Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Annual Summary Report
of
Comprehensive Program Integrity Reviews

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
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Table of Contents

Executive Summary

Section 1936 of the Social Security Act required the Medicaid Integrity Group (MIG) to provide support and assistance to State Medicaid program integrity efforts. To fulfill this requirement, MIG began conducting comprehensive program integrity reviews in 2007. The reviews identified problems that warranted improvement or correction in State operations, and MIG has provided assistance to States in correcting those problems. The MIG reviews also identified noteworthy practices. We recommend that other States consider emulating these practices. Providing States with this annual report is one way of sharing information about noteworthy practices, as well as areas of weakness that need correction or improvement.

By the end of Federal Fiscal Year 2011, MIG had completed a total of 78 comprehensive state program integrity reviews. These reviews included all States (including Puerto Rico and Washington D.C.) and 26 States had been reviewed twice.

This report includes information from 30 comprehensive reviews for which final reports were issued between December 1, 2010 and November 30, 2011. This includes the States of Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Idaho, Indiana, Iowa, Kansas, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, Nevada, New Jersey, New York, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Texas, Vermont, Virginia, Washington, and West Virginia.

Since MIG's first reviews in 2007, we have continued to identify problems in problem enrollment, both in fee-for-service (FFS) and managed care programs. For those States that have had two reviews, some problems were corrected after the first review. More often we found that while some improvements were made, the problem was not completely corrected or the problem remained unchanged from the first review. The MIG plans to work closely with States to ensure that all issues, particularly those that remain from the previous reviews, are resolved as soon as possible. This annual report contains a significant amount of information about noteworthy practices in provider enrollment, and we suggest you pay particular attention to what other States are doing to protect their beneficiaries and the Medicaid program. The report also contains valuable information about managed care oversight, general program integrity issues, and the State-MFCU relationship. Additional information about the issues discussed in this annual report can be found on the CMS website at Program Integrity Review Reports List.

In March 2010 the Patient Protection and Affordable Care Act (the Act) was passed. The reviews discussed in this annual report were conducted prior to the implementation of the new program integrity requirements in the Act. The Act provided new tools to detect, deter, and remedy fraud, abuse and waste in the Medicaid program. Among these tools are:

- the ability to suspend payments more quickly when fraudulent activity is suspected,
- more effective screening measures to prevent fraudulent providers from enrolling in the Medicaid program, and

- streamlined procedures to terminate providers from the Medicaid and Children's Health Insurance Program (CHIP) when they have been terminated by Medicare, Medicaid, or CHIP in another state.

Implementation of these tools will increase the effectiveness of Medicaid program integrity and will result in reduced improper payments from the Medicaid program.

Provider Enrollment and Disclosures

States' first line of defense in program integrity is provider enrollment: preventing providers who should not be in the Medicaid program from becoming enrolled. Federal program integrity regulations require States to obtain certain disclosures from providers upon enrollment and periodically thereafter. When States obtain these disclosures and search exclusion and debarment lists and databases, States can take appropriate action on providers' participation in the Medicaid program.

- Prevention is the most critical ingredient in program integrity.
- Federal regulations require States to collect certain disclosures from enrolling providers.
- The Affordable Care Act (ACA) now requires States to conduct provider screening activities as part of the provider enrollment process.

Noteworthy Practices

The MIG identified a number of noteworthy provider enrollment practices from its comprehensive program integrity reviews. The CMS recommends that other States consider emulating these activities.

Some provider types, such as durable medical equipment (DME) suppliers, home health agencies, transportation providers, and personal care services (PCS), have been deemed high risk for fraud and abuse of Medicaid and other government insurance programs. In response, States have developed methods for increased screening of high risk providers applying to their Medicaid programs.

California and ***New York*** conduct site visits as one means of validating information provided by an applicant trying to enroll in Medicaid. If a California applicant is deemed to be high risk, the processing analyst conducts a more in-depth analysis of the applicant and his business activity. If serious risk factors are found, the applicant is referred for a site visit prior to enrollment. New York's Enrollment and Audit Review Unit also identifies high risk providers and provider types and reviews often include site visits and visits by undercover investigators known as secret shoppers. Also, New York conducts onsite reviews of 100 percent of all new DME enrollment applications and the majority of pharmacies and transportation providers.

Kansas uses questions regarding relationships to family members who may have been excluded from the Medicaid program or other Federal programs; whether family members have outstanding debts to Medicaid programs; and disclosure of the location for provider records during a change of ownership on FFS provider enrollment applications to identify high risk providers. In instances where the provider did not answer these questions truthfully, the State was able to use the failure to disclose in legal proceedings.

Several States have paid particular attention to preventing fraud in their PCS programs and have developed ways of providing oversight of these services. ***Arkansas*** requires individual personal care attendants (PCAs) to enroll and re-enroll as regular Medicaid providers. The PCAs must submit time sheets reflecting arrival and departure times from the beneficiary's home as a condition of payment. ***Nevada*** requires all PCAs to be employed through a PCS agency. The agency must enroll with the State as a Medicaid provider, and must submit

documentation related to areas such as licensure, corporate liability, worker insurances, and criminal background checking. The State also conducts annual visits of home health agencies and conducts pre-enrollment onsite visits for all DME providers.

Prior to implementation of the ACA, ***Ohio*** and ***Virginia*** were already conducting exclusion searches to weed out providers who should not be participating in the Medicaid program. Ohio contracts with a provider management agency that reviews PCA and home health aide contract agreements for training and performance monitoring. All PCAs and home health aides are considered contractors of the State of Ohio, but as non-licensed providers they must meet application criteria and complete background checks. Ohio also checks the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE) to determine if any individuals are excluded.

Virginia conducts monthly checks of consumer-directed PCAs for LEIE exclusions, matching the list by first and last names, and narrowing the list down to those individuals living in Virginia. The Social Security number (SSN) is obtained from the contractor for those individuals who are then searched and verified again using the LEIE.

States have also developed other methods to prevent fraud in the area of provider enrollment. ***California's*** legislation provides for a moratorium on the enrollment of providers in certain service categories, and a three year debarment from applying to Medi-Cal for failing to disclose required information during application. New provider applicants and re-applicants are placed on provisional provider status for 12 months or may apply for preferred 18 month provisional status. California's Alcohol and Drug Program requires that providers receive training on documentation and potential fraud and abuse issues prior to receiving certification to practice and requires reapplication and recertification if a provider moves its operations to another county.

Indiana uses a contractor to enroll all FFS and managed care network providers, ensuring that all provider types are subject to the same enrollment processes. This has eliminated essential discrepancies found in other States, especially for providers participating in managed care networks who may be subject to different credentialing standards.

The ability to remain enrolled in ***Michigan's*** main FFS enrollment system is linked to the renewal of each provider's license. Michigan has a daily system feed that updates provider enrollment status when an in-state provider's license has been renewed with the license bureau. Out-of-state providers are handled manually.

New Jersey's consolidated State debarment list is publicly posted and is shared with the neighboring States of New York and Pennsylvania in an effort to limit the opportunities for debarred providers to cross state lines. New Jersey's Operation X initiative matches the SSNs of excluded individuals against the New Jersey Wage and Labor database to identify those excluded individuals who continue to work for health care entities.

Effective Practices – Provider Enrollment and Disclosures

The MIG's comprehensive reviews also presented an opportunity for States to self-report program integrity practices that the States believe to be effective and demonstrate their commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. States reported the following provider enrollment practices:

Table 1

Exclusion Checks	***Iowa*** sends annual letters to providers reminding them of the prohibition against hiring and contracting with excluded parties and reminding providers of the consequences of non-compliance (i.e., the recoupment of Medicaid payments).
	Massachusetts extended exclusion checking to individuals providing services through waiver programs.
	New York and ***Ohio*** maintain web-based exclusion databases and run provider applications against this file.
	Virginia improved the process of checking Medicaid providers whose information resides in the Medicaid Management Information System (MMIS) for exclusions by incorporating an automated upload of the monthly Medicare Exclusion Database (MED) files.
Background Checks	***Alaska***, ***New Jersey***, and ***Texas*** have staff dedicated to conducting background checks on certain Medicaid providers as part of the enrollment process.
Additional Efforts	***Alaska*** requires certification and periodic recertification of providers participating in home and community-based services (HCBS) waiver programs and requires the provider to be enrolled as a Medicaid provider.
	Arkansas uses a national information data system as a provider enrollment tool to check the applicant enrolling into Medicaid.
	Connecticut's provider applicants are required to answer all questions on the Provider Enrollment Disclosure Questionnaire prior to being considered for enrollment.
	Kansas uses a DME provider attestation form to ensure compliance with a Kansas Administrative Regulation regarding provider participation requirements. Kansas also required all providers, except custodial care providers, to sign a new provider agreement in order to continue their enrollment in Medicaid. In addition, the State's provider application includes specific questions to prevent providers from avoiding payment on outstanding debt owed to the Medicaid program.
	New Jersey developed a policy for reimbursement of out-of-state providers (or non-certified in-state providers) for emergency medical services provided to Medicaid beneficiaries. The policy controls the potential for fraud and abuse by only allowing date-specific reimbursement. The State also deactivates any provider's Medicaid number after 18 months of inactivity.
	Oklahoma's Office of Legal Services (OLS), responsible for provider enrollment, shares provider enrollment information with relevant State agencies. If an agency has information about a provider of concern, they can alert OLS, who can consider not renewing a contract with a particular provider.
	South Carolina requires that its Disclosure of Ownership form be included in managed care provider enrollment packages and the obligation to provide disclosure information was incorporated into the State's managed care contracts.
	Texas and Vermont verify provider licenses at the time of enrollment, ensuring that Medicaid does not allow payments to non-qualified health care providers. Vermont providers are certified for continuing participation either annually or when their license is renewed.
	Texas enforcement division investigators make an unannounced visit to DME providers to assess onsite inventory and to confirm that the provider correctly completed the enrollment application regarding the information about onsite management personnel and subcontractor information.

Weaknesses in State Provider Enrollment Processes

The MIG reviews have identified areas of vulnerability and/or areas of non-compliance with Federal regulations regarding provider enrollment in all program integrity reviews conducted by the MIG since 2007. These inadequacies weaken State programs by allowing providers that should not be in the Medicaid program to be enrolled.

- Vulnerabilities can have greater negative impact on integrity than do some areas of non-compliance with Federal regulations.
- The most frequently cited vulnerabilities have related to provider enrollment.
- The most frequently cited areas of non-compliance have related to provider enrollment.

Disclosures

Problems regarding the collection and storage of ownership and control, business transactions, and criminal conviction disclosures have been identified in nearly all States. In an effort to provide assistance to States, the MIG issued a *Best Practices for Medicaid Program Integrity Units' Collection of Disclosures in Provider Enrollment* document in August 2010, which provided guidance for preventing providers who should not be in the Medicaid program from becoming enrolled. The Best Practices document is available on the CMS website at Best Practices Collection of Disclosures.

Vulnerabilities - Of the 30 States included in this report, 19 failed to require disclosure of business transaction information upon request; 17 did not collect disclosures of ownership, control and relationship information; and 15 failed to collect disclosures of criminal convictions from managed care network providers that Federal regulations would otherwise require from FFS providers.

In addition, 17 States did not capture disclosure information about managing employees during the FFS or managed care enrollment process and/or store the information in the MMIS or another searchable repository. 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. The lack of storage precludes automated exclusion checks on an ongoing basis.

Areas of Non-Compliance - While some States completely failed to meet the regulations, MIG found many instances in which the regulations were only partially met. In many cases, States attempted to correct their enrollment issues after MIG's first comprehensive review. Our second reviews found that some States were successful in correcting their areas of non-compliance. However, while other States did make a number of corrections in their practices, the problems were not completely resolved at the time of MIG's second review.

Twenty-eight of the 30 States included in this report were not in compliance with 42 CFR § 455.104, which requires ownership and control disclosures. And for 12 of the 28, this remains an uncorrected finding from MIG's previous comprehensive review. 42 CFR § 455.105(b)(2) requires disclosure of business transaction information upon request and 24 States were not in compliance with this regulation. This is a repeat finding for nine of these

States. Twenty-three States were not in compliance with 42 CFR § 455.106 which requires disclosure of criminal convictions and this is a repeat finding for 10 of these States.

Reporting of Adverse Actions

The regulation at 42 CFR § 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

Vulnerabilities - Twenty-one States did not report all program integrity-related adverse actions taken on managed care network provider applications. In some cases, the State-managed care organization (MCO) contract did not require the MCO to notify the State when taking actions for program integrity reasons. The failure of MCOs to notify the Medicaid agency of such adverse actions may make it easier for problem providers to find their way into other MCOs and the FFS program undetected. It also precludes the State from reporting such actions to the HHS-OIG.

Areas of Non-Compliance - Sixteen States failed to comply with 42 CFR § 1002.3(b), and this is a repeat finding for six of those States.

Exclusion Searches

State Medicaid Director Letter (SMDL) #08-003 was issued on June 12, 2008 and provided guidance 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. These SMDLs are available on the CMS website at Federal Policy Guidance.

Vulnerabilities – Twenty-five States were either not conducting any exclusion searches (in FFS and/or managed care programs) or the exclusion searches were incomplete.

Verification of Provider Licenses

Vulnerabilities - 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.

Provider Applications

Vulnerabilities - One State's FFS provider enrollment form did not require providers to provide SSNs, but rather made it optional to list an SSN. This obstructs the State's ability to effectively search the LEIE if there are duplicate names or a party of interest's name has been changed. Inconsistencies in the processing of provider enrollment applications were identified in another State. The State and its fiscal agent interpreted the policy and procedure for handling incomplete applications differently. For example, one provider was enrolled in spite of staff having knowledge that the provider's license had been suspended in three other states and the provider failing to answer the question about criminal convictions.

While MIG recognizes the challenges in correcting these complex provider enrollment issues, the corrections are necessary to help curb fraud and abuse on the front end.

Managed Care

States have increasingly adopted managed care as a response to growing expenditures in their Medicaid programs. States have ultimate responsibility for oversight of managed care programs, but they continue to face challenges in controlling fraud and abuse in those programs. The lack of awareness, knowledge, fiscal resources, and the State's organizational structure have contributed to those challenges.

States should provide oversight of managed care programs and policy, including contracts. States should also manage managed care entity (MCE) contracts and ensure contract compliance. Additional efforts would include development of managed care plan policy and oversight of all care provided to beneficiaries enrolled in managed care programs.

- States are responsible for Medicaid funds paid to MCEs from a fraud and abuse perspective.
- MCEs should be actively involved in combating fraud and abuse.
- State-MCE contracts should include requirements for fraud and abuse prevention and reporting.

Noteworthy Practices

The MIG identified two noteworthy managed care practices from its comprehensive program integrity reviews. The CMS recommends that other States consider emulating these activities.

Enrollment in Medicaid

Nevada and ***Texas*** 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.

Fraud Reporting

New Jersey and ***Washington*** developed fraud and abuse reporting requirements for State-MCO contracts. New Jersey requires MCOs to provide quarterly summaries of their fraud and abuse case investigations, and the model MCO contract requires the reports to be completed in a uniform format. The Office of the Medicaid Inspector General must give approval before the Special Investigative Units within the MCOs are permitted to initiate formal investigations. Washington's Regional Support Network (RSN) Mental Health Department contractually requires managed care contractors to report all fraud and abuse to the RSN as soon as it is discovered. The RSN reporting procedure allows the Medicaid Fraud Control Unit (MFCU) the opportunity to make initial assessments and determinations about criminal intent.

Effective Practices – Managed Care

States self-reported several program integrity practices that they believe to be effective and demonstrate their commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Managed care effective practices include:

Table 2

Communication with MCOs	***Delaware*** and ***Rhode Island*** conduct regular meetings with their MCOs to discuss open fraud and abuse cases, allowing MCOs to proactively check their provider networks for similar problems with a provider.
	New York's Division of Managed Care evaluates MCO quarterly and annual fraud and abuse reports and collaborates with the State's Office of Inspector General (OIG) in following up on cases of suspected fraud and abuse.
Evaluation Tools	***Michigan*** and ***New York*** added program integrity components to their performance evaluation tools.
Oversight	***Kansas'*** transportation broker verifies 100 percent of transportation services and one of the State's MCEs closely monitors the prior authorization for home health services and DME.
	Oregon developed a Prepaid Health Plan Collaboration Group to ensure that policies are consistently applied in managed care.
Compliance Plan	***Texas*** MCOs are required to file an annual compliance plan to prevent and reduce fraud and abuse. The Texas OIG reviews the MCOs to ensure that they are fulfilling the requirements of their approved plans.

Weaknesses in State Managed Care Programs

The MIG's comprehensive program integrity reviews have identified several areas of weakness in States' oversight of their managed care programs.

Vulnerabilities - Eighteen of 30 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 (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.

A general lack of oversight over the delivery of managed care services was a problem for eight States, leaving the States particularly vulnerable to fraud and abuse in their managed care programs. Problems included not requiring MCOs to provide encounter data, not conducting any analysis of encounter data, and the lack of regular meetings between the State and its MCOs. Additional issues include not providing training to MCOs, not requiring MCOs to report fraud and abuse to the State, and a lack of policies (on the part of MCOs and sister State agencies) to address fraud and abuse.

Areas of Non-Compliance - One State was not in compliance with 42 CFR § 438.610 which stipulates that MCEs may not knowingly have a relationship with individuals debarred, suspended, or excluded by Federal agencies. In addition, one State failed to comply with 42 CFR § 1002.203 which requires that the State must exclude certain MCEs from participation if these entities could be subject to an HHS-OIG exclusion.

Program Integrity

Program integrity is central to program management and ensuring a program's effectiveness and efficiency. Achieving these goals is a complex undertaking that involves all aspects of program management, from policy development to staffing to day to day operations. Although States often augment their in-house capabilities by contracting with companies that specialize in Medicaid claims and utilization reviews, States have primary responsibility for conducting program integrity activities that address provider enrollment, claims review, and case referrals.

- Ensure fiscal integrity.
- Ensure compliance with Federal rules and regulations.
- Develop, implement, and enforce measures to identify, prevent and reduce Medicaid fraud and abuse.
- Remain flexible to address the fluid nature of Medicaid fraud.
- Ensure that beneficiaries receive appropriate and high-quality services.

Noteworthy Practices

The MIG's comprehensive program integrity reviews identified a number of noteworthy program integrity practices and MIG recommends that other States consider emulating these activities. Noteworthy practices have been grouped into *Cooperation and Collaboration, Data Collection and Analysis*, and *Program Safeguard Activities* sections.

Cooperation and Collaboration

Massachusetts, Ohio, and South Carolina found ways to improve their programs by establishing relationships with both internal and external partners. ***Massachusetts*** established monthly meetings on transportation issues which are attended by the State Medicaid Human Services Transportation Unit, the Surveillance and Utilization Review Subsystem (SURS) Unit, and the MFCU. The meetings focus on fraud, waste and abuse and development of joint strategies to combat those issues. Massachusetts also has quarterly managed care meetings which are attended by managed care contract oversight and legal staff, MCO compliance officers, and the MFCU. The meetings provide a forum to discuss cases, provide training, and to present and exchange strategies to combat fraud and abuse in MCO provider networks. Also, MassHealth developed an effective communication strategy of contacting other MCOs when an MCO terminates a provider for cause and also notifying FFS Medicaid of the termination.

Ohio has established a close relationship with the MFCU and the Ohio Auditor of State. To improve communications on program integrity issues throughout the State agency, the State has established program integrity workgroups which bring managed care and HCBS waiver staff together regularly with State program integrity, auditing and MFCU personnel.

South Carolina has a close relationship with the Medicaid Recipient Fraud Unit (MRFU) and has developed an effective recipient lock-in program. State and MRFU staff work together on recipient fraud cases, enabling the State to address program integrity issues proactively. Recipients placed in the lock-in program are monitored for drug utilization and are required to use one designated pharmacy. A managed care referral can also be made to determine if

the recipient should be required to choose an MCO or a primary care case manager. Since the program's inception in January 2009, service utilization by recipients decreased by 29 percent.

Data Collection and Analysis

Measurement of improper payments can be a significant program management tool because minimizing an error rate requires efforts on the front end to prevent fraud and abuse. ***California*** developed a Medicaid Payment Error Study to identify provider types at greatest risk for payment errors. These data runs have resulted in special focused reviews of pharmacies and adult day health centers. The State also conducts weekly random audits on various provider claims. Based on the results, the State develops new fraud control strategies and determines how best to deploy limited anti-fraud resources.

States are responsible for operating their MMIS and SURS systems, detecting improper payments and recovering overpayments, and performing data mining to detect patterns in provider claims and payments. ***Washington*** overhauled its program integrity activities to be more data driven. The change involved a shift to more data analysis and overpayment identification based upon data alone, without the need for medical record review or onsite visits. This process is supported by cross-division workgroup efforts resulting in policy revisions and changes to the MMIS payment edits.

Colorado has a master Transaction Control Number (TCN) database and a critical events database, which supplement the existing SURS within the MMIS. Colorado uses the TCN database to avoid the review of claims for which recovery of overpayments has already occurred. The database assigns each claim a unique claim control number based on the date of service, allowing the Program Integrity Unit to match claims previously acted on with claims in current and future reviews. The critical events database collects information about significant weather conditions, dates of major legislation and rule changes, and other events which might influence billing. Information stored in the database, in conjunction with its SURS and billing analyses, is used to look for billing abnormalities such as billing levels which could not be reasonably supported because of weather events or significant increases in billing compared to historic averages.

Iowa requires detailed documentation including the completion of a Daily Service Record form by PCAs, based on each beneficiary's approved care plan hours in the State's Consumer Directed Attendant Care program. The Daily Service Record has come to be used as a tool for audit purposes to assist Iowa in various program integrity activities, such as monthly and quarterly post-payment queries identifying outliers and potentially conflicting episodes in which the dates of personal care services overlap with institutional stays.

Montana's six-month review process offers the State a means of reviewing providers who have undergone a recent change of status in the Medicaid program. Each month the fiscal agent furnishes the SURS unit with a listing of Medicaid providers who have met at least one of four conditions in the prior six months. These conditions include providers who are new to the Medicaid program, enrolled providers who terminated their participation in the past six months, providers who terminated their previous Medicaid number and received a new number, and providers with at least one other active number who received a new number in

the most recent six-month period. These providers are selected for audit. The process affords the opportunity for early identification of newly enrolled Medicaid providers (or providers who may be branching out in some way) who may benefit from training and education to eliminate future billing errors. The six-month review process has also facilitated the early detection of aberrant or fraudulent billing patterns and enhanced the State's ability to deal with them.

Program Safeguard Activities

States have implemented a variety of methods for combating Medicaid provider fraud, waste, and abuse which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid beneficiaries. These activities include interactions with beneficiaries, improvements in the audit process, oversight of personal care services, program integrity reorganization, use of exclusion authority, and implementation of compliance programs.

Interactions with Beneficiaries

Connecticut developed a targeted written questionnaire and phone survey to use in conjunction with audits of targeted providers which has been very successful in eliciting detailed beneficiary response to verify services received. This technique has yielded a response rate between 31 to 44 percent. ***Nebraska*** developed a Medicaid fraud tip sheet that is sent monthly, along with an EOMB, to approximately 200 random beneficiaries. The tip sheet includes methods to protect the beneficiary's Medicaid benefits including the problem of signing a blank time card, medical billings, protecting personal information, and avoiding telemarketing scams. ***New York*** uses controls at the point of service to ensure that the Medicaid beneficiary is present for the service. The Cardswipe program verifies a beneficiary's presence at the point of service by requiring that the beneficiary's benefit card be swiped at the time the beneficiary presents for a Medicaid service. The Post & Clear program is a set of enhanced controls designed to ensure that Medicaid claims for services are actually ordered by the provider indicated on each claim.

Audits

Enhancements in the State's audit program were implemented by ***Nevada*** and ***Washington***. Nevada adopted an audit process similar to audits conducted by CMS' Provider Error Rate Measurement program. These audits resulted in $114,000 in actual recoupment and unspecified additional savings after certain problematic claims processing edits were corrected. Through these audits, Nevada also discovered issues with its fiscal agent including data entry errors and fiscal overrides that were not in accordance with policy. Nevada also improved its oversight of personal care services by conducting unannounced reviews, using physical and occupational therapists to improve accuracy of initial service plans, and assigning registered nurses to support MFCU investigations. Washington utilizes a secure online tool to allow providers to conduct a Provider Self Review. The questions walk the provider through an educational process as he evaluates the supporting documentation for the service provided. The provider identifies his own error by determining that his documentation does not support the level of care billed. Participation is not mandatory, but by declining the invitation to participate the provider becomes a prime candidate for an onsite review.

Improved Effectiveness

Delaware's reorganization of its program integrity component has led to significant increases in a number of indicators of program integrity effectiveness, such as audits, recoveries, and

referrals to the MFCU. The program integrity operations grew from a single Surveillance and Utilization Review (SUR) Unit with four full-time equivalents (FTEs) to a larger component that consists of the SUR Unit, a Claims Resolution Unit, a Third Party Liability Unit, and an Edits and Audit and Code Maintenance Unit. This enlargement included an increase in FTEs from 4 to 23 for SFY 2010.

Sanctions

New Jersey State statutes and Administrative Code contain provisions which allow intermediate sanctions against lesser offenders, while permitting the State to take swift and effective actions against providers whose actions represent the greatest risks to Medicaid dollars. The State routinely uses its discretionary authority to exclude providers based on program integrity-related indictments. It does not require convictions to remove problem providers from the program.

Compliance Program

New York requires selected providers to adopt and implement effective compliance programs and annually submit an attestation that they maintain an effective compliance program. The compliance program, including a written compliance plan, must address how the provider proposes to mitigate the risk of fraud or abuse in key areas of activity, such as billing, payments, medical necessity and quality of care, governance, mandatory reporting, credentialing, and other risk areas identified by provider due diligence.

Effective Practices – Program Integrity

States self-reported the following program integrity practices. The CMS does not conduct a detailed assessment of each State-reported effective practice.

Table 3

Cooperation and Collaboration	***Alaska, Idaho, Kansas, Maryland, New Jersey, New York, Texas*** and ***West Virginia*** conduct regularly scheduled meetings to share information and discuss program integrity issues with internal and external partners.
	Colorado and ***Nebraska*** developed multi-agency task forces which encourage cooperation, sharing of information, and a coordinated approach to targeting fraud and abuse.
	Alaska implemented a PERM communication plan and collaboration procedures which define agencies' roles in the PERM process.
	Kansas, Oklahoma and ***Virginia*** have fostered the attitude that program integrity is every employee's business.
	South Carolina's contract with the Department of Health and Environmental Control requires the agency to collect disclosure information when its staff survey institutional providers. Surveyors are also required to communicate change in ownership and licensure information.
	West Virginia's reviews of waiver providers are conducted by Bureau of Behavioral Health employees, ensuring oversight of providers when the State is short-staffed.
Data Collection and Analysis	***California's*** MCEs, sister State agencies, waiver programs, and fraud and abuse hotline staff are required to use a standardized form for reporting suspected fraud and abuse, providing a consistent and efficient method for tracking and identification of cases.
	Maryland's fraud and abuse tracking system has a direct link to the LEIE and also allows the State to upload information directly to the Fraud Investigation Database, maintained by CMS.
	Missouri's provider dashboard is an internal tool that comprises a group of algorithms created from current program policy manuals. Analysts can choose to focus on a particular algorithm(s) to conduct a review, issue overpayments, or send self-audit letters.
	Nevada and ***New York*** developed provider case tracking systems which allow for tight tracking of program integrity cases.
	Oklahoma's database in its MMIS stores provider disclosure information and allows for monthly cross-checking against the MED.
Program Safeguard Activities	***California's*** pharmacy claims are required to have a valid provider license number, which is vetted against the State's Suspended and Ineligible List. This allows the State to restrict prescribing providers, even if that provider is not billing the program.
	South Carolina, New York and ***Vermont*** use provider self-audits to expand their audit capabilities, while ***Virginia*** uses a contractor to enhance its audit program.
	Missouri conducts focused audits of certain provider types. The most recent audit involved the review of more than 19,500 claims.
	The majority of ***Nebraska's*** prepayment reviews include a determination of medical necessity. ***New York's*** audit initiatives also look at medical necessity and accuracy of payments.
	South Carolina's audits of managed care plans focus on exclusion checks and whether the compliance plan and other contractual obligations are being met.
	Montana implemented an annual audit plan which resulted in an increase in the number of postpay audits conducted and overpayments identified.
	Arkansas conducts unannounced onsite investigations for cases regarding questionable billing.
	Montana and ***New York*** send targeted EOMBs and have conducted investigations based on responses to the EOMBs.
	Colorado can execute a payment withhold within 6-10 minutes of receipt of a notice of determination of fraud or willful misrepresentation.
	Idaho has a web-based exclusion list which contains everyone who has ever been excluded from the Medicaid program.
	Iowa identifies excluded individuals working for an agency or provider by matching the LEIE to names in the Iowa Workforce Development database.

Program Safeguard Activities	***Maryland's*** contractors conduct background checks and verify licensure renewals on transportation drivers. ***New York*** updates provider files and can initiate disenrollment based on daily automated license updates.
	State law requires ***Oklahoma*** to achieve no more than a 5 percent payment error rate.
	Alaska updates software every other year in order to capture new billing codes in the MMIS.
	Idaho increased overpayments recovered by implementing recovery of debts through offset.
	Nebraska places edit codes on the provider's number to hold payment for claims until recovery of overpayment is made.
	Texas does not reinstate any provider who the state has excluded for fraud.
	Washington's Provider Fraud Hotline has resulted in uncovering provider billing fraud.
	Nebraska's recipient lock-in program restricts the recipient to one prescribing physician, one pharmacy and one hospital.
	Massachusetts and its SURS area (contractors) have organizational structures that mirror each other, allowing for good working relationships between staff.
	An increase in FTEs has allowed ***Nevada*** to increase SURS cases and recoveries.
	California will meet with providers regarding payment withhold notice letters, in addition to required provider appeal rights.
	A ***Texas*** website allows users to report fraud and provides information about fraud and abuse.
	Washington was awarded a $5.9 million Medicaid Transformation Grant to upgrade its Fraud and Abuse Detection System.
Education	***California, Hawaii,*** and ***Montana*** staff have attended training at the Medicaid Integrity Institute and have used what was learned to train additional State staff.
	Colorado conducted provider education after providers expressed concern about a DRG audit.
	Kansas posts information on its website via a web feed, which notifies providers when information has been updated.
	Oregon provides extensive ongoing training to a broad range of provider types and ***Virginia*** provided several types of training on exclusion checking.
	New York posts information such as the exclusion list, final audit and annual reports, and its annual audit plan on the OMIG website.

Weaknesses in Program Integrity

Program integrity requires managing a Medicaid program so that quality health care services are provided to beneficiaries effectively and efficiently, and ensures that State and Federal dollars are not being put at risk. However, MIG's comprehensive program integrity reviews identified significant areas of weakness in the integrity of States' Medicaid programs.

- **Collect and verify basic information on providers.**
- **Maintain a claims processing and information system – MMIS.**
- **Operate a SURS.**
- **Have methods for identifying and investigating suspected fraud cases.**
- **Refer potential fraud cases to law enforcement.**

Centralized Program Integrity Function

While States have ultimate responsibility for combating fraud, waste and abuse, the authorities and delegation of these responsibilities can differ based on the organizational structure and departmental roles.

Vulnerabilities – Three States lacked a centralized program integrity function, limiting the State's ability to identify, investigate and refer fraud. The lack of a single unit that has overall responsibility for program integrity compliance and implementation has resulted in problems such as not having a comprehensive tracking system for fraud referrals, and not making use of payment suspensions and withholds. Additional issues include not being aware of fraud hotline complaints and the lack of a detailed program integrity plan that identifies how to get critical elements done. Without a centralized program integrity function, States may encounter problems involving unreported issues, duplication of effort, jurisdictional conflicts, and poor coordination of program integrity efforts.

Ineffective Surveillance and Utilization Review Operations

State Medicaid agencies manage nearly all of the processes and systems related to program integrity. However, States have reported that spending on administering the Medicaid program has been cut, and hiring freezes, early retirements, and staff reductions have affected their Medicaid programs.

Vulnerabilities – Four States had problems with ineffective SUR operations, with decreased staffing levels and a lack of policies and procedures as common themes. Although the number of in-house program integrity positions declined in one State, the State was able to continue some effective SUR and recovery activities through contractors. However, the contract was terminated in 2008 and the State had not hired a replacement contractor or developed an alternate mechanism to carry on the equivalent functions. As approximately 40 percent of total overpayment recoveries had previously occurred through contractor activities, this has resulted in a significant decline in recoupments.

Another State had inadequate written policies and procedures for program integrity functions. The lack of current policies and procedures limited the ability of program integrity office staff to effectively communicate Federal regulatory requirements to other departments delegated with program integrity responsibilities. This State also experienced a decrease in staffing

when two of five FTEs were reassigned to the development and implementation of the new MMIS. The number of referrals made to the MFCU had also decreased.

The third State had similar issues of decreased staffing and the lack of policies and procedures for program integrity functions. A decrease in program integrity operations was evidenced in a decline of prepayment and postpayment review activities resulting in referrals to the MFCU. In addition, although State policy allows the use of sampling and extrapolation, the State does not make use of these potentially effective statistical methods when reviewing provider payments.

Issues with the fourth State included: an unusually small number of program integrity staff for the size of the program; a narrow range of field audit activity; a limited number of manual prepayment reviews conducted in the last four years; a low number of MFCU referrals for the size of the program; and lack of oversight of the non-emergency medical transportation (NEMT) program.

Six additional States lacked adequate written policies and procedures. Some States relied on Administrative Code to replace policies and procedures. Others lacked policies and procedures in a specific programmatic area. One State's policies and procedures had not been revised for nearly 20 years. The absence/shortage of current, written policies and procedures leaves the State vulnerable to inconsistency in its operations.

Finally, one State is challenged with a large backlog of 368 program integrity cases, including cases initiated several years ago which are still pending action. The State noted that it does not have adequate resources to resolve all these cases, and the issue is exacerbated by the potential expiration of some cases due to the Statute of Limitations and records retention requirements.

Areas of Non-Compliance - Two States were cited for 42 CFR § 456.3, which requires the State to implement a statewide surveillance and utilization control program to safeguard against inappropriate use of Medicaid services and excess payment of Medicaid funds. In addition to the issues discussed above, these States had no systematic analysis being generated through an active SURS. One State was not in compliance with 42 CFR § 455.13 because it did not require sister agencies to report suspected fraud and abuse in waiver programs to the State. This leaves the State unable to refer suspected fraud cases to the MFCU. Two States failed to comply with 42 CFR § 455.21, which requires the State to refer all cases of suspected provider fraud to the MFCU, comply with document requests from the MFCU, and initiate administrative or judicial action for cases referred to the State by the MFCU. This is a repeat finding for one State.

Edits to Prevent Improper Payments

Computer payment system edits are one way to prevent potentially improper payments and can result in significant cost savings through cost avoidance.

Vulnerabilities – Three States lacked the ability to prevent improper payments for certain services. One of the States was unable to implement any edits for PCS during inpatient stays. The claims were paid through a system outside the MMIS and that system lacked specific edits to limit PCS claims during inpatient stays. The State can only run an ad hoc report to find PCS claims paid during the dates of institutional stays. The second State does

not have MMIS edits in place which would prevent payment of nursing home claims when an individual transfers to hospice. The State relies upon program staff to monitor payments and report if they find duplication. The third State's claims for services for home care workers (HCW) and in-home agencies are paid through a voucher system and do not go through the MMIS. Hence, they are not subject to the edits, audits, and general safeguards of the standard claims processing system. Although, information on processed HCW claims is loaded into SURS, the State was not reviewing these billings as part of routine auditing.

Withholding of Payments

Vulnerabilities –Two States failed to take advantage of their authority to withhold Medicaid payments to a provider in cases of fraud or willful misrepresentation. A third State did not conduct prepayment reviews, nor did it suspend or withhold payments to providers who are suspected of fraud and abuse. The withholding of provider payments only occurred after specific overpayment amounts had been established. By not initiating the withholding of payments at earlier time periods when there is reasonable evidence of fraud or abuse, the State becomes financially vulnerable.

Areas of Non-Compliance - Nine States were not in compliance with 42 CFR § 455.23, which states that the Medicaid agency may withhold payments in cases of fraud or willful misrepresentation and must send appropriate notice of its withholding of program payments within five days of taking such action. Issues included untimely notice and the notice lacked reference to the Federal regulation as required.

Provider Exclusions

Vulnerabilities – Despite having the authority to initiate provider exclusions, two States have not applied this program integrity compliance and enforcement tool. This can result in the retention of providers with questionable program integrity records in the Medicaid program.

Areas of Non-Compliance - Two States were cited for 42 CFR § 1001.1901 because they enrolled and made payments to excluded providers. Eight States were not in compliance with 42 CFR § 1002.212 because they failed to notify certain individuals and entities of a State-initiated exclusion. One State was not in compliance with 42 CFR § 1002.215 because it did not give written notice of reinstatement to the excluded party and to all others who were informed of the exclusion.

Reporting of Local Convictions

Vulnerabilities – Three States were cited for not reporting to HHS-OIG local convictions of crimes against Medicaid. While the States indicated that the MFCU reported such convictions, the State-MFCU Memorandum of Understanding (MOU) did not address who was responsible for reporting and States were not sure if the reporting had been done.

Oversight of NEMT

Vulnerabilities – One State lacked effective oversight over its NEMT program. The State did not require and/or collect disclosure of managing employees, ownership and control, business transactions, and criminal conviction information from NEMT providers, leaving the State vulnerable to enrolling problem providers into the NEMT program.

Additional Areas of Non-Compliance

Section 1902(a)(68) of the Social Security Act includes requirements for providers and contractors regarding Federal False Claims Act policies and handbooks. Problems in four States included not reviewing providers' policies and handbooks, not requiring handbooks to contain information on the Act, and not conducting compliance reviews with providers receiving or making payments of at least $5 million.

Two States failed to comply with 42 CFR § 455.20, which requires verifying with beneficiaries whether services billed by providers were received. These States were not using EOMBs or any other method to verify receipt of services billed.

Two States were not in compliance with 42 CFR § 455.15, which requires that the State refer suspected cases of recipient fraud to an appropriate law enforcement agency and conduct a full investigation if the agency suspects a recipient has abused the Medicaid program. One of the States only referred certain recipient cases directly to law enforcement, while the other State only investigates and refers recipient fraud cases when there is evidence of collusion with providers.

When an individual has been convicted of a criminal offense related to the delivery of health care items or services under the Medicaid program, 42 CFR § 1002.230 requires that the State provide notice to HHS-OIG within specified timeframes, unless the MFCU has already provided such notice. Two States did not know if the MFCU reported all convictions, and the MOU between the States and their MFCUs did not address who was responsible for reporting.

Medicaid Fraud Control Unit

A well-functioning and committed partnership between the State Program Integrity Unit and its MFCU will result in the strengthening of program integrity efforts within the State Medicaid program. In 2008, CMS published *Performance Standard For Referrals Of Suspected Fraud From A Single State Agency to A Medicaid Fraud Control Unit; and Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units* documents in an effort to provide assistance to States. The MIG uses these documents to evaluate the State-MFCU relationship during program integrity reviews. Both documents can be found on the CMS website at http://www.cms.gov/FraudAbuseforProfs/02_MedicaidGuidance.asp.

- **Meet regularly with the MFCU.**
- **Develop and consistently apply one standard for deciding when to refer a matter to the MFCU.**
- **Include the minimum criteria in every referral.**
- **Update the MFCU on ongoing investigations.**
- **Offer education and consultative services.**
- **Reconcile your program activities with the MFCU.**

Noteworthy Practices

The MIG review teams identified the following practice as being particularly noteworthy and recommend that other States consider emulating this activity.

Nebraska's program integrity office and the MFCU have created a well-functioning and committed partnership between the two entities. Activities include regularly scheduled meetings as evidenced by the entities' participation in the health care fraud task force chaired by the Nebraska U.S. Attorney's Office. The program integrity office and MFCU have established a clear understanding of the standards for appropriate referrals, resulting in the MFCU accepting almost all of the referrals from the program integrity office. Nebraska's practices follow the direction in the CMS guidance documents.

Effective Practices

States self-reported several program integrity practices that they believe to be effective and demonstrate their commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice.

Table 4

Referrals	***Connecticut*** developed an enhanced referral package for use in fraud referrals from the State Medicaid agency to the MFCU, resulting in very complete referrals.
	Indiana has created a well-functioning and committed partnership with the State's MFCU, establishing a clear understanding of a standard for appropriate provider case referrals.
	Oklahoma referred 62 cases over the past 4 SFYs (2007-2010) and the MFCU accepted all of the cases. This was due to the high quality of the investigations.
Regular Meetings	***Arkansas, California, Hawaii, Oregon*** and ***Texas*** conduct regularly scheduled meetings and have ongoing communication with the MFCU, contributing to the success of both units.

Weaknesses in State Interactions with the MFCU

Although many States have been successful in strengthening their relationship with the MFCU, other States have made less progress. Issues identified by MIG review teams include lack of clarity within the State-MFCU MOU, ineffective communication between the two parties, and problems with referrals to the MFCU.

Vulnerabilities – The MIG's *Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units* guidance 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. However, the MIG identified communication and relationship issues between the State agency and the MFCU in three States. These issues included decisions to handle cases administratively instead of referring to the MFCU, lack of regular meetings with the MFCU, limited referrals made to the MFCU, and irregularities in tracking of referrals.

One State failed to modify its MOU with the MFCU after a reorganization occurred within the State. The MOU should have been modified to reflect the new organizational relationships in order to avoid confusion in roles and responsibility. In addition, the MOU was signed in 2000 and would need review in any case.

The MIG's *Performance Standard For Referrals Of Suspected Fraud From A Single State Agency to A Medicaid Fraud Control Unit* guidance document provides details on the collection of information that makes up an appropriate MFCU referral. However, MIG identified problems with State referral procedures in five States. One State, and its MFCU, was unaware of the CMS performance standards at the time of MIG's review. The lack of familiarity with these baseline performance standards is especially important in a Medicaid program that contracts out the case investigation and case development functions. While one State did not adopt the performance standards until approximately 18 months after the standards were issued, three other States failed to follow various parts of the CMS guidance for fraud referrals.

Conclusion

States have implemented effective and noteworthy practices that demonstrate program strength and States' commitment to program integrity. The CMS supports these efforts and encourages States to look for additional opportunities to improve overall program integrity. However, while some States have corrected areas of weakness identified in MIG's first reviews, others have only partially corrected the weaknesses or have failed to take any corrective action. The CMS will work closely with States to ensure that all issues, particularly those that remain from the previous review, are resolved as soon as possible. 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.