Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite. 4T20
Atlanta, Georgia 30303-8909

May 7, 2002

Dear Program Integrity Director:

Enclosed is the *Review of State Medicaid Program Integrity Procedures National Report* (National Report) for Fiscal Year 2001. This National Report summarizes observations gathered during the eight reviews conducted in Connecticut, Minnesota, Missouri, New Mexico, Oregon, Pennsylvania, South Carolina and Utah. The Benchmark Practices and observations mentioned in this National Report summarize the findings of those reviews.

The National Medicaid Alliance for Program Safeguards (MAPS) has been engaged in a series of program integrity reviews at Medicaid State Agencies. We conducted on-site reviews in 8 States in FY 2000, 8 States in FY 2001 and are currently engaged in 8 more reviews in FY 2002. These management reviews are designed to help States strengthen their program integrity operations by providing constructive observations and identifying areas of regulatory weakness or non-compliance. Your State's review focused on the functional areas related to its ability to prevent, identify and deter inappropriate Medicaid payments. Comments from your staff played a significant role in the preparation of your State's report.

We hope this National Report will assist your State (and all States) in assessing where your State fits along the fraud and abuse prevention continuum, and in selecting appropriate enhancements that fit your needs. This report, as well as the National Report for the 8 States reviewed in FY 2000, is available on our Web-site at: http://www.hcfa.gov/medicaid/fraud/reports.htm.

If you have questions concerning this report, you may contact your Regional Office Medicaid Fraud and Abuse Network Coordinator.

Sincerely,

Rose Crum-Johnson
Southern Consortium Administrator

Enclosure
cc: State Medicaid Director
MFCU Director

Review of State Medicaid Program Integrity Procedures

National Report

Fiscal Year 2001

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

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Executive Summary

In fiscal year 2001, the Medicaid Alliance for Program Safeguards (the Alliance) performed program integrity reviews in eight States: Connecticut, Minnesota, Missouri, New Mexico, Oregon, Pennsylvania, South Carolina and Utah. The reviews had two main purposes: determine whether each State's program integrity policies and procedures comply with Federal statutory and regulatory requirements, and determine how States identify, receive and process potential provider fraud and abuse information. Additionally, we wanted to identify Benchmark Practices occurring in States and share other practices and observations that can assist States in improving their program integrity oversight. The Centers for Medicare & Medicaid Services (CMS) believes that by sharing this information in a National Report, States can implement some of the Benchmark Practices and other observations identified, depending on their needs.

In general, we found that all eight States were satisfactorily meeting their program integrity responsibilities. We found one Finding of regulatory non-compliance and that was in the area of Provider Enrollment. We noted that the States varied greatly in their Medicaid program integrity practices, often due to the vast differences in size among the States (Attachment 1– Medicaid Populations). To a large extent, this accounted for the variations in practices and procedures we observed.

This report is organized into four functional areas: *Provider Enrollment, Program Integrity/Surveillance and Utilization Review Subsystem* (SURS), *Managed Care*, and *Medicaid Fraud Control Unit* (MFCU). Within each functional area, we discuss the applicable Finding, Benchmark Practices, and observations of how operations are either similar or different among the States reviewed.

Provider Enrollment

All eight States reviewed were not using their full regulatory and discretionary authority to collect and validate information about providers during their enrollment process. Since provider enrollment is the first line of defense in preventing improper payments to providers, States have the necessary authority to evaluate the professional and criminal history of a provider. While collection of some of the information is considered mandatory, other information is available at a State's discretion. One State had a Finding in this area because it did not request mandatory conviction information on provider applications or provider agreements. In addition to following the mandatory requirements, States should collect all the information they can to exercise Balanced Budget Act (BBA) authority permitting them to decline to do business with a particular provider if it is in the best interest of their Medicaid program. For example, States may request other discretionary disclosure information concerning certain subcontractor ownership and business transactions. States use other methods to rid their provider network of entities with whom they do not want to do business. These methods include tracking inactive billers and performing re-enrollment of providers, a Benchmark Practice. The coordination of these processes should be integrated into each State's Medicaid program integrity function.

Program Integrity/SURS
In the eight States visited, we found no instances of regulatory non-compliance in the area of claims review oversight. In fact, we found several States using innovative Benchmark Practices beyond those required by regulations – combined fee-for-service and managed care data warehouse, verification of Explanation of Benefits (EOB) with every Medicaid beneficiary, comprehensive case tracking system, prospective planning, self audit protocol, and provider preclusion.

Still, several States utilize the old Federally mandated requirements for minimum sampling of each type of service provider. But, most have improved on the original idea of an across-the-board, random sample of all participating providers. Today we see sophisticated analysis of claims using software programs run on individual personal computers, accessing years of claims information stored in data warehouses. This multi-level analysis is able to detect subtle patterns of provider abuse. Many States have made significant financial commitments, recognizing the need to invest in improving the talent and tools used to prevent, identify and deter fraud and abuse in their Medicaid programs.

Managed Care
The managed care organizational structure and/or point of responsibility for fraud and abuse prevention, do not appear to be major factors in the total level of fraud and abuse prevention activities in a State. Rather, the largest factor appears to be a function of the managed care penetration rate: in general, the higher the penetration rate, the greater the fraud and abuse prevention effort. The most comprehensive fraud and abuse prevention activities occurred when there was strong oversight at all levels – the State Agency program integrity staff, the State managed care oversight staff, and the managed care plans.

Overall, the managed care area needing the greatest strengthening is provider enrollment, including re-enrollment, and credentialing. States need to ensure that any entity or provider excluded by the HHS OIG is properly prevented from entering into any level of the managed care program when they initially apply for participation, or are removed from payment status if already participating. As part of States' increased activities in the area of Medicaid fraud and abuse in managed care, they should consider ways to best utilize the CMS *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care* which is available on the Alliance's Web site at www.hcfa.gov/medicaid/fraud/reports.htm.

Medicaid Fraud Control Unit (MFCU)
The reviews found that the relationship between the State Agency and the MFCU were good for the most part, and stronger than in the past. States have made many recent changes to greatly improve the productivity and effectiveness of both the Medicaid Agency program integrity units and the MFCUs. These recent changes varied greatly in nature and degree, but involved changes in the organizational structures, staffing, Memorandums of Understanding, and/or a general level of effort to improve the communications and working relationships. Effective operations include strong communications, productive interaction, and information sharing between the Medicaid Agency and the MFCU. However, using the MFCUs to provide basic fraud and abuse awareness training throughout the State Agency could greatly help a State grow even stronger in its program safeguard activities.

Introduction

In January 2001, the Medicaid Alliance for Program Safeguards (Alliance) began its second year of reviewing State program integrity operations to determine how States identify, use, coordinate and communicate fraud and abuse information. National teams consisted of staff from the Alliance who performed reviews in the following eight States: Connecticut, Minnesota, Missouri, New Mexico, Oregon, Pennsylvania, South Carolina and Utah. By conducting these reviews, Centers for Medicare & Medicaid Services (CMS) is addressing its responsibility to provide oversight of State program integrity functions, while at the same time fulfilling a commitment to support State partners who are fighting Medicaid fraud and abuse.

From an oversight perspective, we want to determine if States are in compliance with Federal laws and regulations by reviewing policies and procedures. As a partner, we want to identify ways in which States can improve the integrity of their Medicaid programs.

Background

This National Report is a compendium of information obtained from the eight individual reviews conducted during FY 2001. The results of those reviews are contained in the "Findings" and "Observations" sections of the individual reports. Observations in these individual reports were discussed as either Potentially Beneficial Practices or Opportunities for Improvement. This National Report will present Potentially Beneficial Practices as **Benchmark Practices** and in addition, share other observations that can assist States in improving their program integrity oversight. The **Findings** remain as "non-compliance with regulatory requirements." Only one Finding was identified during this year's reviews.

The non-compliance Finding dealt with the regulation at 42 CFR 455.106(a), requiring the collection of conviction and ownership information. The CMS review team identified one State that failed to require disclosure of conviction or ownership information in the provider application, provider agreement or in any other format. This regulatory requirement is an important element of the State's oversight responsibilities. By instituting appropriate corrective actions, the State should reduce the risk of fraud and abuse in its Medicaid program.

CMS is sharing these effective program integrity policies and procedures so that States can assess where they are along the fraud and abuse prevention continuum. These Benchmark Practices and other observations propose an assortment of ideas and techniques States can adopt. This report will be shared with all States, and should be used as a tool to help them comply with Federal regulations and improve their operations. States should be aware, however, that adoption of some of these procedures may require a change in State law.

For ease of discussion, State activities have been classified into four functional areas, individually discussed below. These areas are: Provider Enrollment, Program Integrity/SURS, Managed Care and Medicaid Fraud Control Unit.

Provider Enrollment

As the first line of defense, an effective program integrity operation ideally begins with the ability to prevent abusive providers from entering a State's Medicaid program. However, State oversight of the provider enrollment function is usually not performed by the Program Integrity Unit. Providers are typically enrolled in another unit or through a contractor, and this physical separation may cause a policy disconnect.

Inherent in the enrollment process is the verification, validation and/or use of mandatory information a provider discloses in the application and provider agreement with a State. Additionally, during the enrollment process, a State has the opportunity to reduce the probability of making improper payments once a provider begins billing the Medicaid program. A State may request additional information from a provider that will help the State evaluate the provider's application.

The following discussion should help States prepare or enhance their program integrity plan of action as well as provide a basis for exercising their BBA authority to decline to do business with parties that would not be in the best interest of the Medicaid beneficiary. Even if a State has been simply reactive in recognizing and dealing with problem providers, they can quickly become proactive by incorporating some practices discussed here.

The review teams evaluated the following mandatory regulatory activities as described in the Code of Federal Regulations (42 CFR) and Public Law.

Exclusions

Section 1902(a)(39) of the Social Security Act outlines provider exclusion requirements. States use a variety of formal and informal steps in their attempt to identify and avoid improper payments to providers that have been excluded from their Medicaid programs. All States receive monthly exclusion information via CMS's *Publication 69 (Pub 69)*. The cumulative list of exclusions in maintained by the OIG in its Excluded List of Individuals and Entities (LEIE). However, some States do not use the information effectively.

One State uses Pub 69 to check its existing provider base but does not evaluate new provider applications. Another State has procedures to check the Publication 69 during the enrollment process, but does not always do so. Additionally, the Pub 69 used was several months old. A third State only reviewed the excluded parties with addresses in that State. A fourth State created and maintained a list of parties that have been excluded from the Medicaid program by that State with some use of the Pub 69 in its enrollment process. On the other hand, one State had no process in place to prevent improper payments to excluded providers. In all of these

examples the complete LEIE is not being used to check both new applicants and the State's existing provider base. This information should also be made available and used by the State's managed care providers.

Other States use the exclusion information sent to them much more effectively. One State's Benchmark Practice is to use a form in its enrollment and re-enrollment processes performed by a contractor. One of the questions on the form is to determine if the applicant's name appears on the LEIE. Another State maintains a file in the MMIS of excluded providers, taken from the LEIE, that is compared on a monthly basis to its active provider database. The provider database is also compared to the monthly Pub 69. These processes ensure that providers are neither admitted to the program nor remain after they have been excluded. In a truly proactive stance, this State also checks excluded individuals against the State labor files to identify the current Medicaid providers of these individuals. The providers are notified and asked to take the appropriate action. The LEIE can be accessed at the OIG Web site at www.hhs.gov/progorg/oig/cumsan/index/htm.

Licensure Verification

The Medicaid program requires providers to have a valid license, under State law, for the medical services they are providing. All States reviewed check for a valid license when enrolling an in or out-of-state provider. The appropriate State licensing agencies are contacted to verify that applicants are currently licensed by obtaining the origination date. However, one State did not capture the license end-date or the fact that the license had expired. The review team was told that unless this information is volunteered by the licensing agency, the State would not know if a license was still valid. It is vital to capture the end-date of the license in order to know if it is valid at any point in time.

Typically, providers in bordering States are enrolled like in-state providers. Usually, the enrolling State institutes a distance limit that would classify a provider as out-of-state. Out-of-State providers are usually in non-bordering States and have limits placed on their participation ranging from duration of participation or only providing emergency care to the time limit of the license. The provider is contacted to determine if their license has been renewed before they are automatically dis-enrolled.

Disclosure

Conviction Policy - 42 CFR 455.106 - states that before a Medicaid Agency enters into or renews a provider agreement, the provider must disclose to the Agency the identity of any person who has ownership or controlling interest in the provider or is an agent or managing employee of the provider, and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or title XX services.

The collection and use of provider conviction information varies from state-to-state. One State had a Finding in this area because they did not request conviction disclosure on its provider applications or provider agreements. Therefore, the State was unable to exercise its authority to refuse to allow the provider to enter into or remain in its Medicaid program. Another State's provider enrollment application and re-enrollment forms do not ask for conviction information. However, the provider agreement does state that conviction information about any agent or

managing employee of the provider must be disclosed. A third State collected the proper criminal conviction information, but did not have a procedure to follow should any criminal information ever be collected.

The collection of this information is very important for several reasons. If conviction information is not collected, it cannot be conveyed to the OIG as required by the regulation and it may allow a provider into the program with whom a State would otherwise not want to do business. Many States limit the disclosure information they collect to what is required in the regulations. As observed in one instance, a State can make a more informed decision by asking for information about *any* criminal conviction. This helps a State develop a more complete picture of the provider that wants to participate in its program and also exercise BBA authority, discussed below.

Ownership - 42 CFR 455.104 - states that each Medicaid Agency must require each disclosing entity to disclose the name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more.

All eight States reviewed were found to be in compliance with the ownership disclosure information mentioned above. One State even performs a business background check to identify business owners, officers, related parties and relationships with other Medicaid providers that were not properly disclosed. This type of information also helps meet the disclosure requirements at 42 CFR 455.105, which allows a State to ask providers for information related to certain business transactions. While this information is not required, a State can ask for it at any time just like the conviction information mentioned above.

Designated Payee

In order to prevent improper payments to billing companies in the name of a provider, certain requirements about the billing company's compensation must be met. According to 42 CFR 447.10, the compensation must be related to the cost of processing the bill and not related to the amount of the bill, or whether or not the bill is paid or collected. Therefore, the contract between the provider and the agent should be evaluated to see if the permissible arrangements exist. While this issue was not extensively reviewed, it is an important tool that can be used to limit improper billings and payments. In order to implement this regulation, one State limits payments only to the provider itself.

BBA Authority

According to 42 CFR 455.105, States can request information that goes beyond the minimum regulatory requirements discussed in the Disclosure paragraph above. For example, a State may request, at any time, information about the ownership of any subcontractor with whom a provider has had business transactions totaling more than $25,000 during the current 12-month period. In addition, States may ask for information about any significant business transactions between a provider and any wholly owned supplier or subcontractor during the 5-year period ending on the date of the request. The examination of this information can reveal details about related organizations, business partners and officers that a State believes taint the provider to such a

degree that allowing them to participate in the program is not in the best interest of the Medicaid beneficiary.

States want providers in their program that can provide necessary quality services to their Medicaid beneficiaries. That is why a provider's disclosure of ownership and criminal convictions is so important for the State to decide if they want to do business with a particular provider. Most States reviewed were aware of this BBA authority, but none are taking full advantage of it.

The Review Teams evaluated the following non-mandatory activities.

Criminal Background Checks
The use of this tool varies greatly among the States reviewed. At least two States do not perform criminal background checks on providers at all. One State performs checks on managers and owners of businesses employing personal care attendants, however, it is up to the business to perform background checks on all their staff members. Another State uses the Medicaid Investigations Unit, located in another State Agency, to run background checks on provider applicants. The Provider Enrollment staff is then advised as to the suitability of the applicant for inclusion in the Medicaid program.

Re-Enrollment
One State annually re-enrolls only out-of-state hospitals in non-bordering States. A Benchmark Practice noted in another State is the re-enrolling of most of their fee-for-service providers. The State plans to continue re-enrolling these providers every 2 or 3 years. While these examples of re-enrollments are not comprehensive, they represent a process that is worthwhile and can be extended to other provider types. In addition, re-enrolling providers every 2 or 3 years can preclude a State from having to track and deactivate provider numbers due to billing inactivity. During our reviews, we encouraged States to re-enroll all providers on a periodic basis.

New Forms
Provider applications vary based on provider type. A Benchmark Practice noted in one State is the creation of a new provider enrollment application that was developed in concert with the Medicaid Fraud Control Unit in the State Attorney General's Office. This joint effort ensures that the contract language incorporates concepts both parties believe are important to protect the Medicaid program.

Inactive Billers
Most States reviewed have a policy to place providers into inactive status if a claim has not been submitted within a specified number of months. The provider number is later revoked if billings do not resume. One State uses a 12-month window for deactivation at which time providers are contacted to determine if they want to remain in the program. If no response is received, they are terminated from the program. This State only re-enrolls previously terminated providers. Another State places providers into a non-participating status after 12 months of no billing activity, and the provider must go through a written reinstatement process to resume billing the program. Other States similarly de-activate provider numbers after 24 months of inactivity.

Communications
The communication of provider information, disclosed during the enrollment process, to program integrity is critical in protecting the Medicaid program from potentially abusive providers. This communication effort needs to be improved in a few of the States reviewed. Additionally, sharing details about aberrant providers and practices with other States will help program integrity efforts in all States.

Other Tools
There are other tools that States can use to enhance their provider enrollment function. An observation was presented in one State to investigate undeliverable returned mail sent to providers. The contractor responsible for provider enrollment, claim payments and general correspondence failed to investigate such returns. The State can pursue the issue by either updating their files or terminating the provider if no updated address is available. If the reason the mail was returned is not pursued, the risk of making an improper payment goes up. Two such risks are that a legitimate payment may be diverted or that the payment for a false claim may be sent to a sham address.

Conclusion
All eight States reviewed were not using their full regulatory and discretionary authority to collect and validate information about providers during their enrollment process. Since provider enrollment is the first line of defense in preventing improper payments to providers, the Social Security Act and 42 CFR 455 provide States the necessary authority to evaluate the professional and criminal history of a provider. While collection of some of the information is considered mandatory, other information is available at a State's discretion. One State had a Finding in this area because it did not request mandatory conviction information on provider applications or provider agreements.

In addition to following mandatory requirements, States should also exercise their discretionary authority to help keep problem providers from enrolling or continuing to participate in its Medicaid program. Discretionary authority includes running potential providers through criminal background checks or requesting disclosure information concerning certain subcontractor ownership and business transactions. Other methods available to States include tracking and removing inactive billers; routinely re-enrolling providers and investigating returned mail. States should also take full advantage of their ability to use discretionary information to decide if enrolling a particular provider is in the best interest of their Medicaid program. This process should be directly tied to the overall Medicaid program integrity function within every State.

Program Integrity/SURS

The term "Program Integrity" (PI) in this report includes investigating potential Medicaid fraud and abuse as well as insuring that claims are paid appropriately, no claims are paid that should not be paid, and claims are paid in the correct amount. The responsibility for these functions has fallen historically to the Surveillance and Utilization Control Subsystem (SURS) units, which

had Federally mandated requirements for minimum sampling of each type of service provider. These requirements no longer exist, and States are free to design a system of paid claims review that meets their individual needs.

It is easy to understand that post-payment reviews make good sound fiscal sense. States with aggressive SURS units have more potential to save money for their programs than less aggressive units. Up to one-half of every Medicaid dollar is State money, and each misspent dollar avoided is a dollar available for another worthwhile purpose. Historically, every dollar expended for anti-fraud and abuse efforts result in at least five dollars in cost avoidance or savings.

The review teams evaluated the following mandatory regulatory activities as described in the Code of Federal Regulations (42 CFR) and Public Law.

Methods for identification, investigation, and referral - 42 CFR 455.13 - 16
States utilize a variety of methodologies for identifying cases for review. Computer programs that simply select random samples automatically are the most basic, tried and true technique. States often supplement these programs with more sophisticated software that can recognize aberrant billing patterns, and flag particular providers for closer scrutiny. The practice of amassing large quantities of information into a single database (a data warehouse) for better claim analysis, is becoming common among States we reviewed. Data warehouses offer many years of information from which to draw patterns of abuse, as opposed to one year or less under older storage systems. One State has managed to compile billing data from both fee-for-service and managed care services into a data warehouse for easier analysis, a recognized Benchmark Practice.

Data Warehouses - Data warehouses can be put to their best use when combined with state-of-the-art decision support software as observed in several States. One State with new software is engaged in a novel experiment of "cyber-networking" with other Client Server SURS users in a "Run of the Month" users group on the Internet. Participants share information about provider billing schemes and describe how to set up targeted SURS reports. The user list is an effective way to share information about common fraud schemes and how to leverage the SURS to find them.

For a detailed look at what information systems software is being used by various States, see the CMS report, *Resource Guide of State Fraud & Abuse Systems*, available on the Medicaid Alliance for Program Safeguards' Web site at www.hcfa.gov/medicaid/fraud/reports.htm.

External Sources - In addition to using data analysis, States obtain leads from external sources. These include: complaints, including those from a toll-free hotline; referrals from other agencies' special projects; multi-agency task forces; and articles in medical industry literature. In addition, the results of successful SURS reviews can be used to prevent similar future schemes through the addition of new edits into the bill-paying software.

Investigations - When it comes to investigation, State PI units vary in their level of involvement, from applying just preliminary screens, to performing complete reviews, to recouping

settlements, and finally to imposing sanctions. Several States still perform the classic SURS data analysis reviews as described under the old Systems Performance Review (SPR) rules (random sample of claims by provider type). Some States also utilize SURS staff to perform desk audits, conduct field investigations in their areas of expertise, and/or recoup overpayments. In one State, staff engages in provider education activities, with an eye toward preventing fraud. Provider education can also prevent an honest mistake from being made or repeated.

One State takes advantage of the fact that two of their SURS investigators are certified law enforcement officers. This permits them to track relevant fraud and abuse data in the FBI's National Crime Information Center and the State Law Enforcement Database. These data provide additional leads for the investigators to pursue.

Special Projects - A special project in one State involved pharmacy claims. The SURS staff's pharmacy experience helped them define the three major areas of concern: prescriptions for brand-name drugs, over-the-counter remedies, and maintenance medications. The State opened 86 cases, recovered or saved $2.1 million, and referred 29 beneficiaries for possible prosecution.

Another special project in a different State involved non-emergency medical transportation. Claims that could not be associated with specific additional service claims were deemed suspect, and were subject to comprehensive on-site investigation. The project is ongoing, but several referrals to the MFCU are anticipated. Interestingly, the review uncovered a need for a more thorough records retention requirement for transportation vendors. Many of the questioned trips were the result of poor record keeping, rather than fraudulent behavior on the part of providers.

Recipient Verification Procedures- 42 CFR 455.20

Medicaid Agencies are required to have a method for verifying with recipients whether services billed by providers were received. The simplest method is to distribute statements to recipients who are listed on paid claims, requesting that they respond if they feel they did not receive a given service. States then follow up on responses indicating non-receipt of service. These Explanation of Benefits (EOB) statements are usually sent to a small sample of beneficiaries. Two small States attempt to contact every Medicaid client who received services, a noted Benchmark Practice. In these latter States, follow up activity is more detailed, and one State estimates that it generates 20 percent of its SURS reviews from EOB pursuits.

SURS oversight of Medicaid Managed Care Service Delivery- 42 CFR 455.20

A detailed discussion of managed care and its relationship with the SURS operation is contained in the "Managed Care" section of this report. In general, we noted that States are moving to include managed care service encounter data into their MMISs. States want to be able to verify that services billed to or paid by Medicaid were services received. They also want to be able to detect aberrant patterns of service. One State has already achieved the goal of integration of encounter data with fee-for-service claims information, although the reliability of the encounter data is not yet up to standards.

The Review Teams evaluated the following non-mandatory activities.

Case Tracking System - The degree of involvement by States in case tracking is an area that varies widely. One State has already automated its case management activities using a self-designed computer software program. Another State is developing a more sophisticated case tracking system scheduled for implementation within a year.

Prospective Benchmark Planning - One State tackled the problem of what to do in the area of program integrity by designing a 5-year plan of activities. In addition, they are using a new client server SURS subsystem using a "power user" approach. Under this approach, the initial power users test and master the system so they can eventually train all staff to maximize their use of the system's capabilities. Another State is proposing to focus on areas like improving fraud and abuse outreach and education and ongoing interaction with internal and external partners.

Self-Audit Protocol - One State has created an innovative, self-audit protocol to encourage fee-for-service and managed care providers to voluntarily report Medicaid overpayments. The self-audit Benchmark protocol provides guidance to providers on the preferred method to calculate and refund inappropriate payments. When providers discover payments to which they are not entitled, they are encouraged to determine the nature and extent of the problem and report the findings to the State. Providers utilizing the protocol can simultaneously refund the amount paid in error while avoiding the potential imposition of penalties of up to twice the amount paid incorrectly.

Preliminary Provider Meetings - One State also invites providers who are under active review to visit the PI office and discuss their case. In a calm, non-confrontational manner, the PI staff presents the evidence that has been gathered to support their position. The provider frequently finds it advantageous to engage in immediate negotiations with the State, rather than risk further discovery and embarrassment, financial and otherwise.

Provider Preclusion - As further evidence of this same State's proactive stance on its PI responsibilities, it developed its own Provider Preclusion list. The State wants providers to know that participation in the Medicaid program is not automatic simply because the provider has not been convicted of a crime. In a Benchmark Practice, this State extends the limits of what inappropriate behavior includes, so those providers must adhere to higher State legal standards than what is required by the Federal government.

Conclusion

In the eight States visited, we found no instances of regulatory non-compliance in the area of claims review oversight. In fact, we found several States using innovative Benchmark Practices beyond those required by the CFR. These innovations include combining managed care encounter data and fee-for-service claim information in a data warehouse, verifying services received with every Medicaid beneficiary, developing a comprehensive case tracking system, utilizing a self audit protocol, and establishing State-level provider preclusions.

Still, several States utilize the old Federally mandated requirements for minimum sampling of each type of service provider. But most have embellished the original idea of an across-the-

board, random sample of all participating providers. Today, we see sophisticated analysis of claims using software programs run on individual personal computers, accessing years of claims information stored in data warehouses. This multi-level analysis is able to detect subtle patterns of provider abuse. Many States have made a financial commitment, recognizing the need to invest in improving the talent and tools used to prevent, identify and deter fraud and abuse in their Medicaid programs.

Managed Care

With the increasing cost of medical care and Medicaid program dollars getting harder to obtain, States have been moving a greater portion of their Medicaid programs from fee-for-service to managed care. Initial managed care pilot programs started in the 1980's, and wherever feasible, grew into a major part of their programs between the mid to late 1990's. In the eight States visited by these national teams, only one State had a very small percentage of its Medicaid population in managed care. One State had a more significant managed care penetration of 40 percent, while the remaining six States had greater than a 63 percent penetration rate (Attachment 1).

Despite this common factor of having a major portion of the Medicaid population covered by managed care, we found large variations in the structure of managed care oversight operations, responsibility for managed care program integrity issues, responsibility for provider enrollment within managed care organizations, and responsibility for monitoring medical services. Out of these wide variations, we identified a few Benchmark practices and observations that could be used to improve operations by a State involved in managed care.

Structure

In four States, the oversight for managed care was split, with some activities integrated into other Medicaid operations. In three of these States, the managed care unit has not been actively involved in fraud and abuse prevention. In the remaining four States, the managed care operations were either totally outside the agency operating the Medicaid program or were a very independent unit within the Medicaid Agency.

Responsibility for Program Integrity Functions in Managed Care

In the State with the least managed care penetration, the managed care unit is just starting to review CMS's *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care* to evaluate potential changes in future contract provisions. In the State with 40 percent managed care penetration, neither the managed care unit nor PI staff are pushing fraud and abuse prevention within MCOs or within the State operations. Similarly, in a State with more than 70 percent managed care penetration, the managed care unit is not focusing on fraud and abuse. Nor does it have a strong relationship with the PI staff to ensure MCOs have strong fraud and abuse prevention programs. As a result, very few fraud referrals have come from the MCOs. Officials are hoping that a new decision support software being established will help improve the State's overall managed care fraud and abuse data analysis and level of effort. In all three of these States, the managed care operations are integrated with other Medicaid operations.

On the other hand, the remaining State with an integrated managed care operation has a much stronger fraud and abuse focus for its 83 percent penetration rate. MCOs have compliance officers responsible for fraud and abuse issues. The State managed care staff meet monthly with key MCO staff and cover compliance and fraud and abuse issues as needed. The State also performs on-site reviews of the MCOs where program integrity can be a focus area. The State recently sponsored joint training with law enforcement, State Agency staff, MCO compliance officers, and other insurers. This training produced a Resource Manual that included State Medicaid Directors letters, fraud related articles, investigative reports, and other regulatory and legislative references. The State has also been active in communicating with other States to share managed care program integrity ideas.

In the first of the States with separate, independent managed care operations, the State with the highest managed care penetration rate of 90 percent did not: (1) define fraud and abuse in its MCO contracts; (2) have fraud cases referred by its MCOs even though the MCOs have compliance officers; (3) have reliable and usable encounter data; or, (4) have much oversight from PI staff. However, the PI unit does plan to start an evaluation of how MCOs identify and resolve potential fraud and abuse issues.

In the other three States with separate, independent managed care operations, with managed care penetration rates of between 63 and 73 percent, the managed care fraud and abuse efforts were more aggressive. One State includes numerous fraud and abuse prevention provisions in its MCO contracts and meets regularly with managed care plans to ensure program integrity is as integral a part of the managed care programs, as it is in the fee-for-service (FFS) setting.

In a second State, the PI unit has oversight responsibility for program integrity functions in the MCOs. There is a special section in its MCO contracts that requires MCOs to develop and obtain State approval of their policies and procedures on prevention, detection and reporting of fraud and abuse. In addition, the MCOs are required to cooperate with the MFCU, though more often cases are referred to the MFCU through the State PI unit. The State also has a combined data warehouse/database for both managed care encounter data and FFS claim data which can be a powerful tool "Benchmark Practice" for identifying aberrant billing patterns and abuses. On the other hand, managed care program integrity efforts could benefit from a more active State training and outreach program to MCO staff, and a better State understanding and closer oversight of the MCO PI operations.

In the third State, the PI unit identified the need to switch its focus from FFS to managed care. They developed a new PI plan using CMS's *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care* as a basis. They have added stronger fraud and abuse language to their MCO contracts, implemented targeted reviews, and developed a matrix management core team for oversight of each MCO. Teams comprised of staff from each of the various bureaus and sections meet twice a month, and monitor the MCOs for compliance with contract provisions, monthly referral reports, and required quarterly fraud and abuse reports.

Provider Enrollment in MC

In every State visited, the main responsibility for enrolling, re-enrolling, and/or credentialing providers lies within the managed care organization. In three States, providers in MCOs must

first be enrolled in the States' fee-for-service program. However, the MCO is responsible for verifying this prior to enrolling a provider. In one of these three States, the program integrity staff ensures the quality of this activity by testing the MCOs' credentialing efforts. In the other five States, MCOs are allowed to enroll providers not enrolled in the fee-for-service program. In these States, there are a variety of credentialing requirements that must be met. For example, in one State the providers must only meet minimum credentialing requirements, such as having appropriate licenses or certifications.

In all eight States, there is the basic requirement placed on the MCOs to ensure they do not make payments to providers that have been excluded from participating in the Medicaid program by the OIG. In the three States that require the MCOs only to enroll providers that are also in the FFS program, the initial prevention to keep excluded providers out of Medicaid is done by the States' provider enrollment function. But, it is the MCO's responsibility to ensure excluded parties already enrolled are not subsequently paid. Two States audit the MCO and/or provider networks to verify the MCOs are not doing business with excluded parties. In another State, the MCO contracts back with the State managed care unit to perform matches of providers under contract with the MCO against the excluded parties list. In the remaining five States, the MCOs are only contractually required to ensure that payments are not being made to excluded parties. In at least two instances, this is not adequately verified by the State. In two States, the MCOs are not consistently or properly using the excluded parties list to ensure that payments are not being made to excluded parties.

Monitoring Medical Services and Encounter Data

Since a strong incentive exists in the managed care environment to provide fewer services than might be needed, monitoring the medical services provided is an important aspect of fraud and abuse prevention. Most of the States visited in these reviews had some method of evaluating quality of care, measuring customer satisfaction, and/or validating reported encounter data. However, these methods varied greatly in their approach.

Two States contract with the local Quality Improvement Organization (QIO- formerly known as Peer Review Organization), to verify that enrollees are receiving quality health services and that health services are accessible. Two States perform enrollee satisfaction surveys to ensure beneficiaries are satisfied with their health plans and medical services. In two States, they take responsibility to oversee the quality of care provided through the MCOs, including developing corrective action plans as needed, educating MCOs, and measuring results through established benchmarks. In two States, they have active programs to closely monitor enrollee complaints, grievances, and the appeals process to identify any potential fraud and abuse issues.

Four States use various approaches to validate reported encounter data, to ensure the beneficiary received the reported services. The approaches ranged from using the QIO to validate the reported data against medical records, to asking beneficiaries to verify data on Explanation of Benefits notices. In one case, the State allows the MCO provider to have the beneficiary verify the data at the conclusion of his visit, which does not prevent the data from being revised before it is reported to the State. In two States, the MCOs do not have a process for verifying with beneficiaries whether services rendered through MC providers were received.

Conclusion

The managed care organizational structure and/or point of responsibility for fraud and abuse prevention do not appear to be a major factor in the total level of managed care fraud and abuse prevention activities. Rather, the largest factor appears to be a function of the managed care penetration rate: in general, the higher the penetration rate, the greater the fraud and abuse prevention effort. The most comprehensive fraud and abuse prevention activities occurred when there was strong oversight at all levels - the State Agency program integrity staff, the State managed care oversight staff, and the managed care plans.

One Benchmark practice is the establishment of a combined managed care and fee-for-service database for identifying potentially fraudulent providers. Of course, this requires accurate and reliable data, a difficulty many States are facing, as they do not validate the encounter data.

Overall, the managed care area that needs the greatest strengthening is provider enrollment, which includes re-enrollment and credentialing. States should ensure that any entity or provider excluded by the OIG is properly prevented from entering into any level of the managed care program when initially applying for participation, or is removed from payment status if already participating. As part of States' increased activities in the area of Medicaid fraud and abuse in managed care, they should consider ways to best utilize the CMS *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care,* which is available on the Medicaid Alliance for Program Safeguard's Web site at www.hcfa.gov/medicaid/fraud/reports.htm.

Medicaid Fraud Control Unit

The basis for State Medicaid Fraud Control Units (MFCU) is found in sections 1903(a)(6), 1903(b)(3), and 1903(q) of the Social Security Act, as amended by the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95-142). The statute authorizes the Secretary to pay a State 90 percent of the costs of establishing and operating a MFCU for the purpose of eliminating fraud in the State Medicaid program, within the definition of the statute. The MFCU has the responsibility to conduct a Statewide program for investigating and prosecuting fraud in the administration of the Medicaid program, the provision of medical assistance, or the activities of providers of medical assistance under the State Medicaid plan.

There is significant flexibility afforded States as to how to organize, locate, and staff this operation. But, the unit must be a single identifiable entity of the State government, must be independent of the Medicaid Agency, and must be certified by the Secretary. Oversight responsibility of the MFCU currently resides with the OIG. However, because the MFCU's responsibility revolves around the State's Medicaid program, there are also specific Federal regulations applicable to both the MFCU and Medicaid Agency to ensure cooperation between them, including a requirement for an inter-agency agreement. This inter-agency relationship was the focus of our team reviews at the MFCU offices.

State Agencies' Responsibility for Case Referral – 42 CFR 455.21
States that have a MFCU must refer all cases of suspected Medicaid fraud to the unit, and we found that the States under review all did. In ideal circumstances, suspected fraud cases that are referred by the PI/SURS to the MFCU are promptly acted upon. When the MFCU declines to prosecute or investigate a case, it should be promptly returned for processing of any administrative action. Some PI/SURS units expressed frustration caused by what they perceived as excessive delays in the return of cases by the MFCU. PI/SURS units that maintain regular contact with their MFCUs are generally happier about the decision making process.

While it is common for MFCUs to request the State agency units to cease all activity when a case is referred, one State's MFCU Director has indicated an interest in rethinking that philosophy. He noted that he has not yet seen a MFCU case investigation that would suffer if the PI/SURS proceeded with administrative sanctions.

Two States receive updates from its MFCU on each referral 30 days after receipt, including a decision whether administrative action by the State Agency would jeopardize any anticipated prosecution. Another State sets the deadline for MFCU action at 45 days, and still another is promised a decision within 6 months. One State uses a cover sheet and keeps a log of all referrals to keep things orderly, and to assure that all needed information is included with the case.

In addition to the standard practice of PI/SURS referring cases of suspected fraud to the MFCU, we noted that one State goes a step further. For every provider, an error rate is calculated based on the percentage of claims rejected for payment. The guideline error rate for referral to the MFCU is 20 percent. Any provider shown to have that percentage of mistakes in the processing of its claims is presumed to be involved in some type of fraudulent activity, and is forwarded for investigation.

MFCU/State Relations and Cooperation - 42 CFR 455.21 and 1007.9
The reviewers noted that Medicaid program integrity efforts greatly benefit from strong communications, productive interaction, and information sharing between Medicaid Agencies and MFCUs. In one State, this strong relationship is largely attributable to the designation of a primary contact and the fact that one of the MFCU attorneys was formerly a staff member of the State Agency's legal staff.

In the State with the smallest MFCU office, this relationship was not as strong as it could have been. The Memorandum of Understanding, though drafted, has never been officially executed. As a result, portions of the draft have not been implemented, contributing to a lack of understanding and trust. In the remaining States the relationships between each State Agency and its MFCU was good for the most part and stronger than in the past.

<u>PI/SURS</u> - In States with fully cooperating PI/SURS and MFCU units, investigators work together and share information on their respective operations. For example, one PI/SURS unit takes fraud alerts generated by the MFCU and forwards them to their provider community, to remind them of the State's policies on various issues that may have fraud and abuse implications (e.g., not paying claims for medications ordered or prescribed by excluded providers.)

There are several other ways for PI/SURS units and MFCUs to cooperate. Most units join with MFCUs to work in task force operations. One unit receives training from its MFCU on investigative technique and case management. We noted that States are helpful to the MFCUs by making records available, and in some cases, the MFCU has direct access to the claims system and other records.

Managed Care - Similarly, the MFCU's relationships with the State managed care component and its managed care plans differ widely. In one State, the MFCU recognizes that since the State's Medicaid program is almost exclusively managed care, it needs to focus a greater portion of its resources on finding fraud in managed care. State criminal statutes allow for prosecution of managed care fraud. In another State, the MFCU is not included in the monthly meetings between the State Agency and the managed care plans. In several States, the MFCU has not been widely used by State Agencies to help provide basic fraud and abuse awareness training to various components within the State Agency.

Task Force Participation

Because it is the MCFU's responsibility to investigate and prosecute fraud, they must work with other law enforcement entities as well as the State Medicaid Agency. The format of this interaction differs greatly among States because each State is organized differently, has different fraud schemes, and differs in the size of its operations. In addition to interacting on individual specific cases, most States have some form of regular health care fraud meetings and/or taskforce meetings. In one State, individual cases are discussed at least weekly and both the MFCU and State Agency staff attend quarterly US DOJ health care fraud task force meetings. In another State, the State has taken the lead in holding monthly meeting among the State Agency PI staff, the MFCU, Attorney General's Office, State Attorney's Office, and the State Health Care Task Force to discuss specific cases. The FBI and U.S. Attorneys' offices are also invited to these. In addition, the State also attends the annual Federal Health Care Task Force meetings.

In a third State, the MFCU director actually serves as one of the coordinators of the Federal Health Care Fraud Taskforce and MFCU staff attorneys are periodically cross-designated as Special Assistant U.S. Attorneys to bring cases in Federal court. In most cases, the State meetings involve additional State agencies such as the Highway Patrol, local police and other local law enforcement agencies, while the larger Federal Taskforce meeting involve more Federal agencies such as the OIG, FBI, U.S. Postal Inspector, and Drug Enforcement Agency.

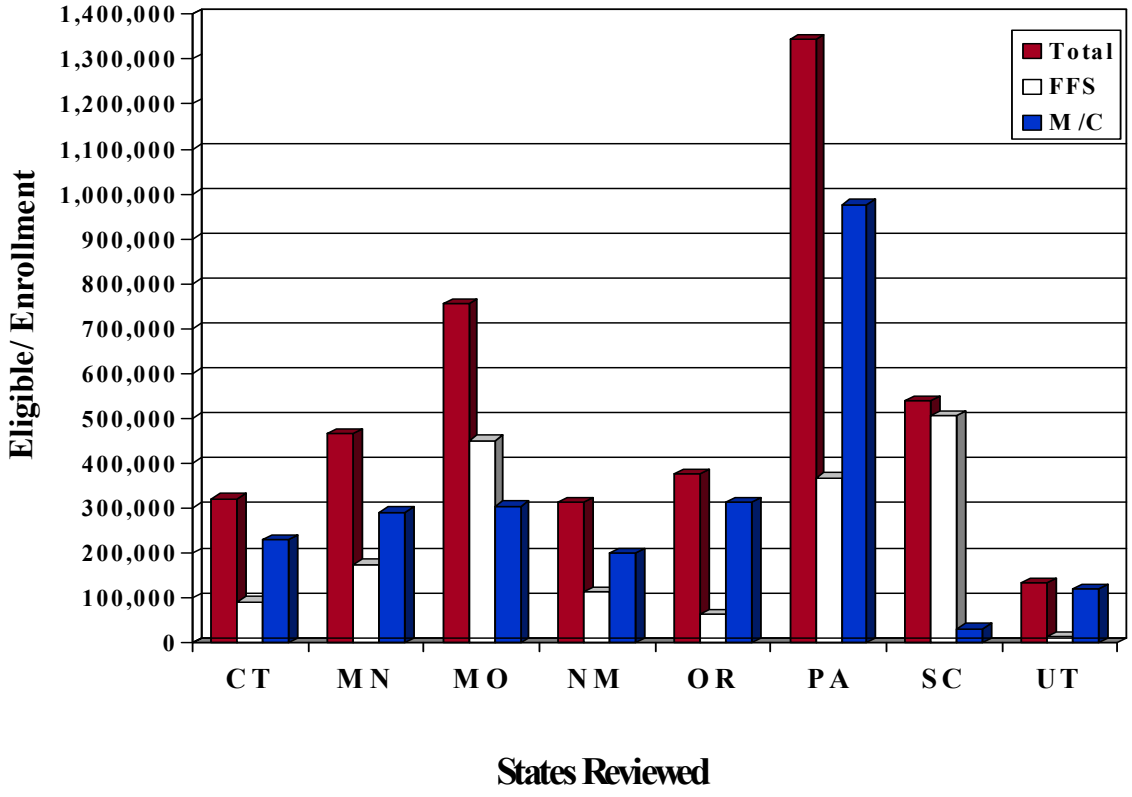
Conclusion

The reviews found that the relationship between the State Agencies and the MFCUs was good for the most part, and stronger than in the past. States have made many recent changes to greatly improve the productivity and effectiveness of both the Medicaid Agency program integrity staff and the MFCUs. These recent changes varied greatly in nature and degree, but involved changes in the organizational structures, staffing, Memorandums of Understanding, and/or a general level of effort to improve the communications and working relationships. Benchmark Practices that greatly benefit the Medicaid program integrity efforts include strong communications, productive interaction, and information sharing between Medicaid Agencies and MFCUs. However, a greater use of the MFCUs in providing basic fraud and abuse awareness training to

various components throughout the State Agencies could help States grow even stronger in their program safeguard activities.

What's Next

CMS believes these reviews highlight its commitment to provide States with assistance in their fight against fraud and abuse, while at the same time fulfilling its oversight responsibilities. The reviews indicate that States are generally meeting their program integrity responsibilities. By incorporating the proposed Benchmark Practices and other observations, where applicable, States have a real opportunity to improve their program integrity functions. States can access this report and others by logging onto our Web site at www.hcfa.gov/medicaid/fraud. If additional clarification of any idea expressed in this report is needed, please contact your CMS Regional Medicaid Fraud and Abuse Coordinator for assistance.

Attachment 1

Medicaid Populations