

Program Integrity in Public Programs



COUNCIL HEALTH PLAN MEMBERS



Managed Care Enrollment



- 15% of Medicaid enrollees, accounting for 55% of Medicaid spending, receive care from DHS through Fee-for-Service (FFS).
- 85% of Medicaid enrollees, which accounts for 45% of Medicaid spending, receive care administered through Managed Care.
- Of those 1,041,463 Minnesotans in Managed Care, the Council's health plan members cover around 931,000 Minnesotans, with the other 109,000 served through three County-Based-Purchasers (CBPs).

What is Program Integrity?



- Health plans' program integrity efforts ensure members receive the quality care for which they are eligible and ensure stewardship of Minnesotans' premium dollars.
- Program integrity is more than just intentional fraud – it also includes waste and abuse.
- Program integrity is a core competency for Minnesota health plans. Plans address program integrity across the board and utilize tools to prevent and identify fraud, waste, and abuse.

Contractual Reporting Obligations to DHS



- **MCOs are vendors that utilize their expertise in delivering access to care for vulnerable populations and in combatting fraud.**
- **MCOs answer to DHS and have contractual obligations around reporting fraud:**
 - Annual Integrity Program Report: Due April 30 each year, detailing investigative activities, corrective actions, prevention efforts, and results from the prior contract year.
 - Monthly Case-Level Reporting (2026 Amendment): Detailed logs of fraud and abuse investigations submitted monthly, requiring reporting on nearly all cases and initiatives.
 - Five-Business-Day Fraud Reporting: Required when the MCO knows or has reason to believe fraud has occurred, with mandatory cooperation with DHS and MFCU.
 - Payment Suspension and One-Business-Day Referral Requirement: When the MCO determines a credible allegation of fraud and imposes a payment suspension, a written referral to DHS and MFCU is required no later than the next business day.

SIU Teams



- **MCOs are contractually required to have Special Investigation Units (SIUs) dedicated to preventing and addressing fraud, waste, and abuse.**
- **MCO SIU teams draw on expertise and personnel from their Commercial lines of business.**
- **The items DHS is working to implement in FFS over the last year are capabilities already employed by health plans.**
 - Pre-service authorizations, pre-payment reviews, post-payment audits, AI tools to support record reviews and investigative prioritization, etc.
- **With the complexity of modern fraud, health plans also utilize innovative tactics.**
 - Social media research to identify residency issues and kickbacks.
 - IP data analysis to identify anomalies in account activity.
 - Performing site visits.
 - Employing former law enforcement and FBI.

2024 Fraud Reporting

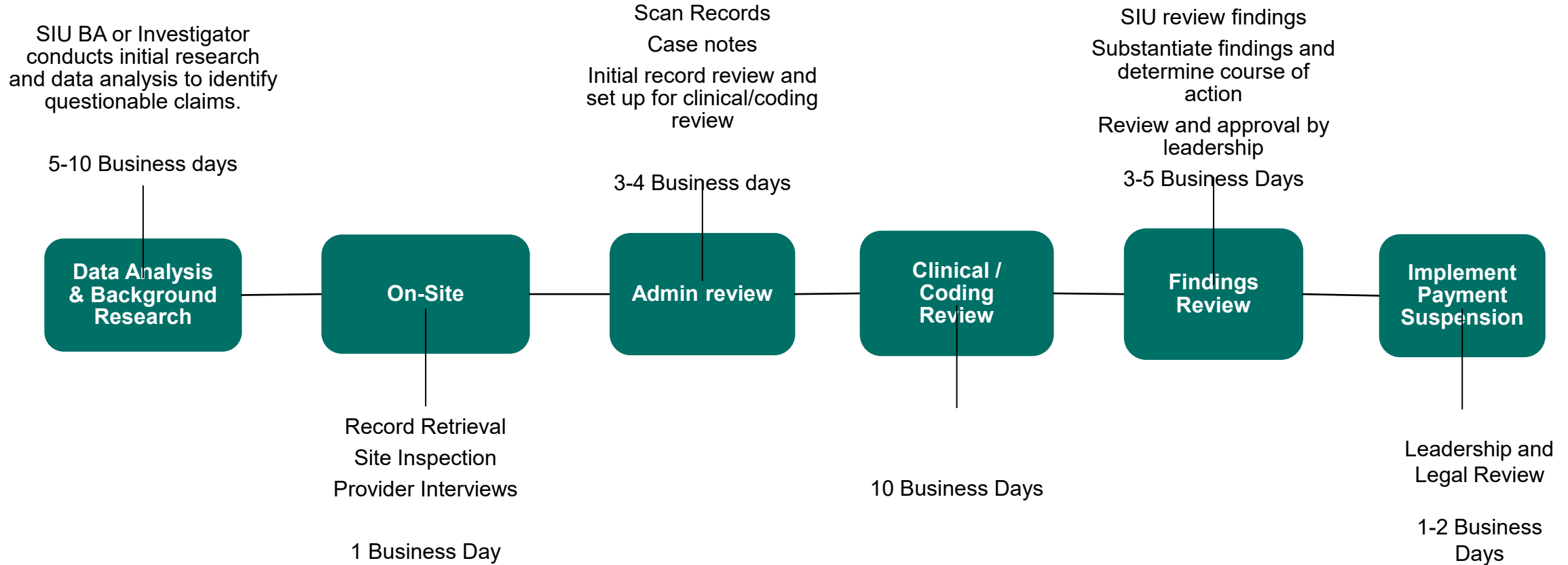


CMS requires all states to submit the Managed Care Program Annual Report (MCPAR), Detailing a range of managed care plan activities, including program integrity. These reports are posted publicly by CMS each year.

2024 Council Member Data:

- Dedicated Program Integrity Staff: 42
- Opened Program Integrity Investigations: 2,123
- Resolved Program Integrity Investigations: 2,181
- Program Integrity Referrals to the State: 103
- Plan Overpayment Recovery: \$1,395,826

SIU Rapid Response Timeline: 30-45 Days



Case Study: Housing Stabilization



Mid 2024: An MCO flagged suspicious patterns of billing and behavior for a provider of Housing Stabilization Services and referred the provider to the DHS Office of Inspector General's Program Integrity and Oversight team.

January 2025 – The MCO implemented a payment withhold and completed a formal referral to the Attorney General's Office Medicaid Fraud Control Unit (MFCU) and DHS PIO with their internal case investigation findings.

May 2025 – DHS designated the HSS program as high risk.

June 2025 – The provider voluntarily withdrew from the HSS program.

Case Study: Adult Rehabilitative Mental Health Services (ARMHS)



With the sunset of the statute requiring any willing mental health provider be included in Network and based on data indicating a need for review, a MCO undertook an in-depth review of its ARMHS Providers.

- **The MCO conducted site visits for every provider that submitted claims for members.**
 - Photographing Offices.
 - Collecting Staff Rosters with Training and Education and Supervisor Information.
 - Collecting Medical Records.
- **153 Sites Visited**
 - MCO Clinicians, SIU Staff, and provider contracting personnel review documentation from each site visit, cross reference medical records and claims on each case, and conduct member interviews
 - **57 practices (37%)** had their contracts terminated and referred to DHS for credible allegations of fraud.
- **Examples of Provider Fraud Caught:**
 - Providers billing for ARMHS services while a member was documented to be receiving care elsewhere (medical transportation, dialysis, physical therapy).
 - Providers billing for services provided to members who confirmed via SIU interview that they were not receiving ARMHS services.
 - Providers billing significantly more time than the medical condition required.

Vested Interest in Preventing Fraud



“There’s an opportunity here to partner with MCOs yet still oversee their activities. They have a vested interest in preventing fraud.”

– Tim O’Malley, Director of Program Integrity, March 9th

Eliminate Barriers to MCO Fraud Prevention



- The Council supports legislation that will improve communication between MCOs and DHS, strengthen plans' ability to include in network only quality providers, and perform the double-checks on services and payments that are essential for catching waste, fraud, and abuse.
- Health plans are also committed to working closely with the Legislature – which is why Council member plan SIU teams are holding a Legislative Program Integrity Event later this month, to give legislators the opportunity to hear directly from those on the front lines of fraud and to get their questions answered from the experts.