Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Program Integrity Review Annual Summary

May 2009

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INTRODUCTION

In March 2007, the Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) began its first year of reviewing States' Medicaid program integrity procedures and processes. Eight comprehensive reviews - Arkansas, Connecticut, Delaware, Michigan, Missouri, Nevada, Oregon and Virginia - were conducted in Federal fiscal year (FFY) 2007. Nineteen comprehensive reviews were conducted in FFY 2008 – Georgia, Idaho, Illinois, Iowa, Minnesota, New Mexico, North Carolina, North Dakota, Oklahoma, Pennsylvania, Puerto Rico, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Wisconsin, and Wyoming. Beginning with FFY 2008, MIG will conduct annual comprehensive program integrity reviews of one-third of the States (including Puerto Rico and Washington D.C.).

The objectives of the reviews are to: (1) determine compliance with Federal program integrity laws and regulations; (2) identify program vulnerabilities and effective practices; (3) help the State improve its overall program integrity efforts; and, (4) consider opportunities for future technical assistance.

For the entirety of this past year's reviews, MIG review teams identified noteworthy practices, which are practices that MIG believes represent innovative processes that successfully further important program integrity goals. Over time, MIG gradually expanded the focus of the reviews to include gathering information concerning program integrity practices utilized by a State that it identifies as particularly effective. During 2008, review reports began to include both categories of practices under the heading *Effective Practices*. Thus, in the *Effective Practices* sections below you will find both those practices the MIG review team believed to be particularly noteworthy as well as those practices which the State itself identified as effective. The MIG's practice of including each State's self-reported effective practices in its reports is meant to provide an opportunity for States to share what they consider to be examples of their commitment to improving program integrity in their Medicaid program.

This report is a compendium of data collected from the 19 comprehensive reviews conducted in FFY 2007 and 2008 for which final reports have been issued. The report includes information about noteworthy practices, effective practices, areas of vulnerability, and areas of non-compliance. The MIG hopes that this report will assist each State in assessing where it is positioned along the fraud and abuse prevention continuum and in selecting appropriate enhancements that fit each State's needs.

EFFECTIVE PRACTICES – PROVIDER ENROLLMENT AND DISCLOSURES

Noteworthy Practices
Preventing abusive or fraudulent entities and individuals from becoming Medicaid providers is a significant part of an effective Medicaid program. The MIG review teams identified the following noteworthy practices regarding provider enrollment and disclosures:

- *Georgia's* program integrity and provider enrollment areas, though part of different divisions, communicate and cooperate with each other to an unusual extent. For example, the units jointly conduct onsite reviews of skilled nursing facilities at which they screen all employees against both the Federal List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System. The program integrity area also performs supplementary provider enrollment functions during fraud and abuse onsite reviews, which helps compensate for provider enrollment area staff limitations.
- *North Carolina* uses at-will provider contracts. It has terminated provider contracts for failure to comply with State rules, clinical policy, regulations and guidance, failure to provide documentation of services rendered and billed, and questionable quality of care and billing practices.
- *Oklahoma* requires providers to re-enroll every three years. During re-enrollment, providers must complete a new application. If they do not, their contracts lapse. All contracts for a given provider type expire at the same time, regardless of when the contract began.
- *Texas* purchased an innovative software package that automates the verification of licenses of potential Medicaid providers and ensures that Medicaid does not allow payments to non-qualified health care providers. The software allows the State to match a provider's information against the State Master File, the LEIE, the Texas State Provider exclusion list, the Texas Medicaid Do Not Enroll List, and the Open Investigations list, so the user can easily determine if the provider is eligible to be enrolled.
- *Wyoming* instructs its fiscal agent to terminate all providers whose mailings have been returned to the contractor, eliminating the ability of those providers to bill Medicaid unless and until the fiscal agent gets the correct mailing address, enhancing the provider enrollment and system maintenance capabilities. The process began approximately two years ago and has resulted in a dramatic decrease in the number of providers with inaccurate addresses. In addition, the fiscal agent terminates providers who have not filed a claim within the past 365 days or providers who have not updated their license.

Effective Practices
The States identified the following provider enrollment practices as being effective:

- *Illinois* maintains its own sanctions database. The system tracks providers who have been or are currently in the process of being sanctioned by the State, and also includes Department of Health & Human Services Office of Inspector General (HHS-OIG) exclusions and reinstatements. The database is updated monthly. Illinois uses the system to screen providers during initial enrollment, within seven days after enrollment, and on a monthly basis. *South Carolina* also maintains a web-based exclusion database.
- *North Carolina* uses its permissive exclusion authority to remove aberrant providers. The State identified and terminated two providers based on their billing practices and failure to provide records.

EFFECTIVE PRACTICES – PROGRAM INTEGRITY

Noteworthy Practices

Federal regulations require that States identify and investigate potential fraud and abuse. The MIG review teams identified the following program integrity practices as being particularly noteworthy. The noteworthy practices have been divided into *Cooperation and Collaboration, Data Collection and Analysis, Program Safeguard Activities*, and *Additional Efforts* sections.

Cooperation and Collaboration

- *North Carolina* sends new policy issuances to the Program Integrity (PI) Section for comment before being released. This practice affords the State a critical review of policies by the PI Section that may ultimately be interpreted and enforced by the PI Section.
- *Oklahoma's* Quality Assurance (QA) committee formulates organizational quality improvement policy and oversees the overall coordination and management of quality assurance activities, including those of the program integrity area. The program integrity area utilizes the QA committee, which is composed of representatives from all components of the Medicaid agency, as a cross-check on its core activities. The QA committee reviews surveillance and utilization review subsystem (SURS) findings and audits and recommends actions such as referrals, provider education, or termination to the State Medicaid Director for final decision. Referral actions against providers can be sent to the Medicaid Fraud Control Unit (MFCU) or the appropriate licensing board.
- *Virginia* has focused on program integrity as an agency-wide priority, reorganizing the Program Integrity Division and hiring a new management team. In addition, the agency targeted durable medical equipment (DME), home health care and pharmacy services as priority areas. The State increased program integrity staffing, while contracting with nationally recognized companies to undertake specialized audits. Other activities initiated to strengthen the Commonwealth's program integrity efforts include: enhancing tracking systems and processes; playing a larger role in Federal program integrity activities (such as participation in the Medicaid Fraud and Abuse Technical Advisory Group); and improving its relationship with its MFCU.

Data Collection and Analysis

- *Arkansas* compensates for limited staff resources by using data-mining services and claims analysis provided by the State's fiscal agent and its quality improvement organization (QIO). The fiscal agent's data warehouse holds seven years of claims data and can be used to rank providers, generate other standard reports or develop customized reports. The QIO utilizes its own data-mining software in retrospective reviews of claims and services and has identified overpayment situations for the State.
- *Arkansas* has undertaken a time-dependent analysis of mental health providers who are suspected of billing for simultaneously providing different kinds of services in different places. It has also initiated similar analyses of overlapping provider billings in several home and community-based services waiver programs.

- *Wyoming* compensates for limited staff resources by using data-mining services and claims analysis provided by the State's fiscal agent. The contractor maintains a data warehouse and decision-support system that is used to rank providers, generate other standard reports, and develop customized reports. Since 1997, the SURS within the Medicaid Management Information System (MMIS) has been supplemented with tools that provide a peer-to-peer analysis across a provider-specific claim type, advanced data analysis and filtering to analyze the universe of claims for abnormalities, and a query system.

Program Safeguard Activities

- *Georgia* initiated a project to validate the physical business address of all DME suppliers by performing a visual check. The suppliers with questionable addresses are reviewed for possible fraudulent practices. The State will continue to utilize this verification process method on all newly enrolled DME suppliers. Another initiative involves an audit of the top five power wheelchair suppliers. Georgia determines if the supplier billed for a more expensive wheelchair than actually provided. A survey is sent out to selected clients to complete. As part of the survey, the clients review pictures of wheelchairs and scooters and identify the type of equipment they received by circling the appropriate picture. Based on the discrepancies detected, the investigators conduct an onsite visit comparing the equipment with the DME supplier's billing.
- *Illinois* conducts site visits on all non-emergency medical transportation (NEMT) providers, during which the State verifies the address and inspects licenses. New transportation providers are also subject to mandatory criminal background checks, and are placed on probation for 180 days, during which time Illinois' Office of Inspector General (OIG) monitors their claims. All DME providers also receive onsite reviews, during which the State checks inventory to determine whether it is reasonably related to billings. Moreover, both NEMT and DME providers must re-enroll in the Medicaid program on a periodic basis.
- *Michigan* can impose a summary suspension (i.e., in high-dollar or otherwise egregious cases of fraud) that temporarily abrogates the existing Medicaid provider agreement and freezes all Medicaid payments until a provider has exhausted all administrative remedies or has been convicted in a court of law. The passage of a State Whistleblower Law in 2005, which offers incentives to the public to report serious cases of fraud and abuse directly to the MFCU, has enhanced the State's ability to combat fraud, waste, and abuse. State Whistleblower Law
- *North Carolina* follows up on every returned explanation of medical benefits (EOMB) by documenting each EOMB returned and telephoning the recipient. The State also recently added four questions to EOMBs which the State believes has increased the rate of return from 12 percent in 2005 to 50 percent currently.

Additional Efforts

- *Iowa* has a robust lock-in program through a contractor. The program has a cost savings of approximately $2 million annually. Recipients abusing the program are locked into a primary care physician, pharmacy, and hospital/emergency room. The lock-in program

creates a safety net approach and limits the recipient's ability to obtain drugs. The program also identifies providers who may be engaging in unsound medical practices.

- *Iowa* approaches document management with a paperless office methodology. The State utilizes content-management software that combines integrated document management, business-process management, and records management. The software has enabled Iowa to retain records for an indefinite period of time.

- *Oklahoma* has incorporated a State-initiated payment error rate measure, with a targeted error rate of no more than five percent, with an objective of changing provider behavior to improve health care quality. Because payment error rate reduction is a national priority, Oklahoma's effort at improving payment error rates within the state is a proactive measure that helps to improve the economy and efficiency of the program. Oklahoma is scheduled for the CMS Payment Error Rate Measurement review in FFY 2009.

Effective Practices

States have reported the following program integrity practices as being effective. State-identified effective practices have been divided into *Cooperation and Collaboration, Data Collection and Analysis, Program Safeguard Activities*, and *Additional Efforts* sections.

Cooperation and Collaboration

- *North Carolina's* Division of Medical Assistance has collaborated with the Division of Mental Health to conduct audits of behavioral health providers. The review process is enhanced by the Divisions' shared policy and integrity experience.

- *North Dakota's* staff, both within the Fraud and Abuse Unit and in other parts of the State agency, communicate well with each other. There are no artificial barriers between organizational units which limit the ability of the program integrity staff to gather information and work cohesively to resolve fraud and abuse issues.

- *Utah's* Bureau of Program Integrity (BPI) includes all internal components involved in program integrity in its meetings and communications. Utah's contracted managed care organizations (MCOs) also take part in monthly BPI meetings.

Data Collection and Analysis

- *Illinois* utilizes a centralized case tracking system that consolidates case management functions for all State OIG investigative, audit, and review activities. The system enables staff to utilize historical information to inform current fact-finding efforts, and interfaces with other State information systems as well as their medical data warehouse. Documents are scanned or imported into the system to create electronic case files, and letters are automatically generated. Additionally, the system facilitates communication and joint decision making regarding provider sanctions as well as tracking of external agency actions (e.g., criminal prosecutions, global settlements).

- *North Dakota* has an experienced full-time investigative pharmacist who is both a subject matter expert on drug issues and committed to identifying and eliminating fraud and abuse across the program. This pharmacist is involved in devising tracking mechanisms and setting up creative data collection methodologies.

- *Oregon's* SURS staff perform creative data analysis in identifying different types of fraud schemes, provider abuse, and overpayment situations, and staff generate backup confirmation for queries developed through the Office of Payment Accuracy and Recovery's data warehouse. The data warehouse provides many components within the State much faster access to standard and customized reports and the ability to do innovative data-mining.
- *Oregon* believes that the quality of its encounter data allows the State to more clearly identify patterns of service delivery and provider practices than is normally the case. This has facilitated fraud and abuse monitoring in the managed care sector; and the State will enhance its data collection and analysis tools further with the advent of a new MMIS.
- *South Carolina's* SURS Unit works with two contractors to develop algorithms to assist in advanced fraud analytics. The State has a library that consists of approximately 350 algorithms. These algorithms are used to identify potential cases of providers who may fall outside of the normal range. The Program Integrity Unit and SURS Unit meet biweekly to discuss patterns and open cases for further investigation.
- *South Dakota's* SURS Unit reviews a randomly sampled paid claims report from MMIS on a weekly basis to ensure that the MMIS is paying according to existing rules and regulations and that providers are billing in accordance with program guidelines. The reports have identified areas of questionable billing practices and payment issues resulting from MMIS enhancements and other changes that would otherwise not have been detected.
- *Virginia* indicated that its MMIS, which was implemented in 2003, is one of the most advanced claims processing systems in the nation. Thousands of edits are built into the system to prevent inappropriate payment of claims.

Program Safeguard Activities

- *Georgia* initiated a broker system for non-emergency medical transportation in 1997 which has been a cost-saving mechanism for the State. Currently the State has three transportation brokers covering five regions. The State teams up with the brokers to verify services with the providers. The State monitors transportation drivers to verify they are providing proper services and checks driver manifests, logs, and sign-offs by family members.
- *Texas'* OIG developed a self-reporting protocol intended to encourage providers to voluntarily investigate and report inappropriate payments as well as possible fraud, waste and abuse in State-administered programs. After following the protocol, the provider makes an initial report to the OIG. This early disclosure of non-compliance to the OIG allows for a better result for the provider than if the OIG discovered and investigated the matter independently.
- *Virginia* has contracted with independent audit contractors for pharmacy, DME, and long term care audits as well as other services. These contracts have helped triple audit recovery totals over a two year period.

Additional Efforts

- *North Carolina* added a Letter of Attestation to Medicaid enrollment packages stating that if the entity receives more than $5 million in reimbursement, it will comply with

Section 6032 of the Deficit Reduction Act (Section 1902(a)(68) of the Social Security Act) regarding the provision of employee education on the Federal False Claims Act. This enhancement places the education requirement on the provider at the time of enrollment. North Carolina Attestation Letter

- *Oregon* is committed to educating both providers and other components within the department on program integrity issues. Senior staff regularly address the annual meetings of health care groups, such as behavioral health providers, pharmacists, and residential treatment facility operators, to communicate policy standards and offer guidance. When widespread billing issues are identified, Oregon develops provider bulletins that give notice of policy expectations before administrative actions commence.

- *South Carolina's* program integrity area has two law enforcement staff assigned to the Attorney General's office who work on recipient fraud. Even though these employees work exclusively in recipient fraud, they also work with the MFCU and Program Integrity Unit when there is evidence of provider/recipient collusion in fraud cases. This provides an additional tool for detecting potential provider fraud.

- *South Dakota's* Medicaid Director has an in-depth knowledge of program integrity functions and systems within the agency and the MFCU.

- *Texas* highlighted its establishment of an OIG within the State agency as an effective practice. The OIG has 530 staff, excluding vacant positions. As one of the largest OIG offices in the country, all four divisions of the State OIG contribute to the integrity of the Texas Medicaid program.

- *Utah's* Bureau of Program Integrity, immediately following its reorganization, placed major emphasis on the development of policies and procedures to promote programmatic continuity and consistency. A detailed manual with written policies and procedures is already in place.

- *Virginia* complied with National Provider Identifier requirements a year prior to the required implementation date.

- *Virginia* has implemented prior authorization for services that have a high potential for fraud and abuse. The prior authorization program requires providers to meet strict clinical and administrative requirements before claims are authorized for payment.

- *Wyoming* utilizes a contractor to provide two field provider representatives who offer onsite assistance to: all in-state hospitals and nursing facilities; the top 25 paid dentists, physicians and pharmacies; newly-enrolled providers; and providers identified as having abnormally high denial rates. The representatives provide educational materials to providers and answer questions.

EFFECTIVE PRACTICES – MANAGED CARE

Noteworthy Practices

As Medicaid moves increasingly from being a predominantly fee-for-service (FFS) model to being a managed care or capitated model, States face new challenges in controlling fraud and abuse in their Medicaid programs. Many States are learning how to address the challenges posed by managed care. Some States are learning that managed care does not eliminate program

integrity issues. The MIG review teams identified the following noteworthy managed care practices:

- *Illinois* requires that all MCO providers be enrolled with the Medicaid program. By doing so, the State is able to maintain centralized control over the screening and credentialing process, and better ensure the integrity of its programs.
- *Michigan* has developed a desk audit tool, including a comprehensive fraud and abuse component, to assess overall MCO contract compliance. The checklist permits State staff to assess ongoing MCO compliance and progress towards compliance or corrective action in virtually all program integrity areas.
- *South Carolina's* MCOs are contractually required to list the State's fraud and abuse hotline on all managed care marketing materials for members and providers. MCOs report all instances of suspected fraud and abuse directly to the Program Integrity Unit for investigation. In addition, the managed care policy and procedure guide is a well-organized, understandable, and comprehensive document that clearly delineates responsibilities between the MCOs and the State.
- *Texas* requires managed care providers to be enrolled with Medicaid as a precondition for health plan credentialing. The State also has a strong set of managed care regulations for MCOs. State regulation explicitly requires that MCOs participating in the Medicaid program implement program integrity strategies, such as creating investigative units dedicated to detection and identification of fraud and abuse, developing annual fraud and abuse compliance plans, and conducting program integrity-related enrollee education. Moreover, Texas' OIG has dedicated program integrity staff who review MCO compliance plans and quarterly reports, and interact with compliance officers on a monthly basis. Texas Administrative Code

Effective Practices
States reported the following managed care practices as being effective:

- *Georgia's* MCOs are required by contract to submit monthly updates and quarterly reports on provider cases, which also note the overpayment amount. The MCOs regularly submit information on problem providers to the Program Integrity (PI) Unit and receive direction from the PI Unit's investigation director on how to proceed with investigations or other actions.
- *Oregon* has established an MCO Collaborative to improve communication across all components of the agency that oversee the managed care programs. Key units within the agency meet on a monthly basis to discuss the full range of managed care oversight and compliance issues. The MCO Collaborative is an important step toward ensuring that the managed care programmatic areas of the agency do not overlook program integrity issues and requirements in the MCO contracting and monitoring process.
- *Utah* included program integrity and provider enrollment standards as components in the managed care compliance standards expected of Medicaid MCOs in the State. The Quality Assessment and Performance Improvement Plan compliance standards, which are monitored by the State's External Quality Review Organization (EQRO), include both of these elements.

EFFECTIVE PRACTICES - MEDICAID FRAUD CONTROL UNIT

Noteworthy Practice

The MIG review teams identified the State Medicaid Agency – MFCU relationship as being particularly noteworthy in ***Oregon and Virginia***. Oregon solicited MFCU input on a planned new MMIS procurement, and the MFCU was responsible for the State changing language in provider enrollment packages to conform to Federal disclosure regulations. Virginia has enhanced communication between the State and the MFCU. During regular quarterly meetings, the MFCU and State staff discuss open investigations and reconcile their case logs. The MFCU also regularly sends the State a spreadsheet of all its open cases under investigation. In addition, the MFCU sends copies of its quarterly reports showing convictions and sentencing to the State.

Effective Practice

In response to our request that they report what they consider to be effective practices, five States - ***Georgia, Iowa, South Dakota, Texas, and Utah*** - reported that they enjoyed an effective relationship between the State Medicaid Agency and the MFCU. States noted a focus on mutual goals, respect for each other's roles, a comprehensive memorandum of understanding, frequent formal and informal communication, joint training of staff, and prompt attention to data requests from the MFCU as contributing to their success. ***North Dakota***, which has a waiver from operating a MFCU, reported a similarly effective relationship with the HHS-OIG.

AREAS OF VULNERABILITY – PROVIDER ENROLLMENT AND DISCLOSURES

The most frequently identified vulnerability overall is the failure to capture disclosure information from agents and managing employees during the enrollment process. This vulnerability was noted in 11 States and affected both FFS and managed care programs. Without such disclosure, the States would have no way of knowing if excluded individuals are working for providers or health care entities in such positions as billing managers and department heads.

One State's provider-enrollment broker failed to capture requisite information on owners, officers, and managing employees that would satisfy the disclosure of ownership, control, business transactions and criminal conviction information requirements of 42 CFR Part 455, Subpart B. In another State, MCOs are enrolled as Medicaid providers, but the State does not require disclosures of MCO ownership or management.

Three States were unable to perform effective exclusion searches because incomplete disclosure information was collected. One State does not capture information on the owners of subcontractors, officers, and managing employees in the enrollment package**.** In addition, the State's staff did not always perform a complete search using the information that was disclosed. Two States capture incomplete disclosure information on owners, officers and managing employees in the MMIS. Therefore, the States cannot check them for exclusions before or after provider enrollment occurs or MCO contracts are approved.

Another State requires disclosure of required information only at initial application. Because provider applications are not renewed, but are effective unless terminated, the State never requires resubmission or updating of disclosures. In addition, this State does not verify any information provider applicants submit, confirming only that the provider applicant has submitted a completed application. If the State requires neither periodic resubmission of disclosures nor verification of the disclosures made at initial application, the State would not know that the disclosures are accurate or whether the State should reject the provider application and refer the action to HHS-OIG.

The lack of post-enrollment exclusion searches was an area of vulnerability for one State. While exclusion searches are conducted at initial enrollment, automated post-enrollment exclusion searches are not routinely performed. Thus, the State would not become aware of exclusions and reinstatements that occurred since the last search.

Two States use their exclusion authority only in cases where another authority, such as the HHS-OIG or the State's medical licensing board, has already sanctioned the provider. Therefore, providers with a history of inappropriate behavior remain in the program as long as the HHS-OIG or the State's medical licensing board has not moved against them.

Six States did not verify the provider's license during the application process. This vulnerability applied to both in-state and out-of-state providers. Without routine independent verification of licensure, the State would not know with certainty that providers submitting applications have licenses in good standing.

Two States permitted out-of-state providers, once enrolled, to remain in the program and continue billing under the same terms as in-state and border area providers. Therefore, the program may be vulnerable to continuous billings for services by out-of-state providers whose activity is difficult to monitor.

Although one State's Administrative Code requires that inactive providers be terminated as providers, there was no established protocol for the State's provider enrollment contractor to terminate provider numbers for inactivity, leaving the program vulnerable to fraudulent billing.

AREAS OF VULNERABILITY – PROGRAM INTEGRITY

The second most frequently identified vulnerability overall is failure to verify with enrollees receipt of services billed by providers. Seven States failed to ensure that their MCOs had a method to verify receipt of services either through EOMBs or any other method. The State continues to be responsible for ensuring this requirement is met when it has contracted service delivery to an MCO. One State's contractor for mental health and substance abuse services also failed to perform recipient verification of services.

Four States lacked effective oversight over MCOs. Although some States' contracts with their MCOs require MCOs to report all suspected cases of provider fraud and abuse directly to the

State, MCOs in some of those States are reporting directly to the MFCU. Several MCOs indicated that they prefer to handle issues internally rather than reporting them to the State to avoid exposing weaknesses to competitors. One MCO reported that while it is required to report suspected fraud and abuse to the State immediately, the State is only notified when the MCO completes an investigation, and only if there are negative findings.

One State lacked oversight over its EQRO. Although the EQRO identified findings in its 2004 review of the State's contracted MCOs, follow-up reviews conducted in 2005 and 2006 did not address whether corrective action had been taken on the 2004 findings. In fact, the EQRO did not address fraud and abuse issues at all.

One State provided inadequate monitoring of its dental contractor's fraud and abuse efforts. The State's contract with the contractor did not require routine reporting of fraud and abuse complaints and investigations in the dental network. State oversight of the contractor was limited to review of the monthly payment invoice.

In one State, each of the State's 100 counties is responsible for its own Medicaid NEMT and each has unique requirements for this service. The State has been unable to consistently check on whether the counties verify delivery of services, check for exclusions, and request disclosures regarding owners and managing employees.

One State relies solely on MMIS edits to prevent unauthorized payments. No other types of prepayment reviews are done.

The program integrity function is not centrally organized within one State agency. State oversight of the program integrity function is assigned to one agency, although staff in sister State agencies perform some program integrity functions and the State's fiscal agent maintains a staff that performs SURS functions. Under this decentralized program integrity structure, staff in multiple State agencies conduct program integrity reviews under the direction of their own agency's management.

The MIG identified vulnerabilities regarding lack of written policies and procedures in two States. In the first, the State had relatively few written program integrity and provider enrollment policies and procedures. In addition, the existing polices and procedures did not all have dates and lacked indication of whether the documents were current. In the case of the second State, the State lacked a written procedure for reporting adverse actions to HHS-OIG.

One State was identified as not maintaining an effective fraud and abuse case tracking system. The current tracking system uses a database that has limitations affecting the effectiveness of the database, including lack of secured access, inability to track which user entered which data, and constraints from inadequate data fields.

Two States failed to ensure that all recipient fraud and abuse was investigated. In both cases, the State agency refers suspected cases of recipient fraud or abuse to a sister agency who is responsible for the investigation and referral to law enforcement where appropriate. However,

the State agency does not routinely follow up with the sister agency to ensure that all cases referred have been fully investigated or referred where appropriate.

AREAS OF VULNERABILITY - MEDICAID FRAUD CONTROL UNIT

The MIG identified serious communication and trust issues between one State agency and the MFCU as evidenced by a significantly low number of Medicaid fraud referrals to the MFCU in recent years. Lack of follow-up on issues raised at meetings, and communication largely oral in nature contributed to the problem. This type of ineffective relationship results in a weakening of program integrity efforts within the State Medicaid program.

In September 2008, MIG issued a *Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units,* which provides guidance for interactions between State Program Integrity Units and MFCUs. The document contains ideas from State program integrity units nationwide. In addition to containing practical ideas for maximizing a program integrity unit's return on investment from its relationship with its MFCU, the document also provides details on the collection of information that makes up a referral, as defined in the *Performance Standard For Referrals Of Suspected Fraud From A Single State Agency to A Medicaid Fraud Control Unit* document, which MIG also issued in September 2008. [Medicaid Guidance Fraud Prevention State Program Integrity Support & Assistance](#)

AREAS OF NON-COMPLIANCE

This section reflects findings from 19 FFY 2007 and 2008 comprehensive program integrity reviews, and identifies the number of States that were non-compliant with each regulation. Most frequently cited were regulations regarding disclosure of information and reporting requirements. While some States completely failed to meet the regulations, MIG found many instances in which the regulations were only partially met.

- Under 42 CFR section 455.104, the Medicaid agency must require disclosure of (1) name and address of a person with ownership and control interest in the provider entity or in a subcontractor in which the provider entity has 5% or more interest; (2) name of any other provider in which the owner of provider entity has ownership or control interest; and (3) whether any person named in #1 is related to another as a spouse, parent, child, or sibling. Disclosure is required either when the provider entity is surveyed (if surveyed periodically), or before entering into or renewing the provider agreement (if not surveyed periodically). The Medicaid agency must require disclosures from the fiscal agent prior to approving the contract with the fiscal agent, and from the provider prior to approving the provider agreement.

  Eighteen States were not in compliance with this regulation.

- The regulation at 42 CFR section 455.106 requires providers to disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made.

  Seventeen States were not in compliance with this regulation.

- The regulation at 42 CFR section 455.105(b)(2) requires that, upon request, providers furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractors.

  Fifteen States were not in compliance with this regulation.

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

  Fourteen States were not in compliance with this regulation.

- The regulation at 42 CFR section 1002.212 requires that a State agency that has initiated an exclusion notify the individual or entity subject to the exclusion as well as other State agencies, the State medical licensing board, the public, recipients, and other interested parties.

  Two States were not in compliance with this regulation.

- The regulation at 42 CFR section 455.15 requires that the State Medicaid agency refer suspected cases of recipient fraud to an appropriate law enforcement agency. If the State Medicaid agency suspects a recipient has abused the Medicaid program, the agency must conduct a full investigation. If the State agency's preliminary investigation leads to a suspicion that a recipient has defrauded the Medicaid program, the case must be referred to an appropriate law enforcement agency. If the agency believes that a recipient has abused the program, the State agency must conduct a full investigation.

  One State was not in compliance with this regulation.

- The regulation at 42 CFR section 455.18 requires that providers attest to the accuracy of information on all claim forms. The regulation at 42 CFR section 455.19 permits an alternative to attestations on claim forms: the State may print attestation language above the claimant's endorsement on checks or warrants payable to providers.

  One State was not in compliance with this regulation.

- The regulation at 42 CFR section 455.21 requires that the Medicaid agency (in all states except North Dakota) must: (1) refer all cases of suspected provider fraud to the MFCU;

(2) comply with the MFCU's document and access requests; and (3) initiate administrative or judicial action for cases referred to the State by the MFCU.

One State was not in compliance with this regulation.

- The regulation at 42 CFR section 455.23 states that the Medicaid agency may withhold Medicaid payments, in whole or in part, in cases of fraud or willful misrepresentation under the Medicaid program. The State agency must send appropriate notice of its withholding of program payments within five days of taking such action.

One State was not in compliance with this regulation.

CONCLUSION

Many State Medicaid agencies have developed and implemented one or more effective practices that enhance their program's ability to identify and reduce Medicaid fraud and abuse. In addition, all of the States reviewed indicated that they had made or planned to make modifications in their practices to address areas of non-compliance and vulnerability identified in MIG's program integrity reviews. For additional information or for questions about issues discussed in this report, please contact the Medicaid Integrity Group at Medicaid_Integrity_Program@cms.hhs.gov.