Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Minnesota Focused Program Integrity Review

Medicaid Managed Care Oversight

July 2024

Final Report

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I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services (CMS) conducted a focused program integrity review to assess Minnesota's program integrity oversight efforts of its Medicaid managed care program for the Fiscal Years (FY) 2020 – 2022. 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. CMS also conducted in-depth interviews with the State Medicaid Agency (SMA) and evaluated program integrity activities performed by selected managed care organizations (MCOs) under contract with the SMA.

This report includes CMS' findings and resulting recommendations, as well as observations, that were identified during the focused review.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified one finding that creates a risk to the Minnesota Medicaid program related to managed care program integrity oversight. In response to the finding, CMS identified **one** recommendation that will enable the state to come into compliance with federal and/or state Medicaid requirements related to managed care program integrity oversight. The recommendation includes the following:

MCO Contract Compliance

> **Recommendation #1:** In accordance with § 438.608(a)(8), Minnesota should work with the MCOs to ensure that whenever a payment suspension is initiated by either the state or the MCO, the MCO must suspend all payments to the provider. In addition, the state should ensure that when the MCO initiates a payment suspension, the MCO makes a written fraud referral to the state and the Medicaid Fraud Control Unit (MFCU) no later than the next business day after the suspension is imposed, which is consistent with the MCO general contract section 9.4.6.9.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid managed care program. CMS identified **five** observations related to

Minnesota'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:

MCO Contract Compliance

Observation #1: CMS encourages Minnesota to develop an effective monitoring tool for the annual submission, review, and approval of MCO compliance plans. Such a tool may include a template or checklist outlining the required compliance plan requirements under CMS regulations and the Minnesota MCO general contract.

Observation #2: CMS encourages Minnesota to strengthen its MCO general contract language regarding beneficiary verification activities by ensuring that MCOs have consistent beneficiary verification policies and procedures that comply with the contractual requirement and a process in place for the state to monitor this process.

MCO Investigations of fraud, waste, and abuse

Observation #3: CMS encourages Minnesota to work with the MCOs to develop and enhance suspected fraud case referrals across a broader variety of provider types. This includes collaborating with the MCOs to ensure the Special Investigations Unit (SIU) staff are adequately identifying, investigating, and referring suspected fraud to the state.

Observation #4: CMS encourages Minnesota to consider implementing an effective mechanism to monitor, track, and verify/validate the accurate reporting of referrals and overpayments identified and recovered by the MCOs.

Observation #5: CMS encourages Minnesota to consider the inclusion of MCO general contract language addressing investigative provider site visits to ensure all MCOs are utilizing this practice.

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 (PCS). 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 SMAs 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 the utilization of health services.

Overview of the Minnesota Managed Care Program and the Focused Program Integrity Review

The Minnesota Department of Human Services (DHS) is responsible for the administration of the Minnesota Medicaid program, and Minnesota Health Care Programs (MHCP). Within DHS, the Office of Inspector General (OIG), Surveillance and Integrity Review Section (SIRS), Special Audits and Investigations (SAI) unit, the Managed Care Oversight Team is the organizational unit tasked with oversight of program integrity-related functions for the managed care program. During the review period, Minnesota contracted with nine MCOs to provide health services to the Medicaid population. As part of this review, three of these MCOs were interviewed: Blue Plus, Medica, and UCare. Appendix C provides enrollment and expenditure data for each of the selected MCOs.

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

In April 2023, CMS conducted a virtual focused program integrity review of Minnesota's managed care program. This review assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. As a part of this review, CMS also evaluated program integrity activities performed by selected MCOs under contract with the SMA. CMS interviewed key staff and reviewed a sample of program integrity cases investigated by the MCOs SIUs, as well as other primary data. CMS also evaluated the status of Minnesota's previous corrective action plan that was developed in response to a previous focused program integrity review of Minnesota's PCS conducted by CMS in 2018, the results of which can be found in Appendix A.

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

This review encompasses the following five areas:

A. **State Oversight of Managed Care Program Integrity Activities** - CMS established requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas. These areas include, but are not limited to: data, information, and documentation that must be submitted under §§ 438.604–606, as well as compliance with contractual program integrity requirements under § 438.608.
B. **MCO Contract Compliance** - Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, such as implementing compliance plans, payment suspensions based on credible allegations of fraud, and overpayment reporting.
C. **Interagency and MCO Program Integrity Coordination** - Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars. Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA.
D. **MCO Investigations of Fraud, Waste, and Abuse** - Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state Program Integrity Unit (PIU) or any potential fraud directly to the state's MFCU. Similarly, as required by §§ 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.
E. **Encounter Data** - In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. In addition, in accordance with § 438.602(e), the

state must periodically, but no less frequently than once every three years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO.

III. Results of the Review

A. State Oversight of Managed Care Program Integrity Activities

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

In Minnesota, these oversight and monitoring requirements are met through the operations of the OIG/SIRS/SAI Managed Care Oversight Team, which is responsible for fraud and abuse oversight of the MCOs. The Minnesota MCO general contract, section 9.4.1.2, requires MCOs to have an SIU, as defined in section 2.144. Responsibilities of the SIU include having a process in place for the detection and investigation of fraud and abuse by its enrollees and providers, including procedures that are designed to guard against fraud, abuse, and improper payments. Contract section 9.4.1.2(5) requires the SIU to have at least one SIU investigator for every 60,000 enrollees.

The state indicated that oversight of the many elements of the state monitoring plan is accomplished through required MCO reporting. The MCOs report daily, weekly, monthly, quarterly, annually, and ad hoc as needed, regarding administration and management, appeal and grievance systems, claims and encounters, enrollee materials, finances, marketing, utilization management, program integrity, network management, availability and accessibility of services, and quality improvement.

During the review period, the Managed Care Oversight Team conducted announced, onsite Asset and Capabilities Reviews of all MCOs, as well as comprehensive performance audits, and initiated MCO-focused audits and reviews in late 2022. If an MCO's performance does not meet the required standards, the MCO will be in breach of contract and sanctions may be imposed.

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

B. MCO Contract Compliance

Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. These requirements extend to any subcontractor that is delegated responsibility for coverage of services and payment of claims under the contract

between the state and the MCO. As part of this review, the MCO general contract was evaluated for compliance with several of these requirements, which are described in greater detail below.

The MCO general contract for Minnesota is developed by DHS's Health Care Administration Purchasing and Service Delivery division. The Contract Management Team has contract oversight of each MCO.

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 9.4.1.2 of Minnesota's MCO general contract explicitly addresses the requirement that all seven compliance plan elements listed above be addressed. A review of the MCOs' compliance plans and programs found that each MCO's compliance plan contained the required elements in accordance with §§ 438.608(a)(1)(i)-(vii).

While Minnesota's MCO general contract meets CMS' regulatory requirements, the state does not perform an annual review of the MCO compliance plans to ensure § 438.608 contract requirements are met. Alternatively, the state indicated that portions of § 438.608 requirements are addressed through a review of MCO annual reports, audits, and reviews completed by the OIG/SIRS/SAI Managed Care Oversight Team.

Observation #1: CMS encourages Minnesota to develop an effective monitoring tool for the annual submission, review, and approval of MCO compliance plans. Such a tool may include a template or checklist outlining the required compliance plan requirements under CMS regulations and the Minnesota MCO general contract.

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 Minnesota, this requirement is met through the MCO general contract section 9.4.1.2(6), which requires all MCOs to implement and utilize a direct method for verifying whether services paid for by the MCO were furnished to enrollees. The MCOs may use a variety of direct methods to verify services, especially for provider types identified by the state or the MCO as high risk for program integrity issues. These provider types may include transportation, personal care assistants (PCAs), medical supplies, and interpreters. The MCO is then required to identify the direct methods and results for verification of services in the Annual Integrity Program Report.

While Minnesota's MCO general contract meets CMS' regulatory requirements, in practice, the MCOs were inconsistent with the number of beneficiary verifications conducted, if any, for the review period. The contract does not provide detailed guidance for this program integrity activity, including a lack of clarification on the recommended or required volume of verifications to be conducted. Overall, this process appears to be ineffective, and Minnesota conducted little if no oversight of this process.

Observation #2: CMS encourages Minnesota to strengthen its MCO general contract language regarding beneficiary verification activities by ensuring that MCOs have consistent beneficiary verification policies and procedures that comply with the contractual requirement and a process in place for the state to monitor this process.

False Claims Act Information

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

The state is compliant with this requirement. A review of the state's policy found that MCOs are required by MCO general contract section 9.4.8 to establish, implement, and disseminate written policies and procedures to all employees including management, contractors, and agents that include detailed provisions regarding the MCO's procedures for detecting and preventing fraud, waste, and abuse and information about rights of employees to be protected as whistleblowers.

The MCO is required to certify to the state by February 1st of the contract year that it has complied with this requirement for the previous contract year.

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.

Minnesota Medicaid MCOs are contractually required to suspend all payments to providers at the state's request and when the MCO determines there is a credible allegation of fraud against the provider for which an investigation is pending under the program, per section 9.4.6.7 of the MCO general contract. Section 9.4.6.9 of the contract requires that when an MCO investigation leads to the initiation of a payment suspension, the MCO must make a written fraud referral to the state and the MFCU no later than the next business day after the suspension is imposed. The MCOs only refer directly to the MFCU when a payment suspension or payment withhold is placed on the provider by the MCO; otherwise, the MCOs only refer to the state.

CMS observed that, although contract provisions address procedures for reporting payment suspensions in accordance with federal regulations, one of the three MCOs, Blue Plus, did not suspend all payments at the request of the state, but instead terminated the provider's contract or placed the provider on a prepayment review. In addition, this MCO was reported to have initiated eight payment suspensions during the review period. However, the MFCU was never notified, and in many instances, the MCO terminated the provider's contract. This is in violation of the MCO general contract as well as Section II of the Memorandum of Understanding (MOU) between the MCO and the MFCU. In addition, the state is not enforcing the requirements of § 438.608(a)(8) by ensuring the MCOs suspend payments to network providers for which the state has determined there is a credible allegation of fraud.

Recommendation #1: In accordance with § 438.608(a)(8), Minnesota should work with the MCOs to ensure that whenever a payment suspension is initiated by either the state or the MCO, the MCO must suspend all payments to the provider. In addition, the state should ensure that when the MCO initiates a payment suspension, the MCO makes a written fraud referral to the state and the MFCU no later than the next business day after the suspension is imposed, which is consistent with the MCO general contract section 9.4.6.9.

Overpayments

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

The state adequately addressed the requirements at §§ 438.608(a)(2) and (d). Specifically:

- Section 4.14.1 of the MCO general contract requires the MCO to report to the state within 60 calendar days when the MCO has identified capitation payments or other payments in excess of amounts specified in the contract.
- Section 9.4.1.2(4)(i) requires internal monitoring and auditing standards, including a provision for the MCO's network providers to report to the MCO when a provider receives an overpayment, to return the overpayment within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO of the reason for the overpayment.
- Section 9.4.6.2 requires the MCO to attempt to recover improper payments from network providers when the MCO identifies improper payments in an audit or investigation solely conducted by the MCO.
- Section 9.4.6.4 states that the OIG/SIRS has the right to recover overpayments identified in audits and investigations conducted by OIG/SIRS.

The state directs the MCO to include identified, collected and prevented overpayments on a quarterly report submitted to OIG/SIRS. The MCOs were provided a template with instructions for reporting overpayments. The information from the reports is used by the contracted actuary (Milliman) for the development of capitation rates.

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

C. Interagency and MCO Program Integrity Coordination

Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars and beneficiaries. Each of these entities performs unique

functions that are critical to providing effective oversight of the Medicaid program. The ability to reduce fraud in Medicaid managed care will be greatly enhanced as these entities develop methods and strategies to coordinate efforts. Ineffective collaboration can adversely affect oversight efforts, putting taxpayer dollars and beneficiaries at risk.

Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA. Minnesota has an MOU in place with the MFCU that meets the regulatory criteria. Specifically, there is an MOU that contains procedures by which the MFCU will receive referrals of potential fraud from the MCOs as required by 455.21(c)(3)(iv). Additionally, the state meets with the MFCU every other month to discuss case referrals.

While there is no requirement for SMAs to meet on a regular basis with their MCOs for collaborative sessions to discuss pertinent program integrity issues regarding fraud, waste, abuse, and relevant contractual concerns, such collaborative sessions are an effective and important process to ensure open communication and strong partnerships. The DHS does hold quarterly collaborative sessions with its MCOs to discuss program integrity issues, such as case referrals, leads, and administrative actions.

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

D. MCO Investigations of Fraud, Waste, and Abuse

State Oversight of MCOs

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

Minnesota has such a process in accordance with §§ 455.13-17 and 438.608(a)(7). Minnesota requires that MCOs report in writing to the state any Medicaid related fraud within five (5) business days after the MCO learns of or has reason to believe such fraud has been committed, per section 9.4.6.6 of the MCO general contract.

Section 9.4.6.6(1) further requires the MCO to maintain a detailed log, in a format approved by the state, of all reports of provider and enrollee fraud and abuse investigated by the MCO or its subcontractors which must be submitted to the state quarterly by the fifteenth day following the end of the quarter for investigations opened or closed in that quarter.

The DHS has provided education to MCOs regarding the definition of fraud, and Article 2 of the MCO general contract further defines fraud and abuse. Both OIG/SIRS and the MFCU have also independently provided training to the MCOs during the review period.

The OIG/SIRS meets quarterly with the MCOs regarding program integrity issues. However, CMS observed a lack of case referrals from the MCOs to the state during the review period.

> **Observation #3:** CMS encourages Minnesota to work with the MCOs to develop and enhance suspected fraud case referrals across a broader variety of provider types. This includes collaborating with the MCOs to ensure the SIU staff are adequately identifying, investigating, and referring suspected fraud to the state.

MCO Oversight of Network Providers

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

All three MCOs reported the use of an internal or contracted SIU tasked with identifying and conducting investigations of potential fraud, waste, and abuse. Indicators of potential issues were identified through different sources, including but not limited to claims, hotline calls, referrals from subcontractors, referrals from OIG/SIRS, algorithms, and data mining. Upon receipt of a case referral from any of these sources, a preliminary investigation is conducted to determine if a case should be opened by the SIU. When a case is opened following the completion of an investigation by the MCO, a referral is sent to the state after a full investigation is conducted. Cases that are determined to be credible are documented and reported to the state and MFCU simultaneously.

Overall, CMS found the reported MCO processes for the investigation of suspected fraud, waste, and abuse to meet CMS requirements and state contract requirements. All three MCOs utilized corrective action plans during the review period. However, only one of three MCOs, Medica, performed investigative provider site visits. Investigative provider site visits can be an effective tool in the detection of fraud, waste, and abuse within the Medicaid program. CMS noted that the MCO general contract does not address investigative provider site visits.

Figure 1 below describes the number of investigations referred to Minnesota by each MCO. As illustrated, overall, the number of Medicaid MCO provider referrals is low.

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

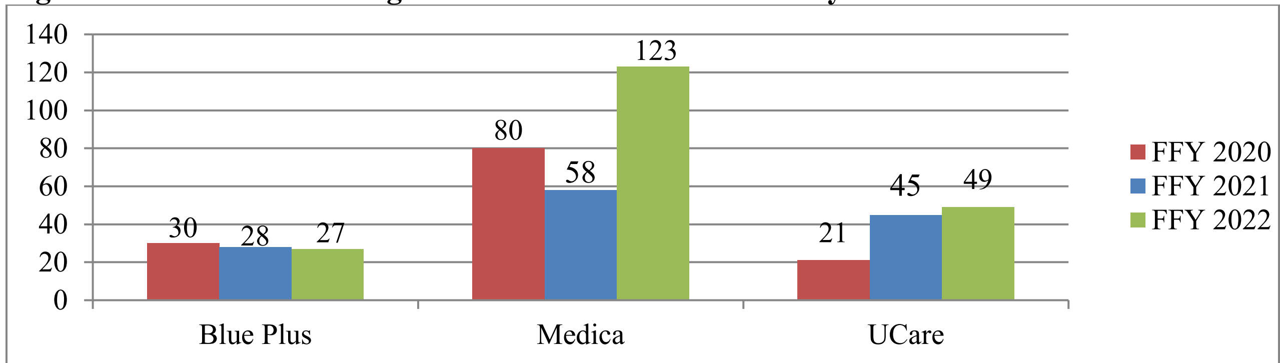

Table 1, below, describes each MCO's recoveries from program integrity activities. The state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process (§ 438.608(d)(4)). Without these adjustments, MCOs could be receiving inflated rates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

Table 1: MCO Recoveries from Program Integrity Activities

Blue Plus's Recoveries from Program Integrity Activities

FY	Preliminary Investigations*	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	0	80	$4,684,413	$2,403,079
2021	0	85	$5,424,453	$589,115
2022	0	72	$1,859,129	$76,993

** During the review period, Blue Plus classified all investigations as full investigations*

Medica's Recoveries from Program Integrity Activities

FY	Preliminary Investigations*	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	0	519**	$206,424	$103,867
2021	0	291	$285,932	$201,852
2022	0	289	$2,979,638	$164,346

** During the review period, Medica classified all investigations as full investigations*
***Includes cases opened prior to FFY 2020, but remained open at the beginning of FFY 2020*

UCare's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	170	197	$452,989	$543,300
2021	173	240	$1,081,920	$741,005
2022	274	164	$2,981,116	$1,986,113

As illustrated above, the overpayments identified and recovered vary widely across MCOs. CMS identified significant discrepancies in the number of preliminary and full investigations as well as total overpayments identified and recovered that were reported by the MCOs in comparison to the numbers the state reported.

Observation #4: CMS encourages Minnesota to consider implementing an effective mechanism to monitor, track, and verify/validate the accurate reporting of referrals and overpayments identified and recovered by the MCOs.

Observation #5: CMS encourages Minnesota to consider the inclusion of MCO general contract language addressing investigative provider site visits to ensure all MCOs are utilizing this practice.

E. Encounter Data

In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. Additionally, § 438.242 further states that state MCO contracts must specify the frequency and level of detail of beneficiary encounter data, including the allowed amount and paid amount, that the state is required to report to CMS under § 438.818. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility. Through a review of the Minnesota MCO general contract and interviews with each of the MCOs, CMS determined that Minnesota was in compliance with § 438.242. Specifically, the MCO general contract sections 3.13.1, 3.13.2, and section 11.5 states the MCOs must 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 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. Minnesota was in compliance with § 438.602(e). Specifically, DHS conducts periodic audits through its separate internal audits division, as well as through the state's Office of the Legislative Auditor. These audits focus on specific areas of interest or concern within the scope of the accuracy and completeness of MCO encounter data. The state also compares the amounts reported in encounter data against the amounts reported in the Quarterly Financial

Report. To the extent that the variance between encounter data and financial data is more than one percent (1%), the state will assess the MCO a penalty, as described in the MCO general contract section 3.14. During the review period, the MCOs were within one percent and no fines were imposed.

In addition, while it is not a requirement, regularly analyzing the encounter data submitted by MCOs will allow the state to conduct additional program integrity activities, such as identifying outlier billing patterns, payments for non-covered services, and fraudulent billing. Minnesota did not have a process to regularly analyze MCO encounter data for program integrity purposes during the review period; however, the state will begin utilizing a Recovery Audit Contractor (RAC) and a Unified Program Integrity Contractor (UPIC) in 2023 to conduct managed care program integrity activities.

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

IV. Conclusion

CMS supports Minnesota's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified one recommendation and five observations that require the state's attention.

We require the state to provide a corrective action plan for the recommendation within 30 calendar days from the date of issuance of the final report. The corrective action plan should explain how the state will ensure that the recommendation has been addressed and will not reoccur. The corrective action plan should include the timeframe for the corrective action along with the specific steps the state expects will take place and identify which area of the SMA is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the corrective action plan, such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of issuance of the final report. If the state has already acted to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

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

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

V. Appendices

Appendix A: Status of Prior Review

Minnesota's last CMS program integrity review, a PCS review, was in June 2018, and the report for that review was issued in January 2019. The report contained eight recommendations for improvement. During the virtual review in April 2023, CMS conducted a thorough review of the corrective actions taken by Minnesota to address all recommendations reported in calendar year 2018. The findings from the 2019 Minnesota focused program integrity review report have been corrected, not corrected, or partially corrected by the state as noted below.

Findings

1. ***The state should consider developing a process to ensure that proper oversight and efficiency of procedures and processes for county assessors, and MCO care coordinators are in place to ensure consistency in PCS assessments.***
   Status at time of the review: Partially Corrected
   DHS has launched the beta phase of the revised MnCHOICES, an electronic web-based assessment tool used by counties and tribal nations. The state expects to launch MnCHOICES in July 2023 and phase in the tool over the next year. In addition, DHS staff hold frequent PCA workgroup meetings with MCOs to ensure consistency in PCA assessments.

2. ***Consider developing detailed oversight responsibilities of each DHS unit responsible for oversight and administration of PCS. A memorandum of understanding, an intra-agency agreement or creating a standard operating procedure that specifies which state unit(s) are responsible for all aspects of PCS monitoring, oversight, and lines of communication between the agencies may be beneficial towards creating a more unified understanding regarding PCS monitoring and oversight responsibilities.***
   Status at time of the review: Corrected

3. ***The state should consider using a modifier, so that its contractors can accurately determine the number of beneficiaries receiving services through the PCS Choice model of its PCS option without having to verify information through a manual process.***
   Status at time of the review: Not Corrected
   The state did not implement the use of a modifier for the purpose of distinguishing PCA Choice. DHS is replacing the PCS program with Community First Choice, or Community First Services and Supports, under the 1915k and 1915i authorities. DHS has been working with CMS to submit the state plan amendments in the near future. CFSS is set up to have an agency model and a budget model, and the coding will clearly delineate who has chosen to be in the budget model/be the participant-employer.

4. ***The state should consider augmenting its regular audits and investigations of its consumer-directed PCS option to avoid creating a vulnerability for the state.***

Status at time of the review: Corrected

5. ***The state should ensure that a National Provider Identifier is not interchanged with the state's Unique Minnesota Provider Identifier.***
   Status at time of the review: During this focused review, CMS was unable to determine if this recommendation has been corrected or not.

6. ***The state should continue to work with the PCS providers to ensure that PCS staff are receiving adequate training in identifying, investigating, and referring potential fraudulent billing practices to the state program integrity unit.***
   Status at time of the review: Corrected

7. ***The state should ensure that the implementation of the Fingerprint-based Criminal Background Checks (FCBC) requirement be fully implemented by the required CMS extended date of July 1, 2018.***
   Status at time of the review: Corrected

8. ***The state should require the use of an electronic visit verification (EVV) system as a method to verify visit activity for Medicaid-provided PCS as required under Section 12006 of the 21st Century Cures Act. The EVV system should verify the date of service, location of service, individual providing the service, type of service, individual receiving the service, and the time the service begins/ends.***
   Status at time of the review: Partially Corrected
   The DHS is implementing the EVV system in phases by service type. The DHS expects providers to start using EVV for affected services during their implementation phase, with the last phase expected to launch by the end of 2023.

Appendix B: Technical Resources

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

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

Appendix C: Enrollment and Expenditure Data

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

Table C-1. Summary Data for Minnesota MCOs

Minnesota MCO Data	Blue Plus	Medica	UCare
Beneficiary enrollment total	406,398	27,614	466,161
Provider enrollment total	117,633	172,592	37,568
Year originally contracted	20+ years	1995	1998
Size and composition of SIU	16	7	11
National/local plan	Local	Local	Local

Table C-2. Medicaid Expenditure Data for Minnesota MCOs

MCOs	FY 2020	FY 2021	FY 2022
Blue Plus	$1,791,412,298	$2,218,632,714	$2,274,547,440
Medica	$472,962,016	$488,919,402	$528,231,848
UCare	$2,086,998,761	$2,556,846,962	$3,247,166,094
Total MCO Expenditures	$4,351,373,075	$5,264,399,078	$6,049,945,382

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	In accordance with § 438.608(a)(8), Minnesota should work with the MCOs to ensure that whenever a payment suspension is initiated by either the state or the MCO, the MCO must suspend all payments to the provider. In addition, the state should ensure that when the MCO initiates a payment suspension, the MCO makes a written fraud referral to the state and the MFCU no later than the next business day after the suspension is imposed, which is consistent with MCO general contract section 9.4.6.9.		

Acknowledged by:

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[Name], [Title]

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Date (MM/DD/YYYY)