Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID
Claims Processing Safeguards

JUNE GIBBS BROWN
Inspector General

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EXECUTIVE SUMMARY

PURPOSE

This is the second of three reports describing Medicaid program safeguards. This report discusses claims processing safeguards. The first report discusses proactive safeguards and the third report discusses post payment safeguards.

This report is intended to provide information about and increase awareness of Medicaid claims processing safeguards. Claims processing safeguards ensure that claims submitted for payment are properly adjudicated.

CLAIMS PROCESSING SAFEGUARDS

System Access Safeguards validate that the claims submitted for payment are from providers authorized to bill Medicaid. Claims from unauthorized providers, are rejected from processing.

Claims Adjudication Safeguards help to ensure that the services listed on a claim are covered, medically necessary and properly adjudicated. They include prepayment provider flags, prepayment procedure flags, concurrent reviews and fully automated computer edits.

Manual Claim Reviews including utilization and medical reviews are conducted by trained specialists. Staff specialists review specific claims with established program and medical policy, with previously paid claims, and with other information to decide if Medicaid should pay for the services.

Audits in the report refers to those manual functions (i.e., pricing and reviews of certificates of medical necessity) that do not require decisions of a medical nature. Audits help identify patients who have other health insurance or who may be eligible for workman's compensation or other payments to cover the cost of their medical care.

Payment Suspensions prevent financial losses while questions concerning overpayments, fraud and abuse are resolved.

OPPORTUNITIES FOR IMPROVEMENT

Based on our prior studies and information gathered during this study, we would encourage States to consider the following opportunities for improving program safeguards:

- **Establish a system that identifies all third party billers/agents and the physicians using their services.** The ability to know who is authorized to bill on behalf of a provider can help eliminate the misuse of provider numbers by clinics and third party billing agents.

- **Reduce the "hassle factor" by providing providers with a complete list of all critical errors on a claim.** Medicaid systems should identify all fatal errors on a claim and notify the provider of all errors at one time. This would help avoid third and fourth claim submissions.

- **Use fatal reject data and edit data to identify problematic providers.** States have the opportunity to use claim reject and edit data to improve claim processing safeguards, to clarify policies and to identify providers who may need additional training on Medicaid policies and claim submission requirements.

- **Use edit, utilization, medical and audit data to identify problematic policies and procedures**. A number of States in our sample have successfully re-engineered their Medicaid policies and procedures using information obtained from edits.

- **Improve State Agency employee and contracted workers sensitivity to potential fraud and abuse issues by providing ongoing training.** With proper training the role of Medicaid staff in spotting and reporting of potential fraudulent and abusive practices can be improved.

We intend to do additional in depth studies on proactive safeguards used by States.

AGENCY COMMENTS

The HCFA believes that the opportunities for improvement described in this report provide valuable information that will be shared with the State Medicaid programs.

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INTRODUCTION

PURPOSE

To provide information about and increase awareness of Medicaid claims processing safeguards.

BACKGROUND

Medicaid is a health insurance program for certain low income and needy people. Within Federal limits, each State decides eligibility, benefit coverage, administrative practices, reimbursement and operational resource requirements. About 70 cents of every Medicaid dollar goes to institutional providers (hospitals, nursing homes). Thirty cents pays for non-institutional services (physician services, laboratory and radiology). Federal law requires States to pay for services provided by certain institutional providers and non-institutional providers. State may elect to offer additional services such as dental care, podiatric care and prescription drugs just to name a few.

The Health Care Financing Administration (HCFA) is responsible for administering Federal matching funds to the States and for legislation and regulations affecting Title XIX (commonly referred to as the Medicaid program). The HCFA also provides guidelines, technical assistance and periodic assessments of State programs. More than 36 million recipients are enrolled in Medicaid. In 1991, 90 percent of these recipients were enrolled in fee-for-service (FFS) programs. By 1998, the number of recipients in FFS had decreased to 46 percent and enrollment in managed care plans increased to nearly 54 percent. Nearly $169 billion was spent by the Federal Government and the States on Medicaid benefits in Fiscal Year 1998.

State Medicaid programs are administered by State Agencies or contractors hired by the State. Most States also have a Medicaid Fraud Control Unit that handles investigations into allegations of fraud and abuse.

States are required by legislation to make every effort to eliminate waste and illegitimate program expenditures. States are required to develop payment safeguards designed to protect their Medicaid funds from unscrupulous and fraudulent providers.

METHODOLOGY

We visited or interviewed over the telephone agency(ies) responsible for administering the Medicaid program in the following eight States:

California	Florida	Illinois
Louisiana	Maryland	Oregon
Pennsylvania	Texas	

These States were selected for site visits because they account for nearly half of all Medicaid expenditures. They were also chosen for their geographic location. Our site visits were conducted during the spring of 1999. During our visits, we discussed program safeguards used by the State's Medicaid program. We spoke to State Agency officials and, when appropriate, to State subcontractors.

Our discussions focused on Medicaid fee-for-service program safeguards. We have not attempted to assess the effectiveness of each safeguard. State Medicaid programs use many different terms to describe safeguards built into their systems. We have divided Medicaid program safeguards into three categories (proactive, claims processing and post payment safeguards).

This is the second of three reports on Medicaid safeguards. This report discusses claims processing safeguards. Claims processing safeguards are those measures taken to ensure that claims submitted for payment are properly adjudicated. Our first report discussed proactive safeguards. Proactive safeguards are those measures taken to prevent fraud, abuse and waste before a claim is ever submitted for payment. The final report discusses post payment safeguards. Post Payment safeguards are measures taken after a claim has been processed to ensure proper payment.

The primary purpose of these reports was to compile a catalog of program safeguards used by State Medicaid programs. Every effort was made to prepare a comprehensive and complete list. Some disagreement as to what constitutes a program safeguard may exist and some safeguards may have been overlooked. Fragmentation of responsibility in many State Medicaid programs often makes it difficult to reach all of the people responsible for Medicaid program safeguards. Consequently, States, their subcontractors and others may have information about other safeguard measures not mentioned in this report.

CLAIMS PROCESSING SAFEGUARDS

Providers, who treat Medicaid patients not enrolled in a managed care plan, must file an electronic or paper claim to receive payment for their services. Claims provide information about the patient and the provider. They provide a listing of the medical treatments and services provided to a patient. They also provide diagnostic information to justify the medical need for the services/treatments being billed.

Claims processing safeguards, as we have defined them for this inspection, do not protect patients from receiving uncovered, excessive or medically unnecessary procedures and services. Claims processing safeguards only affect the claims submitted for payment after a patient has received services. They are designed to facilitate cost effective processing of claims and to protect Medicaid funds by identifying claims that require additional development before they are adjudicated for payment.

For purposes of this report, we have divided claims processing safeguards into two groups. The first group consists of access safeguards that ensure that a claim submitted for payment is from an authorized provider and contains sufficiently accurate information to process the claim. The second group of claims processing safeguards ensures that the claims accepted for processing are properly adjudicated.

SYSTEM ACCESS SAFEGUARDS

Claims processing safeguards protect Medicaid systems from unauthorized access and help to ensure proper payment for medically needed services. They are also used to detect potentially fraudulent and abusive practices.

Before claims for services are adjudicated for payment, they are scrutinized by a series of claims processing safeguards. Computer systems validate that the claims submitted for payment are from providers authorized to bill Medicaid. Claims from unauthorized providers, are rejected from processing. Claims submitted by billing agencies and other third parties on behalf of a provider must also have valid provider numbers or they will be rejected from Medicaid claims processing systems.

Electronic Claim Submission

California, Florida, Louisiana, Maryland and Texas believe that the safeguards currently in use for electronic claims submission are inadequate and do not adequately protect their programs from fraudulent and abusive billers. These States believe that they know little about subcontractors submitting claims on behalf of physicians and other providers.

Consequently, the exact number of providers using billing agencies, clearinghouses, subcontractors and other entities to submit bills on their behalf is unknown. More importantly, adequate safeguards do not exist to ensure that a provider is really using the agency submitting claims using their billing number. States, like Medicare, cannot readily identify the actual party submitting a claim nor can they identify the location from which claims were transmitted.[1]

Florida is in the process of re-engineering their electronic claims program. They plan to use new technology to tighten controls and add additional safeguards to their electronic systems. The new system will log and verify the identity of the computer used to produce claims and the telephone line tied to that computer terminal. The new systems will also log and verify user passwords and provider numbers. Claims from unrecognized terminals, claims received over unauthorized telephone lines and those with invalid passwords and provider identification will be rejected from processing.

Claim Rejection

We defined claim rejects as those manual or computerized functions that prevent a claim from being accepted into the claims processing system. Seven of the eight States we visited reject claims from entering their claims processing system if they contain "fatal errors." Generally speaking, a fatal error is one that would prevent a claim from being posted to an eligible patient's claim history file or to the history file of an enrolled provider. On average, about 15 percent of claims submitted for payment contain fatal errors. In Texas, 500,000 claims are rejected each month, Pennsylvania returns 13,000 claim each day.

The most common fatal errors include missing or erroneous:

- provider and patient identification numbers,
- birth dates,
- diagnostic information, and
- prior authorization information.

Claims with fatal errors are rejected from the claims payment system. Seven of the eight States we visited do not assign claim control numbers to claims with fatal errors. However, these States do have aggregate data as to the number of claims returned to providers each day due to a fatal error.

Claims rejected from processing are returned to the provider (or the provider's agent) along with information about the type of error that causes the claim to be rejected. The provider (or their billing agent) must correct the identified critical error and resubmit the

[1] Additional information concerning electronic claim safeguards and vulnerabilities can be found in *Medical Billing Software And Processes Used To Prepare Claims*. OEI-05-99-00100.

claim. In many States, a claim is rejected from further processing when the first critical error is found. Consequently, claims resubmitted for processing may also be returned because they contain other critical errors. The submit and reject cycle is repeated until all critical errors are resolved.

Unlike the other seven Medicaid programs in our sample, Maryland accepts all claims for processing. An internal control number is assigned to every claim the Maryland Medicaid program receives. The entire claim will be processed to completion even if no payment will be made due to fatal billing errors. In Maryland, all claims complete the entire processing cycle. At the end of the claims process, the provider is notified of all errors found on the claim. It is the provider's responsibility to correct all fatal errors and non-fatal errors and to re-submit the claim for payment. There is insufficient information and data to determine whether one method is better than the other.

In most States, claims for services that require prior authorization must contain the unique prior authorization number assigned by the approving agency/individual. If this number is not on the claim it will reject and no payment will be made.

CLAIMS ADJUDICATION SAFEGUARDS

Claims that successfully enter the claims processing system are assigned an internal control number that is used to track processing, adjudication decisions and payment information. Claims accepted for processing are subjected to prepayment reviews, concurrent care reviews, limitation edits, relationship edits, audits and medical review.
Claims processing safeguards help to ensure that the services listed on a claim are:

- covered Medicaid services,
- medically necessary services, and
- properly adjudicated.

Provider and procedure flags, concurrent reviews, automated edits, manual reviews, utilization and medical reviews, audits and payment suspension are claims processing safeguards used by State Medicaid programs.

Prepayment Provider Flags

Provider flags help States identify claims from problematic providers and problematic services. Flags interrupt the claims processing cycle until claim information is manually reviewed by Medicaid employees. Flags are prepayment claims processing safeguards that help to ensure proper adjudication of a claim and compliance with Medicaid policy and procedures. They often involve obtaining and reviewing additional medical information, contacting third parties and analyzing past patient and/or provider claim histories.

In the eight States we visited, nearly all of the claims flagged for prepayment review involved providers who:

- Were the subject of an ongoing investigation that may involve a substantial overpayment,
- Were found to be billing improperly and had been advised to correct their aberrant billing practice(s),
- Provided excessive and unnecessary services, and
- Had unusual shifts in their claim volume or claim charges.

In most States, very few providers are ever flagged for prepayment review. At the time of our visit, Texas had none, Oregon and Louisiana had less than 3 and Florida had about 30. In Florida, the State's Medicaid program integrity unit identified and requested flags on more than 30 providers with specific problems ranging from excessive services to potential fraud. Louisiana reviews diagnostic codes, procedure codes, patient visits, prescriptions and other criteria to identify providers whose claims differ substantially from their peers. These "*outlier*" providers are flagged for prepayment review to ensure that the claims they submit are properly billed and adjudicated. Florida, Illinois and Louisiana have flags that identify new providers with "fast starts." Fast starts include new and established providers whose claim volume increases dramatically in a relatively short period of time. Only one of our eight States withholds payment until they have researched the cause of the increase in billing.

Providers flagged for prepayment review will have their claims reviewed until Medicaid is sure that unacceptable billing practices have been corrected. Some States use the results of their prepayment reviews to ensure that the problem(s) that led to the establishment of a prepayment flag have been corrected. If the reviews find that the problem no longer exists, the provider flag will be removed. Other States conduct a more in depth review before removing a provider from prepayment review. These States believe that they need to know whether the provider has truly corrected their aberrant practice(s) or simply changed billing to avoid detection.

States appear reluctant to placing providers on prepayment review. They claim that prepayment reviews of provider claims are labor intensive, costly, increase claim processing time and exposes them [the State] to possible litigation. Some States felt that prepayment findings help them develop better policies and procedures to address deficiencies that necessitated the flag prepayment safeguard.

Prepayment Procedure Flags

Procedure specific flags suspend, for manual review, any claim containing the flagged procedure code(s). Procedure flags are more common than provider flags. In Illinois,

claims for anesthesia reimbursement are suspended from the payment system for prepayment review. Illinois also flags claims that appear to contain excessive durable medical equipment and supplies. Some States believe that procedure specific flags are easily circumvented and that providers find ways around the flags and avoid prepayment scrutiny of their claims.

Oregon and Texas conduct an in-depth audit of recent claims before removing providers from prepayment review. These audits help to ensure that the problems that resulted in the provider being placed on prepayment review have been corrected. They help ensure that the provider has actually corrected their aberrant billing practices and not simply found a way around Medicaid safeguards.

Concurrent Reviews

Concurrent reviews examine specific claims to determine whether services are medically indicated and being provided in the appropriate setting for care. They are conducted while patients are receiving services and help minimize overpayments to facilities and providers. Concurrent reviews recognize that under some circumstances obtaining prior approval may delay patient care. Concurrent care reviews are conducted while medical services are being provided.

Of the eight States in our sample, only Pennsylvania uses concurrent care reviews. Pennsylvania uses concurrent reviews to determine the medical necessity of admissions to mental health facilities. The Pennsylvania policy ensures that those in need would have access to care and those who did not need this type of care would get the appropriate level of care. Pennsylvania examines medical records and other information to determine whether a patient's hospitalization was medically indicated. The State also determines how many days of inpatient care it will authorize for payment.

After Pennsylvania instituted concurrent care reviews they saw a decrease in the volume of claims for inpatient mental health services. Payments for mental health admissions in Pennsylvania fell and the length of inpatient stays also decreased. Pennsylvania believes that concurrent reviews help identify medically unnecessary hospitalizations for problems related to mental health. The State found that many of the services patients received while institutionalized could be provided safely in another setting.

Automated Edits

For this study, we defined automated edits as those claims' processing safeguards that are coded into a State's Medicaid claims processing system. Automated edits do not suspend claims from the processing cycle for manual review. Decisions on whether to pay or deny a claim are derived from hard logic programmed into the claims processing system. Automated edits check the quality of data on claims submitted for payment. They help ensure that the services billed by providers are properly processed and paid in accordance with Federal and State laws, regulations and policies.

Today, States rely more and more on automated decisions during the claim processing cycle. Most edit safeguards use hard coded logic to make adjudication decisions about claims and services submitted to Medicaid for payment. The States we visited believe that automated edit safeguards improve claim processing times and are more cost effective than manual reviews of claim data. We categorized edit safeguards into three groups: Quality of data edits, relationship edits and limitation edits.

Quality of data edits deny entire claims, or specific services on a claim, because the claim contains invalid or missing data needed for processing. Unlike rejects, that deny claims before they are assigned an internal control number, quality edits apply to claims assigned an internal control number and accepted for processing.

Quality of data safeguards, in the eight States we visited, automatically deny payment for services containing invalid, or missing data. Claims containing invalid dates of service or missing dates of service, invalid or missing diagnostic or procedure codes and other key information required for accurate processing are denied by claims processing software. No attempt is made to resolve the data error. Claims are processed to completion and the provider is notified as to what items edited during process. The provider is also notified as to how much Medicaid paid for items and services that did not edit.

Limitation edits are hard coded computer program logic that analyze current, and past, claim data to arrive at decisions concerning whether or not to pay for a service. Limitation edits ensure that duplicate payments are not made. They automatically deny non-covered drugs and services. They deny payment for excessive services (i.e., one service every 7 days) and for services that exceed annual maximum allowed limits. They identify services and procedures included in the global payment made for certain surgical procedures to name just a few functions of that limitation edits perform.

In Louisiana, limitation edits are used to limit the number of echocardiograms that State's Medicaid program will pay for during a pregnancy. Services in excess of the allowed number are automatically denied by their claims processing system. In Maryland, limitation edits are used to ensure that the number of pre-authorized services being billed does not exceed the number that was actually authorized. For example, if the State authorized 10 services but the claim is for 12 services, the system will deny 2 services for being in excess of the authorized amount. If less than 10 services are billed, the State pays the lower number.

Relationship edits use patient history information and current claim information to ensure that services being billed do not conflict with past services. They also ensure that the services being billed were provided in the appropriate setting. All of the States we visit use hard coded computer program logic to analyzes current, and past, claim data. Most services, that fail relationship safeguards, are automatically denied payment in most State systems. Services not automatically denied will be suspended from the claims processing cycle for manual review by trained specialists before the claim is adjudicated.

Relationship safeguards identify inconsistencies on the claim being submitted. They also identify services that appear in conflict with past services received by a Medicaid patient. Relationship edits ensure that the sex of a patient agrees with the medical procedures being billed. They also identify and properly adjudicate claims for once in a lifetime services. For example, relationship edits identify and deny male patients receiving hysterectomies. They also identify and deny patient's who have had their appendix or tonsils removed more than once.

In most States, reviewing edits to determine their effectiveness is an ongoing process. In Louisiana, reports on each edit in their system are generated daily and weekly. The weekly edit report lists all edits in Louisiana's claims processing system and provides data as to the number of times a claim or service is edited for each reason. Edits that reject too many or too few claims or services are re-evaluated to determine if they were properly implemented. Edits on the weekly report are then reviewed and analyzed by the State Agency component responsible for the creation of the edit and having responsibility for policy in the program area.

Illinois, like most States we visited, reviews all edits (including those that produced no claim or line item edits) on an ongoing basis to ensure that their claims processing edits function properly. If the edit is not catching any claims or services, Illinois check to be sure the edit was properly designed and implemented. If the edit failed due to improper design, it will be re-designed and remain in the system. If the edit was properly designed and has outlived its usefulness, the edit can be turned off or removed from the system.

Effective edits appear to be a collaborative effort involving policy, program integrity and other Medicaid departments. Some edits are required by HCFA and all States have these edits in their system. Most edits are developed by the State Medicaid programs in response to their specific needs or to address problematic areas. Some edits developed in one State may be of use to other States.

The eight States we visited have anywhere from 500 to 2,000 edits in their claims processing systems.[2] On average, about 20 percent of claims submitted for payment edit for one or more reasons. Oregon is in the process of re-engineering all its edit safeguards; dropping those that are ineffective, modifying other to improve their effectiveness and adding new edits to address emerging problems and new policies. Overall, the trend is for more hard wired (computerized) edits and less human intervention in the claims processing cycle.

[2] Numbers are approximate. States do not uniformly define what is an edit. Some States count as edits only those actions that occur during claims processing. Other States will count rejects, medical review and claims processing interventions as edits.

MANUAL CLAIM REVIEWS

Medical, utilization and audit reviews are claim processing safeguards that interrupt the processing of a claim for manual review by a trained specialist. Staff specialists compare the claims with established program and medical policy, previously paid claims, and other claims to decide if Medicaid should pay for the services.

About 20 percent of the claims processed by State Medicaid programs require manual reviews of the claim submitted and supporting documentation. A large number of the claims requiring manual review are for Medicare patients for whom Medicare is the primary payer and the State Medicaid program is the secondary payer.

Utilization and Medical Review

State Medicaid programs suspend claims for manual review that appear to contain excessive or duplicate services. Utilization reviews compare the services being billed with past services provided to the patient. The reviewer decides whether the services being billed should be paid or denied. Two of the States we visited, use utilization review to confirm whether or not services on a claim are duplicates of previously processed services or non-duplicated services that should be paid.

About 1 percent of the items suspended from claims processing are referred for medical review. Trained medical review staff examine claims and services that appear to be excessive, medically unnecessary or not meeting community standards of care. Medical review staff, composed of nurses, physicians and other specialists review these claims to ensure they meet locally accepted standards of medical practice. They may contact the provider for additional information before deciding whether to pay a claim as submitted or to deny some or all services billed. The final decisions on whether to pay or deny a service lies in their hands.

Audits

For purposes of this study, we have defined audits as those manual functions that do not require decisions of a medical nature. Examples of audits include manual pricing of specific services, reviews to ensure certificates of medical necessity accompany some services and reviews of services requiring additional supporting documentation.

In Pennsylvania, audits help identify patients who have other health insurance or who may be eligible for workman's compensation or other payments to cover the cost of their medical care. Clerical staff examines claims requiring additional documentation. If the required documents are not attached they will request it from the provider or deny the service(s).

Many of the States in our sample use audits, utilization reviews and medical reviews to increase their visibility in the field and to enhance their safeguard efforts. California obtains medical records and other evidence needed to verify all of the items on a claim. Florida and Louisiana expand the scope of their inquiry beyond the claim in process and obtain medical and other records to support all claims paid during a specific period of time.

PAYMENT SUSPENSIONS

All of the States in our sample can suspend payments to providers. Under what conditions and when suspensions take place differs from State to State. The procedures for suspending payments also vary widely. In Louisiana, Florida and Texas payments to providers can be stopped as soon as there is reasonable evidence to indicate an overpayment may exist. Some States suspend payments when evidence suggests fraud or an overpayment has been established. Other States only suspend payment when there is a civil or criminal indictment.

OPPORTUNITIES FOR IMPROVEMENT

The primary purpose of claims processing safeguards is to ensure that claims submitted for payment are properly adjudicated. Claims processing safeguards can also be used to detect fraudulent or abusive providers and to identify problematic Medicaid policies.

Opportunities for improving claims processing safeguards exist. Based on our prior studies and information gathered during this study, we would encourage States to consider the following opportunities for improving their Medicaid program safeguards:

Establish a system that identifies all third party billers/agents and the physicians using their services.

The ability to know who is authorized to bill on behalf of a provider can help eliminate the misuse of provider numbers by clinics and third party billing agents. Medicaid programs that receive claims from agents not listed as authorized should investigate the reason. If the provider failed to notify them of a change in billing agent, Medicaid files could be updated. If the claim is found to be unauthorized, Medicaid may wish to refer a case for potential criminal investigation, contact the billing agency to determine why the error occurred and to secure a plan to prevent future errors. Billing agents/agencies with excessive problems should be banned from submitting claims to the Medicaid program.[3]

Reduce the "hassle factor" by providing providers with a complete list of all critical errors on a claim.

Returning a claim to a provider more than once because it contains fatal errors that prevent a claim from entering the claims processing system is costly. Medicaid systems should identify all fatal errors on a claim and notify the provider of all errors at one time. This would help avoid third and fourth claim submissions.

Use reject and edit data to identify problematic providers.

States have the opportunity to use claim reject and edit data to improve claim processing safeguards, to clarify policies and to identify providers who may need additional training on Medicaid policies and claim submission requirements. Edit and reject data can also be used to identify providers and billing agents who may be trying to defraud their systems.

[3] Additional information about billing companies and system vulnerabilities can be found in *Medical Billing Software and Processes Used to Prepare Claims*. OEI-05-99-00100.

Use edit, utilization, medical and audit data to identify problematic policies and procedures.

A number of States in our sample have successfully re-engineered their Medicaid policies and procedures using information obtained from edits. An opportunity exists for all States to establish a feed back system that links personnel handling edit resolution with policy personnel and with program integrity staff. Information about how edits work or do not work can be used in decisions concerning whether to delete, add or modify an edit. They can be used to identify policies and procedures that may need to be re-engineered. And finally, information obtained in the resolution of edits may indicate the need for a referral for investigation.

Improve front end worker sensitivity to potential fraud and abuses issue by providing ongoing training.

Medicaid staff involved in claims processing (those who develop claims for additional information to resolve edits and those who review medical records) are in position to spot potential fraudulent and abusive practices. These staff need to know the difference between fraud and abuse and when problematic situations should be referred for investigation.[4] With proper training the role of Medicaid staff in spotting and reporting of potential fraudulent and abusive practices can be improved.

AGENCY COMMENTS

We received comments on this report from HCFA. The HCFA believes that the opportunities for improvement described in this report provide valuable information that will be shared with the State Medicaid programs. The full text of HCFA's comments can be found in Appendix A.

[4] Additional information on how to improve the handling of fraud and abuse allegations can be found in our report entitled, *Carrier Fraud Units*. OEI-05-00470.

APPENDIX A

HCFA Comments on this Report

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: JUN 15 2000

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicaid Payment Safeguards: Proactive Safeguards, Claims Processing Safeguards, and Post Payment Safeguards," (OEI-05-99-00070, OEI-05-99-00071, and OEI-05-99-00072)

The Health Care Financing Administration (HCFA) would like to thank the OIG for allowing us the opportunity to review the above-mentioned reports.

Since 1993, the Clinton Administration has done more than any previous administration to fight fraud, waste, and abuse in the Medicare and Medicaid programs. The result is a record series of investigations, indictments, and convictions, as well as new management tools to identify improper payments to health care providers. Last year, the federal government recovered more than $500 million as a result of health care prosecutions.

HCFA has helped fight the battle of Medicaid fraud, waste, and abuse by partnering with States, beneficiaries, providers, contractors, and other federal agencies. The States themselves, are primarily responsible for detecting, prosecuting, and preventing Medicaid fraud, waste, and abuse. HCFA provides funding and technical assistance, and oversees States in their efforts to ensure that taxpayer dollars are spent appropriately. We also provide States with comprehensive guidance and technical support so they can strengthen efforts to prevent improper payments rather than try to recoup them after the fact. HCFA has been working with States to help them develop better data systems and other technological tools for ferreting out fraud, waste, and abuse. We are modifying our National Fraud Investigation Database to include Medicaid cases which will further help in tracking down and stopping unscrupulous providers across the country.

The focus of the National Medicaid Fraud and Abuse Initiative, has been to combat fraud and abuse in partnership with the States. We are also working to help States develop more proactive safeguard measures. The National Initiative was established in June 1997 and we have accomplished many things over the past three (3) years

Specifically, in August, 1997 we conducted a focus group session with States soliciting ideas for preventing fraud and abuse. As a result, we have :

- Worked with our State partners to develop a Medicaid Fraud and Abuse Control Technical Advisory Group (TAG);
- Established a Medicaid Fraud Statutes Website which contains a comprehensive database of state program integrity provisions;
- Developed draft Guidelines for Addressing Fraud and Abuse in Managed Care; and
- Developed a draft Medicaid Managed Care Compliance Plan which will soon be made available to States.

In our National Medicaid Fraud and Abuse initiative we maximize collaboration and communication among States and Federal Agencies. This involves:

- Working with your office, the Department of Justice, the Medicaid Fraud Control Units and Program Integrity Units in their role of prosecuting fraudulent providers,
- Ensuring that all States are aware of fraudulent activities and scams occurring nationwide,
- Promoting consistency by developing national guidelines;

However, we agree that more needs to be done, and we are committed to repeating and building upon the success across the country. The OIG should be aware that HCFA is exploring the feasibility of measuring Medicaid payment error rates on a State-specific and national basis. The purpose of such an initiative would be to measure and ultimately reduce Medicaid payment errors.

We believe the "Opportunities for Improvements" described in each report provided us with valuable information. As we mentioned at the March 9, 2000 exit conference with the OIG, we applaud the presentation of their suggestions as "opportunities." We believe States will view most of these "opportunities" as constructive and when the OIG releases these three reports in final form, we will ask our regional offices to share them with their States.