Medicaid Integrity Program A to Z

Introduction

The Deficit Reduction Act of 2005 created the Medicaid Integrity Program (MIP) in section 1936 of the Social Security Act (the Act), and dramatically increased the Federal government's role and responsibility in combating Medicaid fraud, waste and abuse. Section 1936 of the Act requires the Centers for Medicare & Medicaid Services (CMS) to contract with eligible entities to review and audit Medicaid claims, to identify overpayments, and provide education on program integrity issues. Additionally, the Act requires CMS to provide effective support and assistance to States to combat Medicaid provider fraud and abuse.

The Act also requires CMS to periodically publish its Comprehensive Medicaid Integrity Plan (CMIP). The CMIP is developed in consultation with Medicaid program integrity partners and stakeholders, including but not limited to: the Department of Justice (DOJ), the Federal Bureau of Investigation, the Health & Human Services Office of Inspector General (HHS-OIG) and State Medicaid agencies and State Medicaid Fraud Control Units. The current CMIP can be found at: http://www.cms.hhs.gov/DeficitReductionAct/02_CMIP.asp#TopOfPage. In addition, CMS' Medicaid Integrity Group (MIG), which administers MIP, regularly consults with the Medicaid Fraud & Abuse Technical Advisory Group (TAG) and its MIP advisory committee. Both are comprised of representatives of the partners and stakeholders described above along with other CMS staff involved in program integrity.

What is the Medicaid Integrity Group?

The CMS created the MIG in July 2006 to implement the MIP. The MIG is organized under, and reports directly to, the Director of the Center for Medicaid and State Operations (CMSO). The MIG is led by the Office of the Group Director and its three divisions: the Division of Medicaid Integrity Contracting; the Division of Field Operations; and the Division of Fraud Research and Detection.

Office of the Group Director

The Office of the Group Director serves as the primary point of contact on Medicaid fraud and abuse issues within CMS, and with other partners, including law enforcement and with the States. Specifically, the Office works closely with Senior Leadership throughout CMS to ensure that MIG's efforts remain synchronized with all other Medicaid and Medicare integrity activities. It oversees the preparation of the CMIP, MIP's annual Report to Congress, and various other MIP-related documents, and provides overall support to and direction of the activities of the MIG staff.

Division of Medicaid Integrity Contracting (DMIC)
DMIC is the primary focal point for the procurement, oversight, and evaluation of the contractors that will review provider activities, conduct audits and identify overpayments, and provide education on Medicaid program integrity issues.

Division of Field Operations (DFO)
DFO is the largest of all the MIG divisions with staff working out of CMS regional offices in New York, Atlanta, Dallas, San Francisco and Chicago. DFO works closely with the MIP's provider audit contractors. It also provides oversight, support and assistance to States' program integrity efforts in the form of State program integrity reviews, technical assistance, training, and best practices guidance.

Division of Fraud Research & Detection (DFRD)
DFRD provides research, statistical and data support both to the MIP and the States, identifies current and emerging fraud trends, and conducts special studies as appropriate. DFRD works closely with MIP contractors to identify potential provider billing vulnerabilities and aberrancies.

Medicaid Integrity Contractors

Section 1936 of the Act requires CMS to enter into contracts to perform four key program integrity activities:

1) Review provider actions;
2) Audit claims;
3) Identify overpayments; and
4) Educate providers, managed care entities, beneficiaries and others with respect to payment integrity and quality of care.

CMS has awarded umbrella contracts with several contractors to perform the functions outlined above. These contractors are known as the MICs. There are three types of MICs: Review MICs, Audit MICs, and Education MICs.

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Review MICs

Review MICs analyze Medicaid claims data to identify aberrant claims and potential billing vulnerabilities, and provide leads to Audit MICs of Medicaid providers to be audited. There are five Review MICs:

- AdvanceMed Corporation;
- ACS Healthcare Analytics, Inc.;
- Thomson Reuters;
- Safeguard Services, LLC; and
- IMS Government Solutions.

Audit MICs

Audit MICs conduct post-payment audits of all types of Medicaid providers and, where appropriate, identify overpayments. There are five Audit MICs:

- Booz Allen Hamilton;
- Fox Systems, Inc.;
- IPRO;
- Health Management Systems; and
- Health Integrity, LLC.

Education MICs

Education MICs work with the Review and Audit MICs to educate health care providers, State Medicaid officials and others about a variety of Medicaid program integrity issues. There are two Education MICs:

- Information Experts; and
- Strategic Health Solutions.

MIP Provider Audit Program A to Z

The objectives of the MIP provider audit program are to ensure that claims are paid:

- For services provided and properly documented;
- For services billed using the appropriate procedure codes;
- For covered services; and
- In accordance with Federal and State laws, regulations and policies.

Steps in the MIP provider audit process

Step 1: Identification of potential audits through data analysis.

The MIG and its Review MICs examine all paid Medicaid claims using the Medicaid Statistical Information System. Using advanced data mining techniques, MIG identifies potential areas that are at high risk for overpayments or fraudulent claims that require additional review by the Review MICs. The Review MICs, in turn, identify specific potential provider audits for the Audit MICs on which to focus their efforts. This data-driven approach to identifying potential overpayments helps ensure that efforts are focused on those providers with truly aberrant billing practices.

Step 2: Vetting potential audits with State and law enforcement.

Prior to providing an Audit MIC with an audit assignment, CMS vets the providers identified for audit with partners and stakeholders in the State. This includes State Medicaid agencies, State and Federal law enforcement agencies and Medicare contractors. These entities are provided a list of potential audits generated by the data analysis mentioned above. If any of them is conducting an audit or investigation of the same provider for similar Medicaid issues, CMS may cancel or postpone the Audit MIC audit of the provider. In this way, CMS avoids duplicating the efforts of other Medicaid audits.

Step 3: Audit MIC receives audit assignment.

Upon completion of the vetting process, CMS forwards the audit assignments to the Audit MIC and the Audit MIC immediately begins the audit process. CMS policy is that the audit period, also known as the "lookback" period, generally mirrors that of the State which paid the provider's claims.

Step 4: Audit MIC contacts provider and schedules entrance conference.

The Audit MIC mails a notification letter to the provider. The notification letter identifies a point of contact within the Audit MIC and gives at least two weeks' notice before the audit is to begin. Along with the notification letter, a records request is attached outlining the specific records that the Audit MIC will be auditing. The provider is asked to send the records to the Audit MIC for a desk audit. For a field audit, the provider must have the records available in time for the Audit MIC's arrival at the provider's office. The Audit MIC will coordinate with

the provider to schedule an entrance conference to communicate all relevant information to the provider, including a description of the audit scope and objectives. The entrance conference may be conducted in person or telephonically.

Step 5: Audit MIC performs audit.

Most of the audits conducted by the Audit MIC are desk audits, where the Audit MIC requests provider documentation and reviews the records at its own office. On some occasions, the Audit MIC conducts field audits, in which the auditors actually conduct the audit at the provider's location. Providers are given specific timelines in which to produce records, however because some audits will be larger in scope than others, requests for extensions are seriously considered and are generally granted in such cases. CMS policy requires that the provider be generally allowed the same amount of time to produce requested records as the State Medicaid agency allows in its own provider audits. All audits are being conducted according to Generally Accepted Government Auditing Standards.

Step 6: Exit conference held and draft audit report is prepared.

At the conclusion of the audit, the Audit MIC will coordinate with the provider to schedule an exit conference. The exit conference may be conducted in person or telephonically. Its purpose is to review a summary of preliminary audit findings and tentative conclusions. At this meeting, the provider has an opportunity to comment on the preliminary audit findings and to provide additional information where appropriate. If the Audit MIC concludes, based on the evidence, that there is a potential overpayment, the Audit MIC prepares a draft report.

Step 7: Review of draft audit report.

The draft audit report is shared with CMS for approval and is provided to the State for review and comments. The report is then given to the provider for review and comment. When appropriate, the draft is revised and then shared again with the State.

Step 8: Draft audit report is finalized.

Upon completion of this review process, the findings may be adjusted, either up or down, as appropriate based on the information provided by the provider and the State. The provider will be given credit for payments it is able to justify. The State's comments and concerns will also be

given full consideration. There may be times that CMS determines the State's interpretation of policy contradicts CMS policy. CMS always strives to reach consensus with the State in such situations. Ultimately, however, CMS has the final responsibility for determining the final overpayment in any audit. At this point, the audit report is finalized.

Step 9: CMS issues final audit report to State – triggering the "60-day" rule.

CMS sends the final audit report to the State. Pursuant to 42 CFR sections 433.316 (a) & (e), this action serves as CMS' official notice to the State of the discovery and identification of an overpayment. Under Federal law, the State must repay the Federal share of the overpayment to CMS within 60 calendar days, whether or not the State recovers, or seeks to recover, the overpayment from the provider.

Step 10: State issues final audit report to provider & begins overpayment recovery process.

The State is responsible for issuing the final audit report to the Provider. Each State must follow its respective administrative process in this endeavor. At this point, the provider may exercise whatever appeal or adjudication rights are available under State law when the State seeks to collect the overpayment amount identified in the final audit report.

State Program Integrity Operations A to Z:

The MIG is also responsible for providing effective support and assistance to States. That support takes several forms, including training, oversight, technical assistance and best practices guidance.

Medicaid Integrity Institute (MII)

The MII is a national Medicaid program integrity training center that provides support and assistance to the States' program integrity operations. The MIG created the MII in September 2006 through an interagency agreement with the United States Department of Justice's (DOJ) Office of Legal Education. The MII is housed at DOJ's National Advocacy Center in Columbia, South Carolina.

The MII offers training at no cost to State Medicaid program integrity staff in various disciplines encompassing all aspects of Medicaid program integrity, including fraud investigation, use of algorithms, state of the art data-mining tools and Certified Professional Coder Training (CPT) medical billing codes.

Since its inception in February 2007, through May 2009, the MII has hosted 18 classes involving 885 State faculty and students. By the end of FFY 2009, the MII will sponsor 7 more classes with a projected attendance in those classes of 260 State students and faculty. In addition to the MII, MIG has sponsored four separate CPT coding classes for State staff around the country. By the end of FFY 2009, MIG expects to have provided training in a wide variety of disciplines to 1,250 State staff.

State Program Integrity Reviews

The purposes of State Program Integrity reviews are to:

1) Determine compliance with Federal program integrity laws and regulations;
2) Identify program vulnerabilities and noteworthy practices;
3) Help the States improve their overall program integrity efforts; and
4) Consider opportunities for future technical assistance.

Through State program integrity reviews, MIG staff are able to identify issues in State operations and in turn, assist States in improving program integrity efforts. Each State receives a comprehensive review every three years. In addition to evaluating State compliance and identifying issues in State operations, MIG staff use these reviews to identify and disseminate best practices.

In each of the State program integrity reviews, State staff answer questions in the review guide and provide supporting documentation in the areas of program integrity, provider enrollment, managed care, and Medicaid Fraud Control Unit. That information is then confirmed through review of documentation and interviews with program integrity, provider enrollment, managed care, and Medicaid Fraud Control Unit staff. These reports can be found at: http://www.cms.hhs.gov/FraudAbuseforProfs/05_StateProgramIntegrityReviews.asp#TopOfPage.

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Technical Assistance & Special Projects

The MIG's staff provides ongoing technical assistance to States on a variety of program integrity-related topics including, but not limited to: provider fraud; billing concerns; provider enrollment and exclusions; MII; PERM; statistical assistance; and program integrity regulations. From October 2007 through May 2009, the Division of Field Operations has handled 350 technical assistance requests.

The State Program Integrity Assessment (SPIA) is MIG's effort to identify a state by state baseline of program integrity demographics. It includes information on a wide variety of program integrity functions, staffing and accomplishments. In FFY 2009, MIG will publish the first-ever compilation of SPIA results when it releases the FFY 2007 results. The SPIA is now an annual process and will help identify strengths and opportunities for improvement in Medicaid's program integrity infrastructure.

Upon request, MIG staff provides resources to support State special projects to target suspect providers in high-fraud areas. Between October 2007 and March 2009, MIG employees took part in four special field projects. Three of these were investigations coordinated by the Florida Agency for Health Care Administration. One was an investigation coordinated by the California Department of Health Services. In each project, State and Federal staff interviewed Medicaid recipients and providers and examined medical records which allegedly supported the services billed. For three of these projects, the State agency reviewed billings for services related to the projects. The State reviewed paid claims for similar time periods before and after the special projects. In each case, there was a significant decrease in paid claims after the project. The savings from these three projects totaled approximately $10.1 million.

Best Practices Guidance

The MIG also provides technical assistance in the form of guidance documents. The MIG has taken the lead in drafting State Medicaid Director Letters on topics such as: enhanced Federal Financial Participation for false claims acts; false claims education requirements; tamper resistant prescription pad requirements; cooperation with the MIG; and provider exclusions. The State Medicaid Director Letters are available on the CMS website at: http://www.cms.hhs.gov/SMDL/SMD/list.asp#TopOfPage.

In September 2008, the MIG issued *CMS-MIG Performance Standards For Referrals of Suspected Fraud From a Single State Agency to a Medicaid Fraud Control Unit (MFCU)*. At no time previously had program integrity units been given performance standards on the number of referrals to their MFCUs. Along with the Referral Performance Standards, the MIG issued a Best Practices document that elaborated on whether and when cases should be referred to the MFCU, the content of quality referrals, and how to maintain a good relationship between the State program integrity unit and the MFCU. The Referral Performance Standards and Best Practices document are available on the CMS website at: http://www.cms.hhs.gov/FraudAbuseforProfs/02_MedicaidGuidance.asp#TopOfPage.

In May 2009, MIG also issued its first annual summary of program integrity review results. It included information about effective practices, areas of vulnerability, and areas of non-compliance. This report can be found at: http://www.cms.hhs.gov/FraudAbuseforProfs/Downloads/2008pireviewannualsummaryreport.pdf.

Intra-agency Cooperation

Providers and States alike have asked CMS to better coordinate similar activities such as the MIP audits, the Recovery Audit Contractor (RAC) audits and the Payment Error Rate Measurement (PERM) project. The latter two functions are managed by the Provider Compliance Group (PCG). MIG and PCG staffs have had numerous discussions along these lines and expect more developments in the coming months. CMS expects to see more coordination of audits and better information sharing to lessen the burdens these programs place on providers and States. In addition, MIG has worked with HHS-OIG on coordinating data requests to the States. CMS expects that its proposed enhancement of MSIS data will eventually allow HHS-OIG to obtain its Medicaid claims data from MIG without having to request it from individual states.

Conclusion

The Medicaid Integrity Program plays a valuable role in the protection of the integrity of the Medicaid program nationally. As MIP evolves, CMS pledges to continues its collaborations with Medicaid partners and stakeholders to ensure the program is managed in the most effective and efficient manner possible.

For additional information about any aspect of the Medicaid Integrity Program, please visit our website: http://www.cms.hhs.gov/MedicaidIntegrityProgram.