Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Program Integrity Review Annual Summary

May 2010

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INTRODUCTION

In March 2007, the Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) began its first year of reviewing States' Medicaid program integrity procedures and processes. The MIG conducted 8 comprehensive reviews in Federal fiscal year (FFY) 2007, 19 in FFY 2008, and 18 in FFY 09. Beginning with FFY 2008, MIG conducts annual comprehensive program integrity reviews of one-third of the States (including Puerto Rico and Washington D.C.).

The objectives of the reviews are to: (1) determine compliance with Federal program integrity laws and regulations; (2) identify program vulnerabilities and effective practices; (3) help the State improve its overall program integrity efforts; and, (4) consider opportunities for future technical assistance.

This report is a compendium of data collected from nine comprehensive reviews conducted in FFYs 2008 and 2009 for which final reports have been issued (between January 31 and November 30, 2009). This includes the States of: Florida, Maine, Minnesota, New Hampshire, New Mexico, Pennsylvania, Puerto Rico, Vermont and Wisconsin. The report includes information about effective practices, areas of vulnerability, and areas of non-compliance. In the *Effective Practices* sections you will find both those practices the MIG review team believed to be particularly noteworthy (i.e., practices that MIG believes represent innovative processes that successfully further important program integrity goals) as well as those practices which the States themselves identified as effective. The MIG's practice of including each State's self-reported effective practices in its reports is meant to provide an opportunity for States to share what they consider to be examples of their commitment to improving program integrity in their Medicaid program.

Additionally, this report contains information describing areas of vulnerability and non-compliance. This information is included with the hope that all States will learn from the vulnerabilities identified in others. States should review these areas to make sure they are not similarly vulnerable.

This report is not intended to be a report card. Rather it is a method to share program integrity practices and other information with all States. Therefore, States are only identified by name when describing effective practices. While you will find similarities between issues in this report and the *Program Integrity Review Annual Summary* report issued in May 2009, this report contains a significant amount of new information. The MIG hopes that this report will assist each State in assessing where it is positioned along the fraud and abuse prevention continuum and in selecting appropriate enhancements that fit each State's needs.

EFFECTIVE PRACTICES – PROVIDER ENROLLMENT AND DISCLOSURES

Noteworthy Practices

Preventing abusive or fraudulent entities and individuals from becoming Medicaid providers is a significant part of an effective Medicaid program. The MIG review teams identified the following noteworthy practices regarding provider enrollment and disclosures:

- ***Florida*** enrolls all billing agents as Medicaid providers in an effort to reduce fraud and abuse. The State's enrollment database links billing agents to the providers whom they represent. When problems with a billing agent are identified, all related providers can be quickly identified, and aberrant patterns can more easily be identified.
- ***Florida*** conducts site visits, as a condition of enrollment, to oxygen suppliers and durable medical equipment providers. Community mental health service providers, transportation providers, and some physician group practices are also subject to mandatory site visits before enrollment.
- ***New Mexico*** has statutory and administrative rules and regulations that require national criminal history background checks for direct care providers and medical services providers. The background checks are conducted prior to licensure or enrollment in Medicaid.
- ***Vermont*** conducts periodic provider re-enrollment. Licensed providers are re-enrolled at the term date of their license, while unlicensed providers are re-enrolled annually. Inactive and unresponsive providers are dropped if they do not respond to re-enrollment materials within a specified timeframe.
- ***Vermont*** verifies all provider licenses, using state websites, at the time of enrollment. License verification includes out-of-state providers.
- ***Wisconsin*** conducts a certification review of newly enrolled medical transportation drivers. The provider is subject to a periodic documentation review until the provider proves that it is in compliance with State policies and rules, and is not permitted to begin billing electronically until the audit is completed. Transportation providers are recredentialed annually.

Effective Practices

The States identified the following provider enrollment practices as being effective:

- ***Florida*** requires criminal background checks, including fingerprinting, for each provider or principal of a provider that is a corporation, partnership, association or other entity. Principals are defined as those with an ownership interest of 5 percent or more, partners, subcontractors, officers, directors, managers, financial records custodians, and all individuals who hold signing privileges on the provider's depository account. The State allows for some exemptions.
- ***Vermont*** requires criminal background checks for all personal care assistants (PCAs) and medical transportation drivers. The PCAs are also checked against adult and child abuse registries.

EFFECTIVE PRACTICES – PROGRAM INTEGRITY

Noteworthy Practices

Federal regulations require that States identify and investigate potential fraud and abuse. The MIG review teams identified the following program integrity practices as being particularly noteworthy.

- ***Minnesota*** requires each PCA that works for a personal care provider organization (PCPO) to be enrolled as an individual provider. This allows the State to track the activities of PCAs from one organization to another. In addition, PCA activity can be tracked for services provided to recipients across multiple managed care plans.
- ***Minnesota*** offers training to PCPOs prior to their enrollment. Training includes, but is not limited to, coverage and billing policies, covered and non-covered services, and provider responsibilities.
- ***Puerto Rico's*** use of a multi-agency centralized database has resulted in the identification of more than 200,000 ineligible recipients over the past 2 years. The database includes information pertaining to vehicle and land ownership, business and tax records, and lottery winnings.
- ***Vermont*** has developed a direct and timely date of death information feed from vital records to avoid paying claims after a Medicaid recipient's date of death.

Effective Practices

States have reported the following program integrity practices as being effective. State-identified effective practices have been divided into *Cooperation and Collaboration, Data Collection and Analysis, Program Safeguard Activities*, and *Additional Efforts* sections.

Cooperation and Collaboration

- ***Minnesota's*** philosophy is that program integrity is the responsibility of the entire agency. Program integrity has been built into everything from strong policy on benefits and eligibility to rules and statutes that allow for enforcement.
- ***New Hampshire's*** Surveillance and Utilization Review and Policy Units have a relationship that allows for smooth collaboration when State rules and/or policies and procedures have to be changed or enhanced as new provider fraud and abuse issues come to light.
- ***Vermont's*** program integrity function is closely linked with policy and operations within the Medicaid program. The program integrity area is involved in all areas of the State agency's operations.
- ***Vermont*** has established a Fraud and Abuse Control Team in an effort to address and resolve findings related to fraud, waste and abuse across all sister sub-agencies.

Data Collection and Analysis

- ***Florida*** uses a wide range of surveillance and utilization review tools such as the 1.5, Chi Square, and Early Warning System reports. The State also uses a Decision Support

System profiler and Ad Hoc and pharmacy detection reports in its efforts to prevent, detect, and monitor fraud and abuse. ***Vermont*** uses similar database and analytic tools.

- ***New Mexico*** compensates for limited staff resources by utilizing a contractor's data capabilities. The fiscal agent maintains a proprietary data warehouse and decision support system which can be used to generate standard and customized reports.
- ***Pennsylvania*** has full-time medical economists that use algorithms to analyze data. Specialized software and a data warehouse profiler are used to generate queries to support targeted reviews.
- ***Vermont's*** Medicaid Management Information System (MMIS) captures 97 percent of all claims. All data, except individual lines of a claim that come from a sister agency, is captured.
- ***Wisconsin's*** data warehouse contains 14 years of fee-for-service (FFS) claims data. The information is used to profile and identify billing patterns and aberrant provider behavior.

Program Safeguard Activities

- ***Florida*** undertook a drug rebate program investigation which focused on the dispensing of certain drugs to specific doctors. The State plans to conduct additional investigations of this program.
- ***Florida*** sends explanations of medical benefits (EOMBs) on a quarterly basis to all recipients for whom providers have billed services. Review of the returned EOMBs has given the State substantive leads on program integrity issues.
- ***Florida*** has the discretionary authority to require a $50,000 surety bond for selected providers for the first 12 months of enrollment and for each provider location up to a maximum of 5 bonds. Many providers must renew such bonds annually.
- ***Maine's*** average identified overpayments are in excess of $1 million per full-time equivalent staff (FTE). Actual recoveries average between $500,000 to $650,000 per FTE. Maine doubled its staffing in 2007. The increase in staff was instrumental in achieving the identification of overpayments.
- ***Maine*** has used its permissive exclusion authority to exclude 167 providers in the last four State fiscal years (SFYs).
- ***Minnesota*** highlighted its prepayment edit process which is constantly being refined. The mechanized edit system denies claims that fail to meet standards.
- ***Minnesota*** and its managed care organizations (MCOs) worked together to develop a Universal Restriction Program. Regardless of which entity restricts a recipient, managed care or FFS, the restriction will follow recipients if they change plans, move from FFS to managed care, or vice versa. Edits automatically prevent payment to all providers who are not the recipients' designated providers.
- ***Pennsylvania*** implemented a preferred drug list for the FFS program. From SFY 2005 to SFY 2008, non-dual eligible per member per month pharmacy spending decreased from $71.51 to $46.32 after accounting for Federal and supplemental rebates.
- ***Pennsylvania*** hired a contractor to monitor and retrospectively review hospital services and conduct diagnosis related group validation. Reviews have found a lack of documentation in medical records, incorrect diagnosis and procedure codes, and quality of care concerns.

- ***Wisconsin*** conducts 1,700 to 1,800 desk and field audits per year, on a variety of provider types. Audit activity is tracked in a database that is linked to the data warehouse.
- ***Wisconsin*** performs extensive prior authorization of many services. This process allows the State to have better control over service deployment.
- ***Wisconsin*** has developed a comprehensive system of performing prepay audits through edits and the use of code auditing software.

Additional Efforts

- ***Florida*** utilizes a web-based, event-driven fraud and abuse case tracking system that has document scanning, workflow tracking, and querying capabilities. The system compiles all information needed to track a case over time.
- ***New Hampshire's*** Medicaid business office staff are co-located with the fiscal agent and are actively involved with the provider enrollment process on the front end.
- ***New Mexico*** developed comprehensive policies and procedures to guide all aspects of program integrity work. The documents are used to ensure protocols are followed, to train new employees, and to develop and update program integrity work plans.
- ***Pennsylvania's*** case tracking system includes features such as safeguards for data entry and the ability to generate an email if the owner of the case wants an attorney assigned to the case.
- ***Puerto Rico*** developed a document discussing guidelines for the development of a program integrity plan. The document is a comprehensive strategy aimed at increasing managed care plans' compliance with Federal regulations.
- ***Vermont's*** Office of Vermont Health Access is organized as a publicly run, statewide MCO, the first of its kind in the country. By maintaining control over the screening and credentialing process, the State is able to better ensure the integrity of both FFS and managed care programs.

EFFECTIVE PRACTICES – MANAGED CARE

Noteworthy Practices

As Medicaid moves increasingly from being a predominantly FFS model to being a managed care or capitated model, States continue to face new challenges in controlling fraud and abuse in their Medicaid programs. The MIG review teams identified the following noteworthy managed care practices:

- ***Florida's*** managed care unit seeks guidance from program integrity staff on the fraud and abuse provisions in the managed care contract to ensure that the provisions are meaningful and that MCOs have adequate staff to carry out required functions. Program integrity staff are included in onsite visits to each MCO at initial certification and during onsite reviews at the end of the first contract year. Program integrity staff attend monthly meetings that are conducted by the managed care unit with each health plan to discuss and receive information on fraud and abuse issues.

- ***Pennsylvania*** sponsors an annual program integrity meeting for its MCOs that provides education regarding fraud and abuse. Topics of discussion included fraud and abuse schemes, cooperative relations with stakeholders, and best practices. Meetings also provide training to physicians, designed to increase awareness of fraud and abuse issues in their practices.
- ***Wisconsin*** requires that managed care networks use only providers who have been certified by the State, except in emergency situations. By doing so, the State is able to maintain disclosure information on most providers receiving payment through a managed care plan and minimize the risk of an excluded provider receiving State and Federal funds through an MCO.

Effective Practices

States reported the following managed care practices as being effective:

- ***Minnesota's*** MCO contracts require MCOs to report any suspected fraud and abuse to the State within 24 hours after becoming aware of such. The contract also requires reporting of suspected fraud and abuse by recipients. Program integrity staff periodically visit MCOs onsite to interview compliance and investigative staff.
- ***New Mexico*** conducts monthly meetings with its MCOs and the Medicaid Fraud Control Unit (MFCU) to discuss fraud and abuse cases and provider compliance issues.
- ***Pennsylvania*** uses teams of staff from various functional areas to monitor physical health MCOs for contract compliance and performance standards, including those for fraud and abuse. Behavioral health MCOs are monitored using a Program Evaluation Performance Summary tool. The tool includes a provider credentialing standard requiring a file review of licensing, certifications and criminal conviction information. Managed care policies and procedures for reporting fraud and abuse are also reviewed.

EFFECTIVE PRACTICES - MEDICAID FRAUD CONTROL UNIT

Effective Practices

In response to our request, several States reported what they consider to be effective practices in terms of working with MFCUs. ***Florida, Maine, Minnesota, New Hampshire, and Wisconsin*** reported that they enjoyed an effective relationship between the State Medicaid Agency and the MFCU. States noted a focus on mutual goals and respect, cooperation and collaboration, frequent formal and informal communication, and joint training of staff. In addition, ***Wisconsin*** granted its MFCU access to the MMIS and arranged for training on the new system so that data runs can be requested in a more efficient manner.

AREAS OF VULNERABILITY – PROVIDER ENROLLMENT AND DISCLOSURES

Three States failed to capture disclosure information from agents and managing employees during the enrollment process. This vulnerability affected both FFS and managed care programs. Without such disclosure, the States would have no way of knowing if excluded individuals are working for providers or health care entities in such positions as billing managers and department heads.

Three States failed to capture criminal conviction information in the managed care credentialing process and/or did not report such information to U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG). In one of the States, MCOs are not required to send all criminal conviction information to the State. The information is sent to the county and then the county decides whether to report that information to the State. While another State's MCOs do collect health care-related criminal conviction information, the State does not require MCOS to report the information to the State or HHS-OIG. One State delegates the authority to collect and report criminal conviction information to its MCOs. However, none of the State's MCOs were collecting and reporting such information.

One State failed to capture disclosure of ownership, control and relationship information in the managed care credentialing process. This State also failed to require disclosure of business transaction information, upon request, in the managed care credentialing process.

One State did not verify the provider's license during the application process. Without routine independent verification of licensure (for both in-state and out-of-state providers), the State would not know with certainty that providers submitting applications have licenses in good standing.

One State indicated that its fiscal agent checks providers against the List of Excluded Individuals/Entities at enrollment. However, some provider enrollment application files lacked documentation of an exclusion search.

In another State, direct care workers employed by or contracted with an enrolled provider entity are not checked for exclusions. This relates to entities enrolled by Medicaid that hire persons to provide direct services to Medicaid recipients.

AREAS OF VULNERABILITY – PROGRAM INTEGRITY

The most frequently identified vulnerability in this category is failure to verify with enrollees receipt of managed care services billed by providers. Four States failed to ensure that their MCOs had a method to verify receipt of services either through EOMBs or any other method. The State continues to be responsible for ensuring this requirement is met when it has contracted service delivery to an MCO.

Two States lacked effective oversight over MCOs. One State's MCO contract required an annual fraud and abuse report, with no additional formal written contact during the year. In addition, several of that State's MCOs have memoranda of understanding with the MFCU and the State is not always included in that communication. In the second State, while MCOs were contractually required to inform the State about all cases of suspected fraud and abuse, MIG identified discrepancies between the MCO quarterly reports and the State's tracking database.

One State lacked oversight of personal care services. Credentialing of PCAs is done by the county, not the State, leaving the State unable to track services provided by PCAs. The State is also unable to use claims data to track if such services are being provided by appropriate personnel. If servicing information was captured on the claims, the State would be able to track patterns of potential fraudulent and abusive practices.

One State Medicaid agency, which has delegated managed care oversight to another agency, lacked oversight, tracking, and coordination of fraud and abuse activities. Data sharing is minimal and inconsistent between the two agencies, limiting the overall efficiency and effectiveness of fraud and abuse coordination efforts. In addition, managed care fraud and abuse was not tracked in a systemic manner, increasing opportunities for fraudulent providers to be enrolled in the Medicaid program.

One State lacks a functioning Surveillance and Utilization Review Subsystem, which could be used to target providers and focus reviews on specific codes or issues. Currently, cases are opened for a broad review in hope that a pattern or problem area can be identified.

The MIG identified a vulnerability regarding lack of a written policy and procedure for reporting adverse actions in one State. The State does not have a procedure in place to notify the HHS-OIG of such action. Further, its current procedure does not include notification of all parties as required by regulation.

One State was found to have incomplete provider enrollment files. After a mold infestation which affected paper provider files, the State asked providers to verify their information. However, there was no tracking system put into place to identify which providers responded and which did not, leaving the State unsure if it has accurate and complete provider information.

The failure to ensure that entities are in compliance with the False Claims Act provision of the Social Security Act was noted in one State. While the State notified providers about the requirements and required providers to sign and submit an attestation that they will comply with the requirement, the State has not begun monitoring the entities to determine compliance.

Lack of resources with diverse medical expertise was identified as a vulnerability in one State's program. The State has a medical director and a dental consultant, but most of the medical director's time is spent in areas other than program integrity. Additional consultants would provide expertise for identifying potential fraud and abuse.

AREAS OF VULNERABILITY - MEDICAID FRAUD CONTROL UNIT

Within most States, two agencies share primary responsibility for protecting the integrity of the Medicaid program: the section of the State Medicaid agency that functions as the program integrity unit and the MFCU. Regular meetings between the two entities promote the high level of communication that is integral to the success of both. Many HHS-OIG reports, as well as overwhelming anecdotal evidence, demonstrate that a close working relationship between the two agencies results in the most effective fraud referrals. Perhaps even more importantly, the level of communication established by this close coordination of efforts through regular meetings facilitates the identification of new fraud trends, increases accountability, and generally improves the productivity of the two agencies.

The MIG identified communication and relationship issues between the State agency and the MFCU in two States. One State has no formal process for communication with the MFCU regarding the status of case referrals. All communication is verbal except for the MFCU sending a copy of the conviction letter, in cases of conviction. Another State's relationship with its MFCU is ineffective. Monthly scheduled meetings were not held because of competing priorities, the units do not have procedures for assigning the workload for preliminary and full investigations, and few cases are being referred to the MFCU.

In two States, the State case referral process was identified as a weakness in their programs. In one case, fraud referrals are indirectly routed to the MFCU. The referrals must be first approved by both the State's general counsel and the governor's office of counsel prior to being referred to the MFCU. In another State, the process for determining when to refer a case limits the ability of the MFCU to prosecute fraud cases. The State determines the degree to which policy or law is violated, the merits of the case, and intent. However, these determinations on the part of the State limit the MFCU's authority to determine the prosecutorial merits of all suspected cases of fraud.

These types of ineffective relationships result in a weakening of program integrity efforts within the State Medicaid program. In September 2008, MIG issued a *Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units* document, which provides guidance for interactions between State Program Integrity Units and MFCUs. The document contains ideas from State program integrity units nationwide, including practical ideas for maximizing a program integrity unit's return on investment from the relationship with its MFCU. In addition, the MIG issued a second guidance document that provides details on the collection of information that makes up an appropriate MFCU referral. This document is entitled *Performance Standard For Referrals Of Suspected Fraud From A Single State Agency to A Medicaid Fraud Control Unit* and was also issued in September 2008.

AREAS OF NON-COMPLIANCE

This section identifies the number of States that were non-compliant with each regulation. Most frequently cited were regulations regarding disclosure of information and reporting requirements, the same issues discussed in MIG's 2008 report. While some States completely failed to meet the regulations, MIG found many instances in which the regulations were only partially met.

- Under 42 CFR § 455.104, the Medicaid agency must require disclosure of (1) name and address of a person with ownership and control interest in the provider entity or in a subcontractor in which the provider entity has 5% or more interest; (2) name of any other provider in which the owner of provider entity has ownership or control interest; and (3) whether any person named in #1 is related to another as a spouse, parent, child, or sibling. Disclosure is required either when the provider entity is surveyed (if surveyed periodically), or before entering into or renewing the provider agreement (if not surveyed periodically). The Medicaid agency must require disclosures from the fiscal agent prior to approving the contract with the fiscal agent, and from the provider prior to approving the provider agreement.

  Eight States were not in compliance with this regulation.

- The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractors.

  Six States were not in compliance with this regulation.

- The regulation at 42 CFR § 455.106 requires providers to disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made.

  Six States were not in compliance with this regulation.

- The regulation at 42 CFR § 1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

  Six States were not in compliance with this regulation.

- The regulation at 42 CFR § 455.18 requires that providers attest to the accuracy of information on all claim forms. The regulation at 42 CFR § 455.19 permits an alternative to attestations on claim forms: the State may print attestation language above the claimant’s endorsement on checks or warrants payable to providers.

Four States were not in compliance with this regulation.

- The regulation at 42 CFR § 455.20 requires the Medicaid agency have a method for verifying with recipients whether services billed by providers were received.

One State was not in compliance with this regulation.

- The regulation at 42 CFR § 455.13 requires the Medicaid agency have methods and criteria for identifying and investigating suspected fraud cases, and must have a procedure for referring such cases to law enforcement.

One State was not in compliance with this regulation.

- The regulation at 42 CFR § 455.14 requires the Medicaid agency conduct preliminary investigations to determine whether there is sufficient basis to warrant a full fraud or abuse investigation.

One State was not in compliance with this regulation.

- The regulation at 42 CFR § 455.15 requires that the State Medicaid agency refer suspected cases of recipient fraud to an appropriate law enforcement agency. If the State Medicaid agency suspects a recipient has abused the Medicaid program, the agency must conduct a full investigation. If the State agency's preliminary investigation leads to a suspicion that a recipient has defrauded the Medicaid program, the case must be referred to an appropriate law enforcement agency. If the agency believes that a recipient has abused the program, the State agency must conduct a full investigation.

One State was not in compliance with this regulation.

- The regulation at 42 CFR § 455.23 states that the Medicaid agency may withhold Medicaid payments, in whole or in part, in cases of fraud or willful misrepresentation under the Medicaid program. The State agency must send appropriate notice of its withholding of program payments within five days of taking such action.

One State was not in compliance with this regulation.

- The regulation at 42 CFR § 1002.212 requires that a State agency that has initiated an exclusion notify the individual or entity subject to the exclusion as well as other State agencies, the State medical licensing board, the public, recipients, and other interested parties.

One State was not in compliance with this regulation.

CONCLUSION

Many State Medicaid agencies have developed and implemented one or more effective practices that enhance their program's ability to identify and reduce Medicaid fraud and abuse. In addition, all of the States reviewed indicated that they had made or planned to make modifications in their practices to address areas of non-compliance and vulnerability identified in MIG's program integrity reviews. For additional information or for questions about issues discussed in this report, please contact the Medicaid Integrity Group at Medicaid_Integrity_Program@cms.hhs.gov.