INTEGRITYINTEGRITYPART 15: PROGRAM INTEGRITY

Preventing and detecting Medicaid fraud, waste, and abuse requires a collaborative effort by various parties.

LDH, the Louisiana Legislative Auditor's Office, and the Office of the Attorney General are responsible for identifying and reviewing suspected incidents of fraud, waste, and abuse. This includes the ~~preliminary investigation of credible allegation of fraud, the~~ preliminary and full investigation of fraud, waste, and/or abuse, and any other matters necessary to comply with federal and state regulations. The Office of the Attorney General conducts ~~criminal~~ investigations and prosecutions of fraud and abuse by providers~~, via its Medicaid Fraud Control Unit (MFCU),~~ and ~~by~~ enrollees based ~~on~~ upon LDH and MCO referrals and complaints received from the public.

The MCO is responsible for quality review, compliance, and fraud and abuse investigation. Subjects may be MCO employees, subcontractors, providers, and enrollees. The MCO has no criminal review authority, ~~although it may pursue civil damages, so the MCO~~ and is required to report suspected and confirmed fraud and abuse to LDH and the Medicaid Fraud Control Unit (MFCU). ~~It~~The MCO may pursue civil damages. A summary of the MCO's responsibilities is provided below.

INVESTIGATIONS

All reviews shall be completed within 1~~0~~ year ~~months~~ (~~300~~ 365 calendar days) unless an extension is authorized. Requests for extensions to investigations are to be e-mailed to LDH as needed.

If during the course of a review, the provider fails to substantially comply with the request from the Contractor and/or fails to supply the requested record(s) or information from the Contractor, the Contractor shall place the provider on a payment suspension or payment withhold until the record(s) or information is produced or the provider notifies the Contractor in writing that the record or information cannot be produced.

REFERRALS/NOTICES

All provider and enrollee fraud and abuse must be reported to the appropriate agencies as follows:

Type	Reported To	Reporting Template
Provider ~~(confirmed)~~	LDH and MCFU	MCO Fraud Referral Template
~~*Provider (suspected)*~~	~~LDH and MCFU~~	~~MCO Fraud Notice Template~~
Enrollee ~~(confirmed or suspected)~~	LDH and local law enforcement	MCO Member Fraud Referral Template

LDH and MFCU screen all referrals for potential payment suspension. MFCU may choose to open its own investigation, or it may use the information to expand an existing investigation. For this reason, the MCO

must refrain from contacting the subject of the fraud referral until LDH confirms the MCO may continue its review. ~~There is no such prohibition on contacting the subject of a fraud notice.~~

REPORTING

The MCO must report to LDH monthly and quarterly all audits, overpayments identified, and recoveries by the MCO and its subcontractors, including subcontractors that pay claims (e.g., PBMs, transportation brokers), using the LDH reporting template.

The MCO must adjust encounters when it discovers the data is incorrect or no longer valid or that some element of the claim needs to be changed.

When overpayments associated with fraud, waste, and abuse are identified, the MCO shall start the process of voiding or adjusting claims and encounters within 14 days of being considered final, regardless of recovery status. Overpayments are considered final when all appeals and grievances have been exhausted. All voids should be completed within 45 calendar days of the overpayment being considered final. A 45 calendar day extension will be allowed for those overpayments involving 500 or more claim lines.

OVERPAYMENTS & TIPS

All identified and/or recouped overpayments along with all tips regarding any potential billing or claims issue identified through complaints or internal review shall be reported to LDH by the 15th of the following month through Salesforce using the LDH report template #413.

~~All tips regarding any potential billing or claims issue identified through complaints or internal review shall be reported to LDH by the 20th of the month.~~

The MCO shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse, including tips shared with the MCO by LDH in the monthly tips reports.

FWA COMPLIANCE PROGRAM

The MCO is required to implement and maintain arrangements to detect and prevent fraud, waste, and abuse. The FWA Compliance Plan is due to LDH annually and prior to changes.

LDH Program Integrity may initiate reviews of the MCO's FWA detection and prevention activities.

PROGRAM INTEGRITY MEETINGS

LDH Program Integrity hosts regular meetings to discuss fraud, abuse, waste, neglect, and overpayment issues with the MCOs and the state's Office of Attorney General MFCU, which the MCO Program Integrity Officer and CEO or COO are required to attend. The MCO's SIU investigators are encouraged to participate.

Exclusions & Prohibited Affiliations

The MCO may not employ or contract with an individual or entity that is debarred, suspended, or excluded from participating in any federal health care program, or with any individual or entity that is an affiliate of such an individual or entity. This includes:

- Any person with an ownership or control interest; and
- MCO staff, MCO owners, subcontractors, and network providers.

The list of entities excluded from federally funded health care programs can be found at the U.S. Department of Health and Human Services website [link], the System for Award Management [link], Louisiana Adverse Actions List [link], and the Health Integrity and Protection Data Bank [link].

Field Co

The MCO must conduct all required exclusion screenings monthly. The Exclusion Database Attestation is due to LDH by the 15th of every month. The attestation confirms that the monthly screening of providers, employees and subcontractors has been completed as required in the contract and 42 C.F.R. § 455.436.

In the event payments were paid to an excluded provider, LDH may recover those funds directly from the MCO via deduction from their capitation payment. Upon identification by the state, the MCO will be given 30 days to respond and/or provide documentation that disputes the findings.

Sampling of Paid Claims

On a monthly basis, the MCO must provide individual explanation of benefits (EOB) notices to a sample group of enrollees to verify that services were received by the enrollees as billed.

The MCO shall track and investigate any complaints received from enrollees that the billed services were not rendered as stated.

The sampling of paid claims report is due 30 days after the end of the calendar year quarter.

Overpayments

MCOs may recover any overpayments identified by the MCO; however, the MCO must confer with LDH before initiating recoupment or withhold on providers previously identified through audit coordination to ensure that the recovery is permissible, meaning the funds are not already set for recovery under an open LDH or MFCU review.

Unless prior approval is obtained from LDH, the MCO ~~must~~ shall not employ extrapolation methods to derive an overpayment in a provider audit. ~~LDH follows published CMS guidelines used by Medicare recovery contractors to determine whether an extrapolation is permissible.~~

When requesting extrapolation approval from LDH, the MCO shall include:

- Sampling plan;
- Description of the universe from which the sample was drawn;
- Sampling stratification and measurement units in the statistical sample;
- Summarized description of the reason(s) for the overpayment determinations;

- The formulas and calculation procedures used to determine the amount to be recovered; and
- The confidence level used to calculate the precision of the extrapolated overpayment.

Generally, LDH PI will not approve extrapolation for single instances of documentation errors when there has not been prior education. If prior education has been provided, evidence of the education must be included in the MCE's extrapolation request.

PREPAYMENT REVIEW

La. R.S. 46:460.76, as enacted by Act No. 534 of the 2022 Regular Session, prohibits MCOs from requiring any enrolled provider to be subject to prepayment review unless the requirement is implemented by LDH and in accordance with the provisions of the Medical Assistance Programs Integrity Law, La. R.S. 46:437.1 et seq.

The MCO's policy for prepayment review shall include the following:

- If the MCO identifies a provider they believe should be placed on prepayment review, the MCO shall complete a Prepayment Review Request Form and e-mail the completed form, along with any relevant supporting documentation, to PrepaymentReviewRequest@la.gov.
- The LDH MCO Oversight unit will follow LAC 50:I.5.Chapter 41~~, otherwise known as the "SURS Rule",~~ when reviewing prepayment review requests.
- LDH will notify the MCO via e-mail of the decision on a prepayment review request. If the request is approved, the MCO may place the provider on prepayment review effective the date of receipt of approval.
- Prepayment review is not a sanction and cannot be appealed, nor is it subject to an informal hearing.

AUDIT COORDINATION

~~Surveillance and Utilization Review~~ Program Integrity Unit Audit Coordination

Preliminary Review of Data

- LDH Program Integrity (PI) ~~in conjunction with Surveillance and Utilization Review (SURS)~~ reviews encounter data of all of the MCOs on a regular basis.
- If a potential overpayment is identified for a provider within the MCO's network, ~~SURS~~ PI will send a secure e-mail to the MCO for vetting.

Contact with the MCOs

- The e-mail to the MCOs will contain information pertaining to the potential overpayment. The following information may be sent depending on the information available:

- A description of the issue(s) and provider information.
- An attachment with the encounter data and the preliminary results of each encounter audited.
- A copy of the draft letter containing each area of review.

❖ The MCO is given a deadline to indicate whether the encounter data has been or is in the process of being corrected, adjusted, or audited.

Audit Clearance

❖ If the issues or data anomalies relating to the providers were audited or are in the process of being audited by the MCO, ~~SURS~~ PI will need a copy of the results in order for the SURS case to be closed with "no action".

❖ If the providers were not previously audited by the MCOs, ~~SURS~~ PI will proceed with the audits (i.e., contacting the providers, requesting records, sending recoupment letters, etc.).

Audit

❖ Records will be requested for the ~~SURS~~ PI analyst and/or consultants to review or encounters will be given for the provider to do a self-audit.

❖ All letters have contact information of the ~~SURS~~PI analyst who is performing the audit if additional information or clarification is needed.

❖ If an overpayment is identified, a recoupment letter containing each area of review and the encounter-level detail will be sent.

Conclusion of the Audit

❖ The provider has informal and appeal rights (refer to ~~the SURS Rule~~ LAC50:I.5.Chapter 41 and the Medical Assistance Program Integrity Law (MAPIL) for detailed information).

❖ If a recoupment is identified, ~~SURS~~ PI will collect the amount owed from the MCO via a deduction from the MCO's capitation payment. The MCO may pursue recovery from the provider as a result of the State-identified overpayment.

❖ The MCO will receive an e-mail notification from the ~~SURS~~ PI analyst that the review is complete and provide the timing of the capitation deduction.

Unified Program Integrity Contractor Audit Coordination

Preliminary Review of Data

❖ Program Integrity (PI) in conjunction with the Unified Program Integrity Contractor (UPIC) reviews encounter data of all of the MCOs on a regular basis.

❖ If a potential overpayment is identified for a provider within the MCO's network, PI will send a secure e-mail to the MCO for vetting.

Contact with the MCOs

❖ The e-mail to the MCO will contain information pertaining to the type/scope of the audit.

❖ The MCO is given a deadline to indicate whether the encounter data has been or is in the process of being corrected, adjusted or audited.

Audit Clearance

- If the issues or data anomalies relating to the providers were audited or is in the process of being audited by the MCO, those MCO claims are removed from the potential universe of claims for the UPIC case.
- If the providers were not previously audited by the MCOs, UPIC will proceed with the audit (request records, question providers/recipients, produce a final report, etc.).

Audit

- Records will be requested for UPIC to review.
- If an overpayment is identified, UPIC will produce a final report to the PI Unit. PI will draft/mail all correspondence to the provider, and enclose the final report.

Conclusion of the Audit

- The provider has informal and appeal rights. Refer ~~to the SURS Rule~~ to LAC 50:I.5.Chapter 41 and the Medical Assistance Program Integrity Law (MAPIL) for detailed information.
- If a recoupment is identified, PI will collect the amount owed from the MCO via a deduction from the MCO's capitation payment. The MCO may pursue recovery from the provider as a result of the State-identified overpayment.
- The MCO will receive an e-mail notification from the UPIC analyst that the review is complete and provide the timing of the capitation deduction.