

**Centers for Medicare & Medicaid Services**

**Center for Program Integrity**

**Medicaid Integrity Program**

**Annual Summary Report**

**of**

**Comprehensive Program Integrity Reviews**

**June 2014**



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## Executive Summary

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Section 1936 of the Social Security Act required the Secretary of the Department of Health and Human Services (HHS) to provide support and assistance to states' Medicaid program integrity efforts. To fulfill this requirement, the Centers for Medicare & Medicaid Services (CMS) began conducting reviews of each state's Medicaid program integrity activities in 2007. The objectives of these reviews are to assess states' compliance with federal laws and regulations, evaluate additional program vulnerabilities and noteworthy practices, help the states improve overall program integrity efforts, and identify areas where CMS can provide future technical assistance. The reviews identified problems that warranted improvement or correction in state program integrity operations, and CMS has provided assistance to states in correcting those problems. Comprehensive program integrity reviews have also identified states' noteworthy program integrity practices. We recommend that other states consider emulating these practices. Providing states with this annual report is one way of sharing information about noteworthy Medicaid integrity practices, as well as areas of weakness that need correction or improvement.

By the end of Federal Fiscal Year 2012, CMS had completed a total of 96 comprehensive state program integrity reviews. These reviews included all states (including Puerto Rico and Washington D.C.), and 43 states had been reviewed twice.

This report includes information from 22 comprehensive reviews for which final reports were issued between December 1, 2011 and December 31, 2012. These include the states of Arizona, California, Colorado, Florida, Georgia, Illinois, Maine, Massachusetts, Minnesota, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Utah, Washington, Wisconsin, and Wyoming.

In March 2010, the Patient Protection and Affordable Care Act (Affordable Care Act) was passed. Certain provisions related to payment suspensions, provider screening, and provider terminations were implemented through regulations that became effective on March 25, 2011. Some of the reviews discussed in this annual report were conducted prior to the effective date of implementing the new regulations. Together with the statute, these regulations provide valuable new tools for detecting, deterring, and remedying fraud, waste, and abuse in the Medicaid program. Among these new program integrity tools are the following:

- The ability to suspend payments more quickly when there is credible evidence of fraudulent activity,
- More effective screening measures to prevent fraudulent providers from enrolling in the Medicaid program, and
- Streamlined procedures to terminate providers from Medicaid and the Children's Health Insurance Program (CHIP) when they have been terminated by Medicare, or by Medicaid or CHIP in another state.

Implementation of these tools will increase the effectiveness of Medicaid program integrity, and will reduce improper payments in the Medicaid program.

Since CMS conducted the first comprehensive reviews in 2007, we have continued to identify problems in provider enrollment in both fee-for-service (FFS) and managed care programs. For those states that have had two reviews, many problems were corrected after the first review. However, we often found that problems identified were not completely corrected. We also found that many states still do not fully apply all FFS safeguards and program integrity measures to other delivery systems such as managed care and non-emergency medical transportation. In addition, the regulations implementing the Affordable Care Act introduced new requirements along with enhancing requirements of previous regulations that most states had not yet implemented. CMS plans to work closely with states to ensure that all issues, particularly those that remain from the previous reviews, are resolved as soon as possible.

Besides summarizing the problems found in state programs, this annual report contains important information about noteworthy practices in provider enrollment, program integrity activities in the Medicaid fee-for-service and managed care programs, and the relationships between State Medicaid Agencies and state Medicaid Fraud Control Units (MFCUs). We suggest that State Medicaid Agencies pay particular attention to the most effective approaches other states are using to protect their beneficiaries and the Medicaid program. Comprehensive program integrity review reports on individual states can be found on the CMS website at [Program Integrity Review Reports List](#).

# Program Integrity

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

## Effective Program Integrity Units:

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

## Noteworthy Practices

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

### Cooperation and Collaboration

One state was noted for its communication and coordination of program integrity efforts with internal and external partners. **Colorado** has coordinated program integrity operations across all components of the state's FFS program. The Program Integrity Unit<sup>1</sup> has developed a variety of operational mechanisms and tools to support its work and promote a high degree of coordination. The state tracks all audits that are taking place in Colorado's FFS program, and coordinates audit activities conducted by state staff with audits performed by outside entities and contractors. In addition, the state is performing medical record audits in the state's Home and Community-Based Services (HCBS) waiver programs, which has resulted in the

Program Integrity Unit making suggestions for policy changes. Furthermore, Colorado adopted an Electronic Surveillance Utilization Review System, which has created an electronic data query mechanism for more than 60 people across multiple units. All individuals have access to the data and can share and post reports on audits and other inquiries.

### Data Collection and Analysis

Measurement of improper payments can be a significant program management tool because minimizing error rates requires identifying the most significant sources of payment errors. In its 2012 review, **California** was singled out a second time for its Medicaid Payment Error Studies which identify provider types at greatest risk for payment errors. These studies have resulted in

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<sup>1</sup> States have different titles for their divisions or departments where the majority of program integrity activities occur. The designated Program Integrity Director is usually the manager or has oversight of this department. For this report, a general title of "Program Integrity Unit" is used to refer to any unit/section/department/division where these activities are primarily housed.

special focused reviews and a three percent reduction in error rates with a cost savings of over \$300 million in a four year period.

**Illinois** has developed an in-house predictive modeling system that will utilize cutting edge predictive modeling techniques to detect aberrant provider behaviors at the earliest possible time. It offers a consolidated snapshot of provider patterns and activities drawing on data from diverse sources and different parts of the agency. The profile report gives Illinois staff quick access to complete up-to-date information on providers of interest as they plan investigations, audits, or quality of care reviews. The provider profile tool has been utilized in monitoring probationary non-emergency transportation providers and audits of transportation providers. The profiling tool also helped Illinois establish a recoupment target in dollars for transportation provider audits. Moreover, cost avoidance has been calculated for disenrolling or terminating probationary providers in past years.

### **Program Safeguard Activities**

States have implemented a variety of methods for combating Medicaid provider fraud, waste, and abuse which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid beneficiaries. These activities include provider education and communication, oversight of personal care services (PCS), increased statutory authority, and utilization of a wide variety of sanctions.

#### *Provider Education and Communication*

**California** maintains a web-based provider training program. This Medi-Cal Learning Portal is an easy one stop shop learning center for Medi-Cal billers and providers. Provider services available through the portal include provider seminars, webinars, and eLearning tutorials. The eLearning tutorials for providers are particularly unique, because they include an on-line quiz after each tutorial, thereby enhancing a provider's training and education about topics such as claims follow-up, common denials, computer media claims, crossover claims, internet professional claim submission, real time internet pharmacy claim form, recipient eligibility, and the UB-04 claim form. In addition, in September 2011, California collaborated with the CMS Center for Program Integrity and the California Medical Health Association in conducting a month-long series of provider education and training focused on fraud and abuse in the practice setting, protecting medical identity, and medical record documentation.

**Wyoming's** contract with its fiscal agent includes two dedicated field representatives who conduct provider education and training as directed by the state. The training includes, but is not limited to, a review of provider manuals, claim submission policies and procedures, and systems training on the Medicaid Management Information System (MMIS). The field representatives work with any provider who requests assistance, but certain providers are targeted each year including all in-state hospitals; all in-state nursing facilities; top 25 paid dentists, pharmacies, and physicians; newly enrolled, in-state billing providers; providers identified by Wyoming as having an abnormally high denial rate; and categories of providers as determined in an annual meeting between the state and its fiscal agent. The state reported that the field representatives visit approximately 500 providers each year. This dedicated provider education and training program which targets high-paying providers and high-risk providers on a consistent basis furnishes a strong preventative tool in minimizing fraud, waste, and abuse.

**Colorado** has implemented a unique approach in communicating with providers regarding overpayments. The state began contacting providers via telephone prior to sending out actual demand for payment letters. Colorado reported that the telephone calls have increased efficiencies at many levels (including the appeals process) for the provider, program integrity

staff, and for the Attorney General's Office of Administrative Courts. Making advance notice telephone calls gives state staff the opportunity to speak with providers directly to discuss documents needed for the review of overpayments and to educate providers on Medicaid coverage, billing, and reimbursement rules. Prior to the telephone calls, providers submitted documentation and conversations took place only during the appeals process, after the state had already incurred attorney costs and much time had been spent in staff preparation. The advance notice gives providers additional time to respond and has been effective in reducing time for the appeals process as well as the number of appeals, while increasing improper payment recoveries.

#### *Oversight of Personal Care Services*

**Minnesota's** Surveillance and Utilization Review (SUR) unit<sup>2</sup> collaborates with the Department of Employment and Economic Development to review information on wages earned and hours worked to determine if PCAs have alternate employment. This information is often useful in investigations of suspect billing or conduct. The SUR unit has implemented system edits that impose daily and monthly service limits, identify conflicting claims, and check that claims are billed through an affiliated agency before they are paid. Minnesota's training requirements have also evolved into a three day program called "Steps to Success" for personal care provider organizations and an online training for individual PCAs.

**North Carolina** has contracted with an external entity to conduct independent assessments and reassessments in North Carolina's PCS program. The contractor processes all incoming physician office referrals and conducts beneficiary assessments to make a determination of whether or not a potential PCS beneficiary meets criteria to ensure the most appropriate use of services. Based on the assessment, the contractor issues service authorizations to qualified enrolled home care providers selected by the beneficiary and processes beneficiaries' requests to change PCS agencies. In addition, the contractor authorizes fiscal agent payments to the agency selected by the beneficiary, and payments are limited to the maximum daily allowable units and monthly authorized services. Work processes and directives are issued, approved, and monitored for quality by the state's Clinical Policy section. Consequently, North Carolina has seen a reduction in the number of beneficiaries using PCS and in average monthly expenditures since the inception of the program.

#### *Statutory Authority*

**Florida** has strengthened its efforts to combat Medicaid fraud and abuse by enhancing its regulatory authority and controls. A series of amended state rules have allowed the state to impose fines of up to 40 percent of provider overpayments and to more than double the fines for providers who do not furnish records in a timely manner. Enhanced administrative rules significantly increased sanctions and monetary penalties for egregious billing practices and repeated miss-billings. Under the same rule, failure to comply with Medicaid laws subjects the provider to a fine that can increase from \$500 to \$1,000 per claim, with a maximum penalty of up to 20 percent of the overpayment amount for first-time offenders. Fines for second-time violators have increased substantially per claim, up to 40 percent of the overpayment amount, and even higher with a third violation. Termination from the program may occur as early as the first violation and generally takes place by the second or third violation.

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<sup>2</sup> Many states refer to the staff that process surveillance and utilization reports as their "SURS unit." However, "SURS" is also the acronym for the MMIS component responsible for processing claims data and identifying any anomalies. It stands for Surveillance and Utilization Review Subsystem. For this report, we will refer to the staff as the "SUR unit" and "SURS" will refer to the component within MMIS.

### *Sanctions*

**Illinois** utilizes a wide range of sanctions to foster provider compliance, from provider education up to and including termination. The flexible provider lock-out programs include limiting provider participation for varying periods of time, disallowing the use of alternate payees or granting power of attorney to anyone else, requiring submission of tax returns, restricting a provider's practice to one site, and the use of individual corporate integrity agreements. By requiring certain providers to sign corporate integrity agreements as a condition of their continued participation in Medicaid, Illinois is able to commit providers to such program integrity obligations as adherence to a code of conduct and full compliance with all the statutes, regulations, directives, provider notices, and guidelines that are applicable to the State Medicaid Assistance Program. The corporate integrity agreement can also be used to require specific forms of training, education, and compliance with relevant certification and reporting requirements.



## Effective Practices – Program Integrity

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

**Table 3**

<p><b>Cooperation and Collaboration</b></p>	<p><b>Florida</b> has established regular meetings on program integrity issues and efforts with key internal and external stakeholders. This includes: regular meetings among bureaus within the state agency that are responsible for managed care, policy, quality management and program integrity; program integrity staff involvement in an Edits and Audits Task Force; program integrity participation in bi-weekly Medicare-Medicaid Data Sharing Initiative meetings; and bi-weekly meetings with Florida’s MFCU to discuss data mining, fraud detection projects, and referrals.</p>
	<p><b>Maine</b> has formed a Medicaid Fraud and Abuse Workgroup which has been successful in identifying and outlining ways to improve the detection of fraud by both providers and beneficiaries and the ability to conduct prosecutions. The workgroup consists of members from the Commissioner’s Office, the State Medicaid Agency, and the Attorney General’s Office, which represents both the MFCU and the Governor’s Office.</p>
	<p><b>Minnesota</b> has integrated program integrity practices and effective communications throughout all components of the state agency.</p>
	<p><b>Pennsylvania</b> uses multi-divisional teams for oversight of waiver services and the Medicaid claims processing system.</p>
	<p><b>Tennessee</b> has established a Provider Review Committee that reviews provider matters related to program integrity. The committee consists of the Director of Provider Services, the Division Chief of Managed Care Network, and the Chief of the Division of Audit and Program Integrity. Taking into account the advice of the state agency’s general counsel, the committee’s key function is to review and render decisions on provider-related program integrity issues.</p>
	<p><i>The State of</i> <b>Washington</b> has senior leadership involved in program integrity activities on a national level, and program integrity staff sits on all cross-divisional State Steering Committees and meets regularly with provider enrollment staff to discuss enrollment screening requirements, payment suspensions, reenrollment, and other Affordable Care Act initiatives.</p>
<p><b>Data Collection and Analysis</b></p>	<p><b>Arizona</b> utilizes a large contractor database, which combines personal data from multiple public and private databases, in developing fraud and abuse cases. The contractor maintains more than 17 billion records on individuals and businesses which the state’s Office of Inspector General uses as background information in its investigations.</p>
	<p><b>California</b> issues claims analysis reports to individual providers to see how their billing and/or prescribing trends compare with that of their peers statewide. The comparison with their peers is designed to positively change billing and/or prescribing behavior. For example, if a provider learns that he or she prescribes antibiotics more frequently than the average prescriber, he or she may modify the practice, thus resulting in cost savings to the Medi-Cal program.</p>
	<p><b>Florida</b> utilizes a wide range of surveillance and utilization review (SUR) tools to proactively search for potential fraud and abuse in the Medicaid program and to detect aberrant behaviors, over-utilization patterns, upcoding, unbundling, and double billing.</p>

<b>Data Collection and Analysis</b>	<p><b>Tennessee</b> has developed algorithms, which allow the review of data from other state agency databases, including the Department of Labor’s State Labor Work Force File and the Department of Health’s State Death File.</p>
	<p><b>Wyoming</b> has contracted for a fraud and abuse detection system that includes a case tracking component which allows the user to subsequently open a case and document all activities of the case until it is resolved. The system is web-based and provides querying capabilities for SUR activities, along with the ability to run customized fraud analytics, and can be accessed by the MFCU to conduct its own research.</p>
<b>Program Safeguard Activities</b>	<p><b>Organizational Structure</b></p> <p>Realignment in <b>Arizona</b> resulted in the transfer of the Fraud Prevention Unit to the state’s Office of Inspector General (OIG). The Fraud Prevention Unit processes referrals sent by a sister agency to confirm the eligibility of an applicant in a hospital setting when applying for Medicaid benefits. In calendar year 2011, the Fraud Prevention Unit conducted more than 7,000 investigations with a reported estimated cost avoidance savings of over \$23 million.</p> <p><b>Massachusetts</b> has an interdepartmental service agreement with the University of Massachusetts Medical School (UMMS) to perform SUR functions and other program integrity functions, such as audits. The organizational structure of UMMS’ Provider Compliance Unit mirrors that of the state’s Medicaid program, which facilitates communication with MassHealth analysts on policy issues related to program integrity.</p>
	<p><b>Special Projects</b></p> <p>In <b>California</b>, hospice audits were directed at the small percentage of hospice providers who failed to reimburse the Medicaid program for the share-of-cost they collected from patients in skilled nursing facilities. California also used a U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) case as a trigger for initiating an audit targeted at claims for power wheelchairs, which were far more costly than power scooters.</p> <p><b>Georgia</b> identified hospital claims with readmissions within three days of discharge for the same or related problem.</p>
	<p><b>Use of contractors</b></p> <p><b>Georgia</b> utilized a contractor to identify overpayments from dual-eligible claims.</p> <p>Since <b>New Jersey’s</b> recovery audit contractor program was implemented, the state has recouped over \$4,000,000 in overpayments and identified \$19,000 in underpayments. The contractor’s focus has been on hospital-related services; durable medical equipment; hospice; certain behavioral health services; long-term care; and laboratory claims.</p> <p><b>Rhode Island</b> compensates for limited staff by using its fiscal agent for data mining, claims analysis, and audit capabilities. The fiscal agent performs SUR functions and post-payment reviews using targeted queries.</p>

<b>Program Safeguard Activities</b>	<p><b>Provider Self-audits</b></p> <p><b>New Hampshire</b> utilizes provider self-audits to enhance its overpayment recovery actions. The use of a provider self-audit is a benefit to the SUR unit in light of the unit's limitations in staffing and resources. The SUR unit routinely identifies questionable claims through data analysis or complaints and will request a self-audit from the selected provider by letter. On occasion, a provider may proactively conduct a self-audit.</p> <p><b>New Mexico</b> uses provider self-audits to capture more improper payments than program integrity staff could do alone through state-initiated audits and investigations. The Medicaid agency does not require providers to conduct self-audits; however if the provider chooses not to participate in the self-audit then the Program Integrity Unit conducts a full audit of that provider.</p> <p><b>Pennsylvania</b> utilizes both state-initiated provider self-audits and provider-initiated self-audits.</p>
	<p><b>Arizona</b> continues to expand its state statutory authorities to enhance its ability to monitor, prevent, detect, and take more effective actions against fraud and abuse.</p>
	<p><b>Illinois</b> implemented greater controls in group psychotherapy and Non-Emergency Medical Transportation (NEMT) services. This included promulgating rules limiting who could provide group psychotherapy and the frequency of those services, and implementing a Psychiatric Services Treatment Plan form that must be completed before transportation to behavioral health services will be authorized.</p>
	<p><b>Illinois</b> has implemented initiatives aimed at improving the efficiency and overall management of administrative hearings within the agency, which has resulted in doubling the number of cases resolved and dollars recouped.</p>
	<p><b>Minnesota</b> maintains a beneficiary lock-in program that works closely with managed care entities (MCEs) to bring about universal restriction, which means that regardless of whether beneficiaries are initially restricted by an MCE or the FFS Medicaid program, the restriction will follow the beneficiaries if they change plans, move from FFS to managed care, or vice versa.</p>
	<p><b>North Carolina</b> has worked with contractors to build a prepayment review program. This program places providers on notice that 100 percent of their claims will be reviewed manually before they are paid because of problems noted in either the volume or billing of claims.</p>
	<p><b>Pennsylvania</b> maintains a state exclusion list which is accessible through its website, and providers are directed to search potential employees against the list.</p>
	<p><b>Wyoming</b> has implemented a comprehensive program for verifying services with beneficiaries on a monthly basis and has an approximate 30 percent return rate.</p>

## **Weaknesses in Program Integrity**

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

Federal Medicaid regulations require all state agencies to:

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

### **Centralized Program Integrity Function**

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

*Vulnerabilities* – Three states lacked a centralized program integrity function, limiting the state's ability to identify, investigate, and refer fraud. The lack of a single unit that has overall responsibility for program integrity compliance and implementation was related to problems such as inadequate or fragmented systems for tracking audits, investigations, and fraud referrals. Additional issues included lack of communication across divisions, inconsistent application of state policies such as sampling and extrapolation, failure to make use of payment suspensions and withholds, and the inconsistent reporting of adverse actions against providers. Without a centralized program integrity function, states may encounter problems involving unreported issues, duplication of effort, jurisdictional conflicts, and poor coordination of program integrity efforts.

### **Ineffective Surveillance and Utilization Review Operations**

State Medicaid Agencies must have effective processes and systems designed to identify overutilization, abusive billings, waste, and outright fraud. The traditional Surveillance and Utilization Review Subsystem (SURS) in each state's MMIS is one fundamental program integrity tool, but many states have added sophisticated refinements and enhancements. Where states do not have adequate policies and procedures or platforms in place for performing effective pre-payment and post-payment reviews, they place themselves at risk for allowing improper payments.

*Areas of Non-Compliance* - One state was cited for non-compliance with 42 CFR 456.3, which requires the state to implement a statewide surveillance and utilization control program to safeguard against inappropriate use of Medicaid services and excess payment of Medicaid funds. The state only had one staff member who was running limited reports, and staff was unable to perform data mining, algorithm development, or automated exception processing. Most of its investigations were generated from complaints. Furthermore, the state has not used its SURS since the previous CMS review, indicating that the entire subsystem was deemed unusable and turned off after incorrect SURS reports were generated from data supplied by the MMIS.

Another state was not in compliance with 42 CFR 456.4, 456.6, and 456.22, as it did not

have policies and procedures for monitoring its SUR program, did not have appropriate clinical staff available to properly monitor utilization of services, and did not have policies and procedures for an ongoing evaluation of services through a sample basis. Three states failed to comply with 42 CFR 455.21, which requires the state to refer all cases of suspected provider fraud to the MFCU, comply with document requests from the MFCU, and initiate administrative or judicial action for cases referred to the state by the MFCU.

*Vulnerabilities* - Two states lacked policies and procedures for program integrity functions. The absence of written policies and procedures leaves the state vulnerable to inconsistency in its operations.

### **Suspension of Payments**

Effective March 25, 2011, the revised federal regulation at 42 CFR 455.23 requires State Medicaid Agencies to suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending, unless the agency has good cause not to suspend, which must be documented. The regulation also addresses requirements on provider notifications, coordination with MFCUs on the continuation or cancellation of payment suspensions, fraud referral guidelines, and the reporting of payment suspensions to the HHS Secretary.

*Areas of Non-Compliance* - Twelve states were not in compliance with the federal regulation at 42 CFR 455.23. Issues included not suspending payments to providers, not documenting when a good cause exception was implemented, not meeting all requirements of the regulation in the notice to the provider, and not meeting the CMS guidelines when referring to the MFCU. Ten states had not implemented payment suspensions in cases referred to MFCU after March 25, 2011, when the regulation went into effect. Two states indicated that they were not able to do so, as there was no state authority to support this action, and in one of these states, no action could be taken unless it was ordered by the Superior Court. In addition, of the 10 states not suspending payments, five had no written documentation for a good cause exception, although several claimed to have verbal requests from the MFCU to not suspend payments. In two states, referrals to the MFCU did not meet the CMS guidelines now incorporated in 42 CFR 455.23. In two other states, the notice to the provider did not contain all elements required by the regulation.

### **Notification of State-Initiated Exclusions (Provider Terminations)**

*Areas of Non-Compliance* - Nine states were not in compliance with 42 CFR 1002.212 because they failed to notify certain individuals and entities of a state-initiated exclusion.

*Vulnerabilities* - Despite having the authority to initiate permissive exclusions of providers, three states have not applied this program integrity compliance and enforcement tool. This can result in the retention of providers with questionable program integrity records in the Medicaid program. In addition, one state had not developed policies and procedures for implementing state-initiated exclusions.

### **Reporting of Local Convictions**

*Area of Non-Compliance* - One state was not in compliance with 42 CFR 1002.230, which requires that the State Medicaid Agency must provide notice to HHS-OIG, within specified timeframes, when an individual has been convicted of a criminal offense related to the delivery of health care items or services under the Medicaid program, unless the MFCU has already

provided such notice. Neither the state nor the MFCU was notifying HHS-OIG of criminal convictions, and the state-MFCU Memorandum of Understanding did not discuss which entity was responsible for reporting to HHS-OIG.

### **Oversight of Non-Emergency Medical Transportation (NEMT)**

*Vulnerabilities* - Two states lacked effective oversight over their NEMT programs. In one case, the state had not obtained provider ownership and control disclosures or criminal conviction disclosures (even though background checks are done), conducted exclusion checks on private transportation vendors or drivers, or verified the provision of services with beneficiaries. This was a repeat issue for this state. In another state, the SUR unit did not have access to the NEMT claims processing system, and there was no program integrity guidance or policy communication between the SUR unit and the staff who oversee the NEMT program.

### **Additional Areas of Non-Compliance**

Section 1902(a)(68) of the Social Security Act includes requirements for providers and contractors regarding Federal False Claims Act policies and handbooks. Problems in nine states included not reviewing providers' policies and handbooks, and not conducting compliance reviews of providers receiving or making payments of at least \$5 million.

One state failed to comply with 42 CFR 455.20, which requires verifying with beneficiaries whether services billed by providers were received. This state was not verifying services in its In-Home Support Services and disabled services centers. This was a repeat finding.

Two states were not in compliance with 42 CFR 455.15, which requires that Medicaid agencies in states with no certified MFCU conduct a full investigation of each case in which fraud or abuse is suspected or refer the case to the appropriate law enforcement agency, and that the state refer suspected cases of recipient fraud to an appropriate law enforcement agency. One of the states that had no MFCU did not adequately conduct a full investigation, deferring instead to the MCEs to do so. Although the MCEs did initially report the case, the state did not remain involved to ensure that an adequate full investigation occurred and that appropriate steps were taken to resolve the issue. This was also a repeat finding. The other state was not referring potential beneficiary fraud to an appropriate law enforcement agency. Instead, cases of suspected beneficiary fraud were referred to county departments of social services, which were then responsible for referring to law enforcement.

## Provider Enrollment and Disclosures

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

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

### Noteworthy Practices

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The CMS identified several noteworthy provider enrollment practices from its comprehensive program integrity reviews. The CMS recommends that other states consider emulating these activities.

Several states are striving to reduce the risks associated with provider enrollment by streamlining enrollment processes for all provider types. This provides consistency in enrollment processes between FFS and managed care programs, and helps to screen providers in high risk services like PCS.

Both **Arizona** and **Illinois** require that all managed care network providers be enrolled with the State Medicaid Agency in the same manner as FFS providers. This standardization has eliminated discrepancies found in many states where managed care network credentialing standards may differ from the state's enrollment processes, and the state is relying on contracted MCEs to collect network provider disclosures, check providers and affiliated parties for exclusions, and oversee other aspects of the provider enrollment process.

In PCS, **Minnesota** requires that personal care attendants be enrolled as individual providers, that they undergo required provider training, and that they establish affiliations with home health agencies or personal care provider organizations and bill through these agencies. Similarly, **North Dakota** requires all personal care assistants and the agencies that employ them be enrolled in the Medicaid program and complete the same enrollment process as FFS providers.

Another state is utilizing more stringent controls during the enrollment process to ensure providers understand the requirements of the program, which in turn, later assists the state during administrative appeals. **Maine** requires all providers to attest to having read the terms and conditions of its provider manual prior to participation in the Medicaid program, and to certify that they understand key sections of the manual and will abide by the terms and conditions. This procedure strengthens the state's ability to have enforcement actions upheld during the appeals process in civil cases where the state later finds providers who falsified their applications in some way or engaged in fraudulent or abusive billing practices.

## Effective Practices – Provider Enrollment and Disclosures

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

**Table 1**

<b>Exclusion</b>	<b>Utah’s</b> expanded provider file database allows the provider enrollment section to capture and maintain all disclosure information on FFS and managed care providers. This expanded provider file capacity provides the state the opportunity to monitor excluded individuals at all levels of a business entity.
	<b>Checks</b>
<b>Background</b>	In <b>Tennessee</b> , all MCE providers are registered and assigned a provider identification number in the Tennessee MMIS. The presence of a single repository of registered providers gives the state the capacity to perform comprehensive monthly exclusion and debarment checks on MCE personnel and network providers to keep disqualified individuals out of the TennCare system.
	<b>Illinois</b> performs background checks, fingerprinting, verification of safety training certification, and onsite visits prior to enrolling non-emergency transportation providers.
	<b>New Mexico</b> requires criminal background checks and fingerprinting of all providers who will have “direct, unsupervised contact with clients.”
	<b>Checks</b>
<b>Additional Efforts</b>	<b>North Carolina</b> conducts extensive background checks on multiple state and national databases for all names disclosed during the enrollment process.
	<b>New Jersey’s</b> Medicaid Fraud Division performs background checks on provider types known to be high risk for fraudulent activities. The unit reviews all new applications and change of ownership requests.
	<b>Colorado’s</b> HCBS programs consult with the Program Integrity Unit prior to enrolling a potential provider.
	<b>Florida</b> has implemented a web portal provider enrollment system, and has automated its license verification processes to allow daily checking of provider licensure information and weekly checking of facility licensure data.
	<b>Georgia</b> realigned the provider enrollment function under the Program Integrity Unit. This change permits a more direct involvement in monitoring the enrollment of providers wanting to enter the Georgia Medicaid program.
	<b>Maine</b> centrally enrolls all providers, and providers have the option of enrolling electronically through a web portal.
	<b>Minnesota’s</b> provider agreement includes live hyperlinks to all relevant state and federal regulations. This facilitates provider awareness of their legal obligations and enables applicants to read the pertinent regulations in full.
<b>Pennsylvania</b> enrolls all managed care network providers in the same manner as FFS providers.	



## Weaknesses in State Provider Enrollment Processes

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Inadequate enrollment safeguards expose state programs to fraud, waste, and abuse by providers who should not be enrolled in the Medicaid program. Comprehensive state program integrity reviews have identified areas of vulnerability and/or areas of non-compliance with federal regulations regarding provider enrollment in all program integrity reviews conducted by CMS since 2007.

- Provider enrollment issues are the most frequently cited area of non-compliance and vulnerability in state program integrity reviews.
- Vulnerabilities can have greater negative impact on program integrity than do some areas of non-compliance with federal regulations.

### Disclosures

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

*Areas of Non-Compliance* - CMS found that none of the 22 states included in this report were in full compliance with all three regulations on disclosures. Some states were out of compliance with all three disclosure regulations. For the most part, states attempted to correct their enrollment issues after CMS's first comprehensive review. Our second reviews found that some states were successful in correcting their areas of non-compliance. However, while other states did make a number of corrections in their practices, the problems were not completely resolved at the time of CMS's second review. In addition, a substantially revised regulation on ownership and control disclosures at 42 CFR 455.104 took effect on March 25, 2011. Many of the states covered in this summary had not yet modified their provider applications and managed care and fiscal agent contracts to account for the new disclosure requirements at the time of their onsite reviews.

All 22 states included in this report were not in compliance with 42 CFR 455.104 which requires ownership and control disclosures. For 18 of the 22 states, this remains an uncorrected or partially uncorrected finding from CMS's previous comprehensive review. Similarly, 14 states were not in compliance with the regulation at 42 CFR 455.105(b)(2), requiring disclosure of business transaction information upon request, which was a repeat finding for 9 of the states.

Nineteen states were also not in compliance with 42 CFR 455.106, which requires disclosure of health care-related criminal convictions. This was a repeat finding for five of the states.

*Vulnerabilities* – Some states did not collect disclosures from managed care network providers that federal regulations would otherwise require from FFS providers. Of the 22 states included in this report, 13 failed to require disclosure of business transaction information upon request; 13 did not collect disclosures of ownership, control and

relationship information; and 13 failed to collect disclosures of criminal convictions from managed care network providers.

In addition, 10 states did not capture disclosure information about managing employees during the FFS or managed care enrollment process and/or store the information in the MMIS or another searchable repository. States that do not collect these disclosures have no way of knowing if excluded individuals are working for providers or health care entities in such positions as billing managers and department heads. States that collect the disclosures but lack storage in a searchable database cannot perform automated exclusion checks on an ongoing basis.

### **Reporting of Adverse Actions**

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

*Areas of Non-Compliance* - Ten states failed to comply with 42 CFR 1002.3(b). This was a repeat finding for seven of those states.

*Vulnerabilities* - Fourteen states did not report all program integrity-related adverse actions taken on managed care network provider applications. In some cases, the state's MCE contract did not require the MCE to notify the state when taking actions for program integrity reasons. The failure of MCEs to notify the Medicaid agency of such adverse actions may make it easier for problem providers to find their way into other MCEs and the FFS program undetected. It also precludes the state from reporting such actions to the HHS-OIG.

### **Exclusion Searches**

State Medicaid Director Letter (SMDL) #08-003 was issued on June 12, 2008 and provided guidance on checking providers and contractors for excluded individuals. This guidance was later superseded by the new federal regulations at 42 CFR 455.436, which took effect on March 25, 2011, and requires State Medicaid Agencies to undertake additional database searches. Many reports covered in this annual report were issued after the new regulations took effect, and many states were cited for related findings and vulnerabilities because they had yet to adapt their policies and procedures to the new database search requirements. An additional SMDL (#09-001) was issued January 16, 2009, and provided further guidance to states on how to instruct providers to screen their own staff and subcontractors for excluded parties. These SMDLs are available on the CMS website at [Federal Policy Guidance](#).

*Vulnerabilities* - Sixteen states were either not conducting any exclusion searches (in FFS and/or managed care programs) or the exclusion searches were incomplete.

### **Verification of Provider Licenses**

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

### **Provider Applications**

*Vulnerabilities* - One state's FFS provider enrollment application included a disclosure form that had confusing instructions which led to some applicants omitting required information

related to criminal convictions.

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

## Managed Care

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

States should provide closer oversight of the program integrity policies and activities in managed care programs. Part of this oversight involves ensuring that MCE contracts include essential program integrity provisions and that managed care plans are monitored for compliance.

Regarding program integrity in Medicaid managed care, states should keep in mind:

- States are responsible for the appropriate use of Medicaid funds paid to MCEs.
- MCEs should be actively involved in combating fraud and abuse.
- State-MCE contracts should include requirements for fraud and abuse prevention and reporting.

### Noteworthy Practices

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

#### Enrollment in Medicaid

**Wisconsin's** MCEs are contractually required to use only those providers who have been enrolled by the state, except in emergency situations. This practice minimizes the risk of excluded providers receiving state and federal funds through an MCE, removes the burden of data collection from individual MCEs, and reduces duplicate requests for information from providers who may participate in more than one MCE and/or also be a FFS provider.

#### Oversight of Managed Care Investigations

**Rhode Island's** managed care division provides enhanced oversight of managed care provider investigations. There is a close working relationship between the state, MCEs, and MFCU. The state requires MCEs to report all active and closed investigations on a quarterly basis. The reports are sent to both the state and the MFCU. During quarterly meetings between the state's program integrity staff and MCEs, cases are reviewed and findings discussed. In addition, MCEs refer all cases of suspected fraud to the MFCU within five days of determination, and simultaneously notify the state. Overall, the enhanced communication ensures timely investigations and allows the MFCU to be involved in providing guidance and follow up as needed.

#### Managed Care Operations Manual

**Tennessee's** Program Integrity Unit has developed a written comprehensive program integrity manual to serve as a resource for TennCare and contractors so they can see how all the moving parts of managed care program integrity fit together. The manual is designed to

promote coordination and synchronization within the TennCare program to ensure program accountability and wise use of resources. Contractors are given a copy of the operations manual as part of their operating procedures within the TennCare program.

## Effective Practices – Managed Care

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

**Table 2**

<b>Credentialing and Disclosure Forms</b>	<b>Tennessee</b> requires that MCEs use a common disclosure form when enrolling and/or credentialing network providers.
<b>Communication</b>	<b>Arizona</b> conducts a semi-annual Compliance Officer Network Group meeting that includes all MCE compliance officers and other external stakeholders. The meeting provides training and updates on fraud and abuse issues for all participants.
	<b>Florida</b> has established regular meetings among key components within the state agency responsible for managed care programs, including program integrity. Florida also conducts technical assistance calls and quarterly meetings to educate MCEs regarding the state’s program integrity expectations and has conducted a webinar on fraud and abuse reporting.
	In <b>Georgia</b> , MCEs seek guidance from program integrity staff before proceeding with investigations in the managed care program to determine if the provider is under investigation by another entity. In addition, the state holds quarterly meetings with its MCEs to discuss and review information on fraud and abuse issues.
	<b>Massachusetts</b> conducts regular meetings with MCEs, the Program Integrity Unit, and MFCU. In addition, Massachusetts contacts all MCEs when any plan terminates a provider for cause and notifies the FFS side of Medicaid.
	<b>New Jersey’s</b> Medicaid Fraud Division hosts monthly meetings with MCEs to provide guidance in developing cases, and the MFCU meets quarterly with MCEs to provide training on current fraud and abuse schemes and discuss cases.
<b>Oversight</b>	<b>Florida</b> has developed a “Fraud and Abuse Tool Kit” which MCEs must use during the contracting process to ensure compliance with core program integrity provisions. Florida also developed a checklist to assess MCEs’ compliance with licensure and certification provisions and the collection of required disclosures in their credentialing and re-credentialing processes.
	The State of <b>Washington</b> has developed a two-tier system to monitor MCEs that includes a focus on program integrity and involves staff from managed care and quality care management, along with a second-tier review by the state’s External Quality Review Organization.

## **Weaknesses in State Managed Care Programs**

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

*Areas of Non-Compliance* - Two states failed to have policies or contractual language demonstrating compliance with 42 CFR 1002.203, which requires that the state have provisions to exclude certain MCEs from participation if these entities could be excluded based on their relationship with another entity or individual that has had a criminal conviction or civil monetary penalties due to health care-related fraud or abuse, or has been excluded from participating in Medicare or a state health program.

*Vulnerabilities* - Thirteen of 22 states failed to ensure that their MCEs had a method to verify with beneficiaries receipt of managed care services either through Explanations of Medical Benefits or other appropriate methods. This is another area where program integrity safeguards required in the FFS program do not always carry over into managed care delivery systems.

A general lack of oversight over the delivery of managed care services was a problem for six states, leaving the states particularly vulnerable to fraud and abuse in their managed care programs. As noted earlier, issues in provider enrollment, such as the collection of disclosure information related to ownership and control interest and health care-related criminal convictions, often extends to the managed care environment. Numerous states did not closely monitor whether MCEs were collecting the appropriate disclosures from their network providers during the credentialing process. Additional problems found by the CMS review teams included, but were not limited to, a lack of policies and procedures for managed care oversight and insufficient monitoring of MCEs' program integrity efforts.

A broad range of issues were observed in managed care program integrity, including:

- Inadequate review of MCE compliance plans,
- Not ensuring that MCEs check for debarred or excluded individuals,
- Insufficient monitoring of contract compliance,
- Not requiring MCEs to report all cases of fraud and abuse to the state,
- Not staying informed of ongoing MCE investigations, and
- Not ensuring that excluded providers were prevented from participating in the managed care system.

# Medicaid Fraud Control Unit

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## State Interactions with MFCUs

A well-functioning and committed partnership between the state Program Integrity Unit and its MFCU will result in the strengthening of program integrity efforts within the state Medicaid program.

To maintain an effective relationship with the MFCU, each state should:

- Meet regularly with the MFCU.
- Develop and consistently apply one standard for deciding when to refer a matter to the MFCU.
- Ensure that every referral meets the CMS performance standards.
- Update the MFCU on ongoing investigations.
- Offer education and consultative services.
- Reconcile program activities with the MFCU.

In 2008, CMS published two documents to assist states in continuously improving their relationship with the MFCU. CMS uses these documents to evaluate the state-MFCU relationship during program integrity reviews. The guidance document titled, *Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units* contains ideas from state Program Integrity Units nationwide, including practical ideas for maximizing a Program Integrity Unit's return on investment from the relationship with its MFCU. It also contains specific examples of actions taken by states that have created well-functioning and committed partnerships between the two entities. CMS's *Performance Standards for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit* provides details on the collection of information that makes up an appropriate MFCU referral. Effective March 25, 2011, the referral performance standards were given the force of law as part of the regulation at 42 CFR 455.23. Both documents can be found on the CMS website at [Medicaid Guidance Fraud Prevention](#)

## Effective Practices – State Interactions with the MFCU

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States self-reported several practices in maintaining good relationships with their respective MFCUs that they believe to be effective and demonstrate their commitment to program integrity. The CMS does not conduct a detailed assessment of each state-reported effective practice.

Table 4

Referrals	<b>Massachusetts</b> has a high rate of referrals accepted by the MFCU due to ongoing training of program managers on the kinds of provider and program information needed by the MFCU to help it successfully prosecute provider fraud and also due to the development of policies and procedures for referring provider cases to the MFCU that involve credible allegations of fraud.
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	<p><b>Minnesota's</b> collaborative and strong working relationship with the MFCU has resulted in an increased volume of quality referrals to the MFCU, support from the MFCU to implement payment suspensions based on reliable or credible evidence of fraud, and ongoing training for personal care provider organizations by the MFCU. Further, the MFCU has an MOU with each of the four largest Medicaid MCE contractors.</p>
	<p>The referral form used by <b>Utah</b> was developed in collaboration with the MFCU and contained all of the mandatory performance standards. Both units work closely in deciding which cases should be referred.</p>
<b>Regular Meetings</b>	<p>The State of <b>Utah</b> and its MFCU meet formally on a monthly basis to discuss cases and other relevant issues, with additional contacts occurring in person or via e-mail. The state's MCEs are included in these meetings at least quarterly. In addition, both units provide cross-training as needed.</p>

## **Weaknesses in State Interactions with the MFCU**

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The *CMS Performance Standards and Best Practices* documents have served as the standards for evaluating states' relationships with their MFCUs. In addition, as mentioned previously in the report, one of the implementing regulations of the Affordable Care Act laid out additional requirements for MFCU referrals that were applicable to those reviews that occurred after March 25, 2011. Findings related to the regulation at 42 CFR 455.23 can be found in the **Program Integrity** section of this report, under "Suspension of Payments."

*Vulnerabilities* - Improvements have been noted in this area since the last series of reviews was reported. Among the 22 states noted in this report, the CMS review teams identified three vulnerabilities in two states. One state utilized separate databases for investigations and referrals to the MFCU, respectively. However, these databases were not linked in a manner so that all information about a case could be tracked, and the team could not determine the status or the rationale for the referral of two cases sent to the MFCU. In the second state, both the state agency and the MFCU reported the relationship between the two organizations as inharmonious, citing examples of variances in practices, policies, and terminology which resulted in significant challenges to each organization's ability to achieve its goals. In addition, this state had yet to implement the new referral standards, and was, instead, utilizing procedures jointly established with the MFCU from an earlier date.



## Conclusion

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States have continued to implement effective and noteworthy practices that demonstrate a strong commitment to program integrity. CMS supports these efforts and encourages states to look for additional opportunities to improve overall program integrity. However, the reviews discussed in this report show that states also have areas of weakness either newly identified or uncorrected in whole or in part from previous reviews. CMS will work closely with states to ensure that all issues, particularly those that remain from previous reviews, are resolved as soon as possible. For additional information or for questions about issues discussed in this report, please contact the Medicaid Integrity Group at [Medicaid Integrity Program@cms.hhs.gov](mailto:Medicaid_Integrity_Program@cms.hhs.gov).