Insights

HHS OIG Recommends Greater Efforts by Medicaid Managed Care Organizations in Identifying and Addressing Medicaid Fraud and Abuse

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The Health and Human Services Office of Inspector General ("OIG") published a report in July of 2018 ("Report") regarding weaknesses by Medicaid Managed Care Organizations ("MCO") to identify fraud and abuse in the Medicaid program[1]. In general, the OIG found that MCOs lacked the controls and processes necessary to adequately monitor program compliance and coordinate with State Medicaid programs to communicate, refer, and enforce provider fraud and abuse. The Centers for Medicare and Medicaid Services ("CMS") concurred with nearly all of the OIG's recommendations described in the Report but failed to identify any specific changes.

As is the case in most states, Indiana utilizes MCOs to administer a significant portion of the Medicaid benefit. Various Federal laws and contracts between MCOs and State Medicaid agencies require MCOs to implement certain program integrity measures, including monitoring and submitting claims data to the State Medicaid agency, identifying and collecting Medicaid overpayments, imposing prepayment review, and investigating and referring cases of potential fraud to the Medicaid agency or the State Medicaid Fraud Control Units. Indiana's MCO contracts contain similar program integrity requirements.

The OIG conducted a survey requesting 2015 data from the MCOs with the largest expenditures in each of the 38 states that provides Medicaid services through MCOs, and interviewed various MCO and State officials. The OIG's findings as detailed on the Report are as follows:

- Some MCOs identified few cases of suspected fraud or abuse.
- Some MCOs referred few cases of suspected fraud or abuse to the State Medicaid agency.
- MCOs generally pursued corrective action measures against enrolled providers (prepayment review, payment suspension, corrective action plan or educational measures) but did not always inform the State Medicaid agency.
- MCOs did not always inform the State Medicaid agency when they terminated provider network agreements.
- MCOs did not always identify and recover Medicaid overpayments.

The OIG recommended that CMS takes steps to improve and incentivize information sharing between MCOs and State Medicaid agencies on matters related to fraud and abuse to reduce or mitigate the findings. CMS agreed with most of the OIG's findings. CMS's response, included in the Report, does not identify any specific measures CMS intends to implement in order to address the OIG's findings. However, the topic of Medicaid fraud has been discussed recently in Congress, and CMS announced new efforts to clamp down on Medicaid

fraud on June 26, 2018[2]. Accordingly, providers in Indiana could experience increased monitoring and auditing efforts, and enforcement action by Indiana's four MCOs over the next several years.

Feel free to contact Brandon W. Shirley, bshirley@kdlegal.com, or Leah S. Mannweiler, lmannweiler@kdlegal.com, for related questions or assistance appealing adverse State or MCO determinations.

[1] See Weaknesses Exist in Medicaid Managed Care Organization's Efforts to Identify Fraud and Abuse. Available at https://oig.hhs.gov/oei/reports/oei-02-15-00260.pdf

[2] See CMS announces initiatives to strengthen Medicaid program integrity. Available at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-06-26.html