

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Medicaid Integrity Program
Best Practices Annual Summary

June 2011

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WELCOME LETTER

Dear State Program Integrity Director:

The Medicaid Integrity Group (MIG) is pleased to present you with our third annual Medicaid Integrity Program Best Practices Annual Summary for 2011. One of our statutory mandates is to provide effective support and assistance to States to help better combat provider fraud and abuse. This report is one way we assist in this effort.

In this annual summary, you will find best practices you should consider implementing in each of your States. We have included the States which conduct those best practices to encourage you to contact your colleagues there to learn more. We have also included findings of regulatory non-compliance and vulnerabilities we have identified. We urge you to examine your own programs to strengthen where you may have vulnerabilities.

Since our reviews began in 2007, the most frequently cited areas of non-compliance (42 CFR §§ 455.104, 455.105, 455.106 and 1002.3) have related to provider enrollment. These problems have been identified in nearly every State. We have, however, noticed a positive trend in States' awareness of regulatory requirements and knowledge of how the requirements should be implemented. We hope that our *Best Practices for Medicaid Program Integrity Units' Collection of Disclosures in Provider Enrollment* guidance (issued August 2010) will be helpful to you in correcting these findings.

We have also observed an improvement in State–Medicaid Fraud Control Unit (MFCU) relationships and hope that our *Best Practices For Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units and Performance Standard for Referrals of Suspected Fraud From a Single State Agency to a Medicaid Fraud Control Unit* documents have facilitated this improvement.

We are pleased to report that as of Federal fiscal year (FFY) 2010, all States (including Puerto Rico and the District of Columbia) have participated in classes at the Medicaid Integrity Institute (MII). Between FFY 2008 and FFY 2010, a total of 1,604 State staff have attended 39 classes at the MII. In addition to MII training, MIG has provided onsite CPT Coding Outpatient Boot Camp training to 203 State staff, with additional training planned for FFY 2011.

We hope 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. All final program integrity review reports are posted on our website at: www.cms.gov/MedicaidIntegrityProgram. You will find other valuable information there as well.

Sincerely,

Angela Brice-Smith, Director
Medicaid Integrity Group

EDITOR'S NOTE

As you know, MIG has been conducting triennial comprehensive reviews of State program integrity operations since March 2007. Through FFY 2010, the MIG has reviewed every State (including Puerto Rico and the District of Columbia) at least once, with 10 States having been reviewed twice.

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 includes identified best practices of eight comprehensive reviews for which final reports were issued between December 1, 2009 and November 30, 2010. This includes the States of Alabama, Arizona, Idaho, Kentucky, Louisiana, Mississippi, Tennessee, and the District of Columbia.

In the *Best Practices* sections you will find both those practices the MIG review team believed to be particularly noteworthy (i.e., practices that MIG considers to be best practices) 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. The CMS has not independently assessed each of the self-reported effective practices. The report also includes information about areas of vulnerability and areas of non-compliance.

Also included is information about the Affordable Care Act (ACA) and some of the activities that States have already been doing that are similar to the new program integrity requirements in the ACA. While a summary is presented here, more detailed information about these efforts is found in the body of this report.

Section 6503 of the ACA requires States to register billing agents, clearinghouses and alternate payees. At the time of its review, the State of Kentucky was already requiring billing agents and payees to sign an agreement with the State to prevent submission of false claims.

The ACA requires at section 6401(b) that States comply with provider screening requirements for Medicare at section 1866(j)(2)(B) of the Social Security Act, which includes database checks. Under the final rule implementing the provider screening provisions of the ACA, CMS-6028-FC, States are required to check specific databases for all Medicaid providers, prior to enrollment and on a routine basis thereafter. These requirements are set forth at Federal regulation sections 455.436 and 455.450(a)(3), and include checking the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System (EPLS) each month for excluded providers and searching the Social Security Administration's Death Master File. At the time of their review, the States of Tennessee, Arizona, Kentucky, and Alabama were already conducting database checks of some or all of these databases.

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Section 6501 of the ACA requires a State to terminate any provider (individual or entity) that has been terminated by Medicare or by another State's Medicaid program. Pursuant to the final rule, the termination requirement also applies to providers in the Children's Health Insurance Program (CHIP), and applies to terminations effective January 1, 2011. Federal regulation section 455.416(c), effective March 25, 2011, requires a State to terminate a provider that has been terminated by Medicare or another State's Medicaid program or CHIP as of January 1, 2011. The State of Kentucky has the ability under regulation to terminate providers at will, "immediately for cause or in accordance with State and federal law", which will permit it to comply with the requirements of Section 6501 without additional rulemaking or legislation.

BEST PRACTICES – PROVIDER ENROLLMENT AND DISCLOSURES

Noteworthy Practices

An important piece of an effective Medicaid program integrity operation is preventing abusive or fraudulent entities and individuals from getting into the Medicaid program. States' provider enrollment policies and practices are important tools in protecting Medicaid dollars. The MIG review teams identified the following noteworthy practices regarding provider enrollment and disclosures:

- ***Kentucky*** requires billing agents and payees to sign an agreement in an effort to deter providers and billing agents from submitting false claims. The agreement includes all applicable electronic billing rules and regulations, as well as an attestation that the billing agent understands that persons submitting false claims are subject to civil and/or criminal sanctions under applicable State and Federal statutes. (Now required under ACA section 6503.)
- ***Kentucky*** utilizes innovative techniques during the process of initial provider enrollment and re-enrollment, including an especially thorough exclusion checking process. Its techniques include a centralized provider enrollment process in which all providers, including managed care network providers, must be enrolled by State provider enrollment staff, and a link on the Kentucky Department of Medicaid Services website to the Kentucky Sanctioned Provider list for public viewing. In addition, during initial enrollment Kentucky reviews not only the LEIE, but also checks the EPLS and the State's Medical Licensing Board.

Effective Practices

The ***District of Columbia*** identified its durable medical equipment (DME) supplier enrollment process as being effective. The District regulations require pre-enrollment site visits for all suppliers within a 30 mile radius of the State agency in order to verify information submitted on the provider application. Suppliers outside the radius must have a telephone interview. The regulations also require providers to attend orientation, which includes fraud and abuse training, before they can be enrolled in Medicaid. All DME suppliers are required to reenroll every three years.

BEST PRACTICES – PROGRAM INTEGRITY

Noteworthy Practices

State Medicaid agencies have an array of tools and best practices with which to promote Medicaid program integrity and combat fraud and abuse. The MIG review teams identified the following program integrity practices as being particularly noteworthy.

- **Louisiana** demonstrates effective oversight of non-emergency medical transportation providers by sending a notice to enrolling providers which includes instructions that before the enrollment process can continue the provider must check with the State's program integrity area to verify if an owner or co-owner has been convicted of a felony or any other criminal offense. Prior authorization by a contractor is required for all transportation services, and a Medicaid Transportation form must be signed by the beneficiary, provider, and the driver as proof of service.
- **Louisiana** program integrity staff teamed up with mental health rehabilitation (MHR) staff from a sister agency to conduct a 100 percent review of all MHR providers. The project involved the monitoring and auditing of approximately 131 MHR providers and resulted in a number of major findings of fraud or abuse. Louisiana saved \$64,797,452 through cost avoidance and made 49 overpayment recoveries that netted \$585,604.54. The project also resulted in 14 referrals to the MFCU.
- **Louisiana** not only works closely with its provider enrollment contractor, but supervises and monitors the provider enrollment functions as well. This arrangement allows for the State and its contractor to be "joined at the hip" from the initial process of enrolling providers to performing pre-payment claims reviews and providing statistical services such as sampling and extrapolation. Since all processes and procedures used by the contractor must be approved by State staff, the Program Integrity Unit's oversight greatly speeds up communications between the entities and allows them to achieve increased efficiencies.
- **Tennessee** has developed algorithms which allow the review of data from other State agency databases including the Department of Labor State Wage File and the Department of Health State Death File. For example, the State Wage File is run against the LEIE database to determine if excluded persons are working for a health care-related employer. The State then checks persons and employers to determine if they are accepting TennCare payments. (Now required under ACA section 6401.)
- **Tennessee** uses a three step process to verify and validate managed care encounter data. Encounters are processed through a software program which assesses data quality and accuracy prior to adjudication. The software selectively rejects "bad" data based on a standard set of edits and audits and sends the "bad" data back to the managed care organizations (MCOs) for cleaning and resubmission. Encounters are then processed through the fee-for-service (FFS) claims engine using the same edits and audits as applied to FFS claims. The State also uses a contractual withhold every month that requires a certain percentage of clean claims. As a result, there is currently less than a 1 percent error rate for encounter data in the Medicaid Management Information System (MMIS).

Effective Practices

States have reported the following program integrity practices as being effective in identifying and investigating potential fraud and abuse. 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

- **Arizona's** Office of Investigations is designated as a Criminal Justice Agency. This designation has expanded the State's access to major sources of criminal justice information and allows the State to receive and share restricted criminal justice information with other Federal, State, and local agencies.

Data Collection and Analysis

- **Arizona** uses a large contractor database in developing fraud and abuse cases. The contractor maintains more than 17 billion records on individuals and businesses which Arizona uses as background information in investigations. (Now required under ACA section 6401.)
- **Kentucky** has an efficient Date of Death data match procedure for providers and beneficiaries. The State's fiscal agent compares a monthly file from the Department of Vital Statistics to data in the MMIS to determine if claims were submitted for or by deceased providers and beneficiaries after the date of death. Recoupment letters are generated and the system automatically inserts date of death information into the MMIS provider file. (Now required under ACA section 6401.)
- **Kentucky's** program integrity area has access to a database of all controlled substance prescriptions filled in Kentucky. Access to the system helps identify outliers and reduce the time and cost involved in drug diversion investigations.

Program Safeguard Activities

- **Alabama** conducts routine checking for excluded providers by running its Medicaid provider list, through its fiscal agent, against the LEIE each month. Soon after the MIG review, the State began checking its State list of excluded providers with the Department of Industrial Relations to see if any excluded persons are working elsewhere, for example, as managing employees. The State exclusion list includes both the Medicare Exclusion Database (MED) and Alabama-initiated exclusions. (Now required under ACA section 6401.)
- **Alabama's** recent legislation on mobile dentistry included requirements for mobile or portable dental operations aimed at prevention of fraud and abuse. Requirements include providing an official business address within the State, being associated with an established dental facility, maintaining records at the business address, and providing an information sheet (treatment, billing service codes, etc.) to patients at the end of their visit.
- **Arizona** makes use of statutory provisions which enhance its ability to prevent, detect, and take action against fraud and abuse. Some of these provisions include: subpoena power and the authority to compel examinations under oath granted to the program integrity director, and a balanced billing statute which authorizes Arizona to assess heavy civil penalties and/or reduce future payments to providers who attempt to collect amounts from individuals that exceed the value of claims billed or approved reimbursement rates.

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- **Kentucky** developed innovative techniques of checking for providers with outstanding debt. One technique is the Application Collection process. When providers try to re-enroll in Medicaid after being terminated or inactivated due to non-billing for two years, they are reviewed for outstanding debt. Another tool is the 270 Day Report on active providers which allows staff to review the accounts receivable database for debts which are over 270 days old in order to collect the outstanding debt.
- **Kentucky** has the regulatory authority to terminate providers at will. Kentucky Administrative Regulations give the State the right to terminate providers at its discretion prior to a hearing. Thirty days notice must be given prior to the termination. This provision enables the State to remove potentially problematic providers from the program before questionable outlays to those providers can accumulate. In addition, the State's provider agreement provides that the State may terminate a provider agreement "immediately for cause or in accordance with state and federal laws" as long as written notice is served by registered mail. (Now required under ACA section 6501.) Kentucky's provider enrollment staff also makes use of regulatory authority to terminate providers who do not submit bills over a 24 month period.
- **Tennessee** has a new law that makes it a felony to lie or willfully withhold evidence in connection with an investigation of fraud. While the intent to defraud can be difficult to prove in court, the new law makes it easier for the State to obtain criminal convictions and subsequent exclusions of problem providers because there is a lower threshold of evidence needed to prove that a provider lied or withheld information during the course of an investigation.

Additional Efforts

- The **District of Columbia** assigns professional staff to specific provider and service types. Staff familiarity with specific program eligibility and billing policies improves effectiveness in conducting claims payment reviews. The District set an annual recovery goal for each staff member as an incentive to improve performance.
- **Idaho** reported that its program integrity staff conduct very thorough preliminary investigations and refer cases to the MFCU whenever there is reliable evidence of provider fraud. The program integrity area has experienced investigators; it was the investigatory unit for criminal investigations before the MFCU came into existence in 2007.
- **Mississippi's** Division of Medicaid conducted an independent evaluation of the program integrity area to assess functionality, structure and effectiveness.
- **Mississippi** uses a consulting statistician to determine accurate dollar loss values on program integrity cases. The statistician enhances the efforts of the MFCU during prosecution by providing a detailed analysis of the loss.
- **Mississippi** contracts with an independent audit vendor to adjust facility rates for providers to the most accurate amount. This contractor supplements limited State staff.

BEST PRACTICES – MANAGED CARE

Noteworthy Practices

As Medicaid continues to move 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

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Medicaid programs. The MIG review teams identified the following noteworthy managed care practices:

- *Arizona* and *Tennessee* require all managed care network providers to be enrolled in Medicaid, allowing the States to maintain centralized control over the screening and registration process and better ensure the integrity of the programs. This requirement minimizes the risk of an excluded provider receiving State and Federal funds.
- *Arizona* sponsors a semi-annual Compliance Officer Network Group meeting that includes all MCO Compliance Officers, all program integrity staff and other State divisions, the Attorney General's Office, and CMS Regional Office staff. The meeting provides all stakeholders with updates and training on fraud and abuse issues, an introduction to new program integrity staff, and opportunities to network among agencies. The State reports that as a result of these meetings the number of referrals from MCOs has increased, and MCOs have communicated more among themselves on program integrity issues. Also noted is a greater MCO willingness to report and share information about suspected provider fraud.

Effective Practices

Kentucky reported that quarterly MCO meetings with State agencies involved in program integrity have been effective. Attendees at this meeting include the MCO's chief compliance officer, the program integrity coordinator for the MCO's administrative contractor, State staff, State Office of Inspector General (OIG) staff, along with Medicaid financial management and medical management staff when warranted. The meetings include a review of beneficiary and provider fraud cases as well as a discussion of member issues (e.g., lock-in program status and collection letters) and provider issues (e.g., outstanding debts and date of death notices). The meetings enable the State to monitor MCO activities closely and offer the State the opportunity to provide ongoing education and guidance to the MCO.

BEST PRACTICES - MEDICAID FRAUD CONTROL UNIT

Effective Practices

In response to our request, four States reported what they consider to be effective practices in terms of working with the MFCU.

- *Alabama* and *Louisiana* 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.
- *Kentucky* reported a cooperative relationship among the State Medicaid agency, the State OIG, and the MFCU. A three-way memorandum of understanding clearly delineates each agency's responsibilities and obligations and allows the limited number of staff in each department to concentrate on specific responsibilities and do them well. The close coordination of work by the different agencies stands in contrast to the low level of coordination in the years prior to the MIG review, in which the State reported unusually low numbers of program integrity investigations.
- *Tennessee* established a Provider Fraud Task Force in 2007, which includes representatives from the Office of the Attorney General, the MFCU, and the State agency. Both the State

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and the MFCU credit the task force with laying the foundation for greatly improved collaboration between these two essential program integrity components.

AREAS OF VULNERABILITY – PROVIDER ENROLLMENT AND DISCLOSURES

Vulnerabilities in States' provider enrollment processes have been identified in nearly all program integrity reviews conducted by the MIG since 2007. In August 2010, the MIG issued a *Best Practices for Medicaid Program Integrity Units' Collection of Disclosures in Provider Enrollment* document, which provides guidance for preventing providers who should not be in the Medicaid program from becoming enrolled. The document is found on the CMS website at <http://www.cms.gov/FraudAbuseforProfs/Downloads/bppedisclosure.pdf>.

Exclusion Searches

On June 12, 2008, CMS issued a State Medicaid Director Letter (SMDL #08-003) providing guidance to States on checking providers and contractors for excluded individuals. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers to screen their own staff and subcontractors for excluded parties. Five States failed to comply with this guidance in the FFS or managed care programs.

One State only checks the LEIE when a provider applies for FFS Medicaid and not thereafter on a monthly basis.

Another State requires disclosure of information about persons with ownership or control interests, agents, and managing employees on its provider applications, but does not verify whether such persons are excluded from Federal health programs by HHS-OIG. This issue was identified in FFS, managed care, and home and community based waiver programs.

Two States are not maintaining complete information on owners, officers and managing employees in their MMIS. Therefore the States cannot conduct adequate exclusion searches of the LEIE or the MED.

One State's exclusion checking procedures are internally inconsistent. Fee-for-service provider enrollment is handled by several entities. During a walkthrough of the provider enrollment process, the team noted that staff in one area checks all names, including managing employees, against HHS-OIG's LEIE during the enrollment process, while staff in another area only checks the names of the provider and members of a practice if the provider is part of a group practice. The Medicaid agency also does not maintain complete information on owners, officers and managing employees in the MMIS or an equivalent repository. Therefore, the State cannot conduct adequate monthly searches of the LEIE or the MED. In addition, the office that contracts with entities to provide services to Medicaid beneficiaries does not adequately check potential contractors for exclusions. In the managed care credentialing process, the review team also found that owners and managing employees are not always checked for exclusions at the time of or after enrollment. In the same State, providers likewise do not always screen their staff and contractors for excluded individuals.

During a walkthrough of the enrollment process in another State, the MIG team noted that individual providers and practitioner groups are not checked against the MED during initial enrollment, while institutional providers were checked. An excluded provider would only be

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detected during a subsequent automated monthly check of the State's provider network against the MED. Because the process contains a lag time before new providers are checked, the State is left open to temporarily allowing certain types of excluded providers into the Medicaid program.

Additionally, individual providers and practitioner groups do not receive the Disclosure of Ownership and Control and Criminal Conviction form during the application process. This leaves the State unable to check for exclusions on individuals with ownership or control interests in individual provider or practitioner groups. State contracting staff collect MCO ownership, control and criminal conviction information during the Request for Proposals process but do not check to see if the individuals listed have been excluded. Since MCOs are not enrolled or registered by the provider registration unit and not given a registration number, they are not subject to the State's automated monthly exclusion searches, leaving the State vulnerable to having excluded individuals in key MCO positions indefinitely.

Verification of Provider Licenses

Four States 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.

Disclosure of Ownership, Control and Relationships

Three States failed to capture disclosure of ownership, control and relationship information in the managed care credentialing process, that 42 CFR § 455.104 would otherwise require from FFS providers.

Disclosure of Criminal Convictions

Three States failed to capture criminal conviction information in the managed care credentialing process and/or did not report such information to HHS-OIG. One State's contracted Pre-paid Ambulatory Health Plans (PAHPs) do require disclosure of criminal conviction information from individual providers in the credentialing and re-credentialing process, but the State does not have a procedure for the PAHPs to notify the State if there is a self-disclosure. Further, the PAHP would only forward such information to their credentialing committee, not to the State. This leaves the State unable to pass on the unreported information to the HHS-OIG.

In another State, hospitals in the Pre-paid Inpatient Health Plans (PIHPs) or the Board members failed to provide the State with any disclosures regarding the criminal convictions of their agents or managing employees or persons with ownership or control of the PIHPs.

One State's MCO contract does not require MCO provider personnel to disclose health care-related criminal conviction information and the application used by the MCOs during provider credentialing does not contain language with sufficient specificity to meet the regulatory requirement.

Disclosure of Business Transactions

Two States failed to require disclosure of business transaction information, upon request, in the managed care credentialing process.

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Disclosures from Managing Employees

Four States failed to capture disclosure information from managing employees during the provider enrollment process. 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.

Street Address for Exclusion Searches

In one State, the MIG review team's review of provider applications found in the case of one provider that the address given for two owners and eight board members was the same Post Office (P.O.) Box listed as the correspondence address for the entity. The listing of a P.O. Box instead of a street address can hinder the efforts of provider enrollment staff to identify specific individuals during an exclusion search.

AREAS OF VULNERABILITY – PROGRAM INTEGRITY

The MIG's 2009 and 2010 annual summary reports discussed vulnerabilities in States' managed care programs, and similar vulnerabilities continue to be identified in MIG's comprehensive program integrity reviews.

Managed Care Oversight

One State Medicaid agency lacked oversight of PAHPs. During interviews, the MIG team was told that the State knew that Federal regulations were being met by the PAHPs because of contractual requirements to do so. Yet no one from the State was able to articulate how the State agency verifies that the PAHPs have operationalized the State contract requirements.

Another State provided insufficient oversight of the program integrity work of its contracted MCOs. While the State's MCOs report cases of suspected fraud and abuse directly to the MFCU, they do not consistently report them to the State and are not contractually required to do so. Similarly, while all MCOs file an annual report to the State that includes referral information, this may not be frequent enough for the State to maintain effective oversight. In addition, the State did not maintain a central repository of program integrity targets. The State's failure to centrally track providers who are under investigation leads to a potential duplication of effort. There is no way of knowing if the same providers are under review by the State program integrity area, the various MCOs, and the MFCU.

Verification of Receipt of Services

Two States failed to ensure that their MCOs had a method to verify with beneficiaries receipt of managed care services either through explanations of medical benefits forms 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.

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Incomplete Files

One State's case investigation files were incomplete. Federal regulation stipulates that a full investigation must continue until appropriate legal action is initiated, the case is closed or dropped due to insufficient evidence, or the case is resolved. Two closed cases sampled by the MIG review team lacked a valid case closure justification. In both cases, medical records and x-rays were returned to the providers before the State's Quality Improvement Organization was able to review them for an opinion as to accuracy, validity and medical necessity. The cases were never referred to the MFCU and the State had no policy regarding why these cases were closed.

One State was found to have incomplete provider enrollment files. Files for providers enrolled prior to 1999 did not include a current Medicaid provider agreement. When a current agreement is lacking, a provider has not indicated it would comply with the requirement to provide disclosure of business transactions upon request of the State or HHS-OIG, report any changes in ownership or control, report any restrictions on the provider's license, and comply with all applicable provisions of State and Federal law.

Policies and Procedures

The MIG identified a vulnerability regarding lack of adequate written policies and procedures in one State. The State supplied several draft policies to the review team, and its managers discussed the full range of policies which they envisioned in different program areas. However, at the time of the review, only seven new policies and procedures had been finalized. The policies awaiting drafting or finalization affect program integrity, managed care, and provider enrollment operations. The temporary absence/shortage of written policies and procedures leaves the State vulnerable to inconsistency in its operations.

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 one State. This State demonstrated little coordination and communication between the State agency and the MFCU. There were no regularly scheduled meetings and no standards for determining whether a case should be referred to the MFCU. The results from a sampling of full investigations indicated information on investigations was not always shared between the State and the MFCU. This type of ineffective relationship can 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

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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. It also contains specific examples of actions taken by States that have created well-functioning and committed partnerships between the two entities. 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. The SMDLs can be found on the CMS website at http://www.cms.gov/FraudAbuseforProfs/02_MedicaidGuidance.asp#TopOfPage.

AREAS OF NON-COMPLIANCE

This section identifies the number of States (of the eight States included in this report) 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 2009 and 2010 reports. 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 percent 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.

Seven 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.

Seven 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 U.S. Department of Health and Human Services information about certain business transactions with wholly owned suppliers or any subcontractors.

Six States were not in compliance with this regulation.

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- 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.

Five 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.

Two States were not in compliance with this regulation.

- The regulation at 42 CFR § 438.608 stipulates that an MCO or PIHP must have administrative and management arrangements or procedures that are designed to guard against fraud and abuse.

One State was not in compliance with this regulation.

- The regulation at 42 CFR § 438.610 stipulates that MCOs, primary care case management entities, PIHPs, and PAHPs may not knowingly have a relationship with individuals debarred, suspended, or excluded by Federal agencies.

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 § 1001.1901 states that Federal health care programs are prohibited from paying for items or services furnished, ordered, or prescribed by excluded individuals or entities unless and until the provider has been reinstated by HHS-OIG.

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.