The Medicaid Managed Care Plan’s Role in Preventing, Detecting, and Reporting Fraud, Waste, and Abuse

Whether perpetrated by providers or beneficiaries, fraud, waste, and abuse continue to be a major concern in Medicaid managed care. This fact sheet provides a brief overview of the role and responsibilities of managed care plans (MCPs) in preventing and detecting suspected fraud, waste, and abuse.

Compliance Activities Required of Managed Care Plans

Many MCPs are required by law to have in place a compliance plan that is designed to guard against fraud, waste, and abuse. Under Federal regulations, an MCP’s compliance plan must establish and implement each of the following seven elements:

1. Written policies, procedures, and standards of conduct that articulate the organization’s commitment to comply with all applicable Federal and State standards.
2. A compliance officer and a compliance committee that are accountable to senior management.
3. Effective training and education for both the compliance officer and the organization’s employees.
4. Effective lines of communication between the compliance officer and the organization’s employees.
5. Enforcement of standards through well-publicized disciplinary guidelines.
6. Internal monitoring and auditing.
7. Provisions for promptly responding to and correcting detected offenses.

To view the specific types of MCPs that are required to have such a plan and the full text of these seven requirements under 42 C.F.R. § 438.608, visit [http://www.ecfr.gov](http://www.ecfr.gov) on the U.S. Government Printing Office website.

In addition to developing and implementing a strong compliance plan, MCPs that receive or make payments of $5 million or more annually under a State Medicaid program have additional compliance requirements. Section 1902 (a)(68) of the Social Security Act requires that these MCPs provide to their employees, contractors, and agents, in the form of written policies, certain information regarding State and Federal laws on false claims, whistleblower protections, and the MCP’s fraud detection and prevention procedures.

Screening

All MCPs should also put in place measures to screen employees and providers. Screening should identify all persons who have been excluded from the Medicaid program by the U.S. Department of Health & Human Services, Office of Inspector General (HHS-OIG) or prohibited from participating in Federal contracts under the Federal debarment regulations. Persons who are excluded cannot receive Medicaid payments, and the organizations they are part of also cannot be reimbursed by Federal healthcare programs for the work they do. Per Federal regulations at 42 C.F.R. § 438.610, failure to screen for debarments can also have potentially serious consequences for the MCP.

An individual or entity that has been excluded is reported on the List of Excluded Individuals/Entities (LEIE), which is available at [http://exclusions.oig.hhs.gov/](http://exclusions.oig.hhs.gov/) on the HHS-OIG website. An individual or entity that is debarred is reported on the Excluded Parties List System (EPLS), which is available at [https://www.sam.gov](https://www.sam.gov) on the System for Award (SAM) website, maintained by the General Services Administration. MCPs should familiarize themselves with lists of terminated providers. If a provider on one of these lists seeks to join an MCP network, the MCP should follow State and Federal policy guidance and contract requirements when deciding whether to offer a subcontract or credentialing to the applicant.
The Affordable Care Act includes a provision that requires a State Medicaid agency (SMA) to terminate any provider (individual or entity) that has been terminated by Medicare or another State Medicaid program. Through rulemaking, the Centers for Medicare & Medicaid Services (CMS) defined termination to only apply to those providers who were terminated for cause, meaning fraud, integrity, or quality, and expanded the requirements to include the Children’s Health Insurance Program (CHIP). MCPs need to be aware of these requirements. They must determine if and how they apply to MCP network providers in the States in which they operate. MCPs are advised to work with SMAs to determine a process for identifying providers terminated by the SMA.

Investigating and Reporting

If an MCP detects fraud, waste, or abuse, the MCP has an obligation to promptly investigate the situation in the manner specified in the MCP’s contract with the SMA. Based on the contract or State policy guidance, MCPs will generally report cases of suspected fraud, waste, or abuse to the SMA, the State Medicaid Fraud Control Unit, or, in some cases, to another designated law enforcement agency. Some situations may require immediate reporting, such as when patient safety is at risk, evidence may be destroyed, or monetary loss may be material. Information on what should be included in a referral of suspected fraud, waste, or abuse may be found in the CMS publication “Fraud, Waste, and Abuse Referral Guidelines for Use by Managed Care Plans.”

Resources

1. For more information on fraud and abuse in Medicaid managed care, consult the HHS-OIG report, “Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards” (December 2011), available at https://oig.hhs.gov/oei/reports/oei-01-09-00550.pdf on the HHS-OIG website.
2. States that have their own Medicaid databases showing termination include California, New York, and Texas. Their termination databases are available as follows:
   • Suspended & Ineligible Provider List, available under “References” at http://www.medi-cal.ca.gov/references.asp on the California Department of Health Care Services website;
   • Restricted, Terminated or Excluded Individuals or Entities, available at http://www.omig.ny.gov/data/content/view/72/52/ on the New York Office of the Medicaid Inspector General website; and

This fact sheet was current at the time it was published or uploaded onto the web. Medicaid and Medicare policies change frequently so links to the source documents have been provided within the document for your reference.

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