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States Have Missed Some Opportunities to Improve Medicaid Managed Care Organizations' Provider Fraud Referrals

Why OIG Did This Review

- Fraud in Medicaid managed care depletes critical resources and may cause harm to enrollees.
- State Medicaid agencies (States) play a key role in protecting taxpayer dollars by overseeing Medicaid managed care organizations (MCOs) and ensuring that MCOs identify potential fraud—including provider fraud—and refer it to States and Medicaid Fraud Control Units (MFCUs).
- OIG and CMS have cited concerns about a lack of fraud referrals in Medicaid managed care and States' efforts to oversee MCOs' fraud referrals. This evaluation examines how States use contract requirements and other practices to improve the volume and quality of MCOs' provider fraud referrals.

What OIG Found

States' contracts generally required MCOs to refer provider fraud to the State but had key differences:

- Most States reported that their contracts required MCOs to refer "any potential fraud" to the State and/or MFCU, while some other States' contracts used terms such as "credible allegations of fraud."
- States' contracts specified different timeframes for MCOs to make referrals, with timeframes varying from 1 day to 270 days and some States not setting a specific timeframe at all.
- A few States reported that their contracts did not specify the actions the State could take if MCOs did not comply with fraud referral requirements.

Further, some States did not provide fraud referrals training or feedback to MCOs, despite the potential of these practices to improve referrals.

Almost all States identified program-wide actions related to communication, guidance, or processes that CMS could undertake to help them improve the volume or quality of MCOs' provider fraud referrals.

What OIG Recommends

We recommend that CMS help States improve MCOs' provider fraud referrals in these ways:

1. Work with States to ensure that all MCOs are contractually required to refer potential fraud promptly.
2. Urge States to ensure that their contracts with MCOs specify actions the State can take to address MCOs' noncompliance with provider fraud referral requirements.
3. Work with States to expand the feedback provided to MCOs about provider fraud referrals.
4. Assess the feasibility of Federal program-wide actions that States identified as potentially beneficial for improving MCOs' provider fraud referrals and implement those that CMS determines are most promising.

CMS concurred with the first two recommendations. CMS did not explicitly concur or nonconcur with the other two recommendations but indicated that it has undertaken actions to implement them.