews.
- The state should have policies and procedures which establish guidelines for the identification of waste cases. Parameters would prevent cases not meeting the criteria for waste from being improperly classified and, therefore, exempted from fraud and abuse program integrity activities, such as suspect providers being reported to the state or MFCU, payment suspensions, and termination actions. Also, the state should implement contractual requirements in its new MCO model contract requiring the reporting and monitoring of all program integrity-related recoveries, including those attributed to waste.

## Section 2: Status of Corrective Action Plan

Louisiana's last CMS program integrity review was in September 2012, and the report for this review was issued in December 2013. The report contained one finding and seven vulnerabilities. During the onsite review in March 2017, the CMS review team conducted a thorough review of the corrective actions taken by Louisiana to address all issues reported in calendar year 2013. The findings of this review are described below.

**Findings –**

1. ***Inadequate oversight of managed care operations in the first year of statewide implementation, including not having methods and criteria for oversight of the Bayou Health plans and the state Medicaid agency. (Uncorrected Repeat Finding) (42 CFR 455.104)***

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

   - The LDH-BHSF created a full-time position to oversee the MCOs; this position was filled in July 2013. Oversight for compliance of the MCO contracts in monitoring fraud, waste, and abuse efforts was immediately initiated and communication facilitated between the MFCU, PIU, Bayou Health plans, and the state Medicaid agency. This position is also responsible for the development of written policies and procedures to establish baseline expectations and ensure the Bayou Health plans' and the state Medicaid agency's program integrity activities meet expectations.
   - The LDH-BHSF created a training and procedure manual to cover all program integrity managed care oversight duties and functions. The manual was completed on January 1, 2017.
   - The PIU has implemented regularly scheduled monthly and quarterly meetings with MFCU and MCOs' SIUs.

**Vulnerabilities –**

1. ***Louisiana failed to verify services received directly with the Bayou Health plans and behavioral health beneficiaries.***

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

   - ***The LDH-BHSF incorporated contract language into all MCO contracts to require sampling and verification of paid claims.***
   - ***Policies and procedures were included in the training manual.***
   - ***A reporting deliverable for monitoring was implemented in February 2015.***
   - ***Louisiana's three prepaid MCOs are contractually required to provide an explanations of benefits to a minimum sample size of 200 to 250 claims per year.***

***2. Ineffective provider enrollment practices and reporting for FFS and managed care, including, but not limited to, failing to properly search for excluded providers; properly capturing necessary information for enrollment; or properly handling the termination of providers being removed from the program.***

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

- Internal procedures manuals used by program integrity staff and provider enrollment contract staff are located online through a security protected website, and are for internal use only.
- Each MCO must submit a *Disclosure of Ownership* form. Updates to a change to management, ownership, or control interest are required annually and within 35 days of the change.
- The MCOs use the *Louisiana Credentialing Application* or the standard Council for Affordable Quality Health Care's (CAQH) credentialing form. Providers must allow providers to use CAQH's credentialing form, if available for their provider type.
- Each MCO must report for cause health plan provider agreement terminations to the state within seven days of the termination, and report again quarterly on the approved quarterly fraud, waste, and abuse report. The plan provider terminations that are for cause are included on a monthly tips report to the plans.

***3. Louisiana failed to properly conduct exclusion searches per the regulation at 42 CFR 455.436.***

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

- The LDH's Provider Enrollment Unit conducts exclusion searches for FFS providers against the LEIE, SAM, and the Provider Enrollment, Chain, and Ownership System upon enrollment, re-enrollment, and change of ownership. The Provider Enrollment Unit also performs a monthly sweep against the LEIE.
- The Managed Care Exclusion Unit stated that the contracts were updated to require all MCOs to screen all employees, subcontractors, and providers monthly for exclusions and prohibitions. The plans attest monthly that the screenings were completed, as required by *Exclusion Database Attestation* form.
- The PIU notifies the MCOs of FFS exclusions, and periodically conducts reviews of the exclusion databases against paid encounters and FFS claims to verify that excluded providers are not receiving payments.
- The Molina-SURS Department recovers FFS amounts paid to excluded providers, if applicable.
- Payments made by plans to excluded providers are eligible for recovery from the managed care plan by the state.

***4. Louisiana failed to properly capture ownership and control disclosures per the regulation at 42 CFR 455.104.***

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

- The ownership and controlling interest information is now required on the application. The information at the time of enrollment, re-enrollment, and change of ownership is manually checked against the federal databases and the Louisiana State Adverse Actions List Search database.
- Each MCO submits a *Disclosure of Ownership* form. Updates are required annually and within 35 days of a change to management, ownership, or control interest.
- The MCOs are required to use the *Louisiana Credentialing Application*, or the standard CAQH credentialing form, and must allow providers to use CAQH, if available for their provider type.

***5. Louisiana failed to properly capture criminal offense disclosures per the regulation at 42 CFR 455.106.***

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

- The provider enrollment FFS enrollment application was amended to require the disclosure of current and prior criminal offenses since March 2012.
- The *Annual_Disclosures_Appendix_A* has been amended to include the disclosure of criminal offenses. If the MCO fails to disclose a criminal conviction, LDH may terminate their plan's contract.

***6. Louisiana failed to properly capture business transaction disclosures per the regulation at 42 CFR 455.105.***

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

- The provider enrollment FFS enrollment application was amended to require business transaction disclosures, since March 2012.
- The *Annual_Disclosures_Appendix_A* has been amended to capture information regarding subcontractor and supplier business transactions. These business transaction disclosure requirements are also listed in the provider contracts.

***7. Louisiana failed to properly provide exclusion notifications to the HHS-OIG and the state Medicaid agency per the regulations at 42 CFR 1002.3 and 42 CFR 1002.212.***

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

- The state's provider exclusions and terminations are published on the *State Adverse Actions List* website.

- All plans are required to notify LDH regarding for cause provider terminations within seven days and report for cause provider terminations on the quarterly *145 Fraud and Abuse Report*.
- Program integrity managed care oversight includes providers reported as termed for program integrity-related reasons on the LDH's tips report which is distributed monthly to all plans, Molina SURS, state program integrity contacts, and MFCU. Molina-SURS Department reviews the LDH and MCO tips report for issues occurring in FFS. If the Molina-SURS Department determines that opening a case is warranted, any SURS action is tracked in the SURS database.

## Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Louisiana to consider utilizing:

- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the Regional Information Sharing Systems for information provided by other states including best practices and managed care contracts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to Louisiana are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- 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. The CMS annual report of program integrity reviews includes highlights of states that have been cited for noteworthy and effective practices in managed care. These reports can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf.

## Conclusion

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP 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 the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

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