BEST PRACTICES FOR MEDICAID PROGRAM INTEGRITY UNITS' INTERACTIONS WITH MEDICAID FRAUD CONTROL UNITS

Medicaid Integrity Group

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Introduction

The Centers for Medicare & Medicaid Services (CMS) and its Medicaid Integrity Group (MIG) are committed to providing effective support and assistance to States in their efforts to combat provider fraud and abuse. This Best Practices document is intended to further that objective, and build upon the resources contained in the *Medicaid Program Integrity Medicaid Fraud Control Units Informational Manual* issued jointly in 2007 by the National Association for Medicaid Program Integrity (NAMPI) and the National Association of Medicaid Fraud Control Units (NAMFCU). It provides guidance for interactions between State Program Integrity Units (PIUs) and their Medicaid Fraud Control Units (MFCUs), and contains specific examples of actions taken by States that have created well-functioning and committed partnerships between the two entities. While these recommendations are not all-inclusive, we hope that the ideas contained herein will assist in building strong collaborative relationships, and result in the strengthening of program integrity efforts within State Medicaid programs.

RECOMMENDATIONS:

Meet Regularly with the MFCU

Within most States, two agencies share primary responsibility for protecting the integrity of the Medicaid program: the section of the State Medicaid agency that functions as the PIU and the MFCU. Regular meetings between the two entities promote the high level of communication that is integral to the success of both. Many HHS-OIG reports, as well as overwhelming anecdotal evidence, demonstrate that a close working relationship between the two agencies results in the most effective fraud referrals. Perhaps even more importantly, the level of communication established by this close coordination of efforts through regular meetings facilitates the identification of new fraud trends, increases accountability, and generally improves the productivity of the two agencies.

The formation of this type of coordination of effort should be collaborative. The process of determining the frequency, location, and representatives can assist in establishing the foundation for the continued partnership. Some States with an established workgroup or liaison committee meet as often as bi-weekly, while others opt to meet on a monthly basis. Especially in States with relatively few staff, it may be appropriate for the PIU and MFCU directors to be present, whereas in a larger State, the operational responsibilities may be delegated to other staff members.

Other suggestions to promote the overall success of the group include:

- Create an established agenda, including topics such as case updates; new complaints and possible referrals; MFCU issues; report requests; policy changes; “hot” issues; fraud trends and joint activities;

- Appoint a representative responsible for selecting meeting dates and times to ensure that appointments for future meetings are not overlooked when things become busy;
- Identify key participants from each unit. States should also consider inviting program staff (*e.g.*, long-term care, acute care, waiver, mental health) to join the workgroup, either when particular issues are on the agenda, or even as permanent members;
- Use the meetings to discuss open PIU investigations that the PIU believes will ultimately be referred to the MFCU. Requesting MFCU input early in the life of the case both improves the quality of referrals from the State Medicaid agency and the likelihood that referrals you make will be accepted and actively pursued by the MFCU;
- Appoint a representative to record action items; and
- Add language about the formation of such a workgroup into the Memorandum of Understanding (MOU) with the MFCU.

Examples: After reviewing HHS-OIG audit reports, Indiana's SUR looked for providers who were employing excluded individuals. It began by pulling all the excluded pharmacy technicians from Indiana from the List of Excluded Individuals/Entities (LEIE) website. From there, the SUR invited the MFCU to join in the project. The MFCU took the list developed by the SUR and queried those individuals work histories from Indiana's workforce development database. There were several excluded individuals identified who were either currently working in a facility that was paid by federal health care dollars, or had been working in such a facility during the time of their exclusion. At that point, the MFCU opened individual cases and began seeking recovery from the providers in those instances. As a result of these findings, the SUR and the MFCU developed a provider publication titled *Federal Health Care Program Exclusions*, available at: http://www.indianamedicaid.com/ihcp/Bulletins/BT200715.pdf. The monthly coordination meetings served as a useful forum for this ongoing joint project. The project has since expanded to include reviews of other provider types, such as nurse aids and physician specialties.

Florida uses a dual process. First, the two agencies hold a meeting every two weeks focused on staffing specific cases. In addition to discussing possible new referrals, the meetings are used to discuss certain open MFCU investigations. To that end, the meetings bring together the PIU analyst who worked the case prior to referral and the MFCU investigators currently assigned to the matter. In addition to those bi-weekly meetings, the two agencies also have a high level meeting every 60 days to discuss an array of broader issues. The underlying purpose of the 60 day meeting is to allow management to discuss direction, allocation of resources, and general investigative topics.

To enhance its communication and working relationship, Virginia utilizes its workgroup meetings to engage in regular cross-training. During the monthly meetings between the MFCU Investigative

Supervisor and the SUR unit Manager, the MFCU provides tips on ways to uncover Medicaid fraud. Reciprocally, the SUR unit provides MMIS training to MFCU staff.

After determining that it was experiencing a high level of fraud in its mental health program, Maryland Department of Health and Mental Hygiene OIG (MD-OIG) began inviting staff from that program to its workgroup meetings. Discussions within the workgroup between program staff, the MD- OIG and the MFCU led to an understanding of what types of provider misconduct would be most successfully pursued by the MFCU, and led to the successful prosecution of a large number of mental health cases, most of which included significant repayment of fraudulent billings.

Develop and Consistently Apply One Standard for Deciding When to Refer a Matter to the MFCU

42 CFR section 455.21(a)(1) requires that States refer instances of suspected fraud to their MFCU. But over the years, many States have expressed difficulty in interpreting and applying this regulation, and, perhaps as a result, have come to different conclusions as to the weight of evidence needed before behavior can be properly described as an instance of "suspected fraud." As well, many MFCUs have reported that they do not receive the number of referrals from their PIU that they believe are warranted; at the same time, MFCUs frequently express frustration at the number of cases referred that lack any substantial evidence of criminal misconduct. These apparently conflicting complaints from MFCUs seem in large part a consequence of the diversity of States' understanding of a critical issue: how strong must be the evidence of fraud before the PIU should refer the case to the MFCU?

After discussions with representatives of both State PIUs and MFCUs, the MIG has developed a definition of "suspected fraud" which we believe strikes the proper balance between referring a case lacking significant evidence of fraud, and investigating cases well past the point when intent to commit fraud is apparent. While States are not required to adopt this exact standard, we hope that it will prove helpful to those who are looking for assistance with this issue. Additionally, it is strongly suggested that States adopt *one* standard as the lens through which it reviews all discovered overpayments, and that the PIU clearly articulate that standard to the MFCU so that its staff understands what it can expect of any case the PIU refers.

Recommended Standard for Determining Whether a Case Should be Referred to a MFCU

The PIU should make a referral to its MFCU whenever there is ***reliable*** *evidence that overpayments discovered during an audit are the product, in whole or in part, of fraud committed by the provider and/or one or more of the provider's staff or contractors. Reliable evidence is evidence that has been corroborated, that is based upon information from a person whose relationship with the suspected perpetrator is such that the person*

could reasonably be expected to have knowledge of the misconduct (such as an employee or ex-employee), or that is based on data analysis that reveals aberrant billing practices that appear unjustifiable based upon normal business practices.

Pursuant to 42 CFR section 455.2, "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law."

"Corroboration" of suspected fraud can include a wide array of information and materials. Broadly speaking, corroboration often is found in the form of a *pattern* of aberrant behavior. In the audit setting, examples include significant numbers of clinical notes containing identical descriptions of the services provided, large quantities of missing records without legitimate explanation, documents that show indications of having been tampered with subsequent to the provider receiving notice of the audit, or calendars showing that services were provided for shorter periods than were billed. In the data analysis setting, examples include data revealing such behavior as a laboratory provider routinely billing an unusual combination of high dollar tests or a physician billing every month for multiple members of a family on the same day using the same office visit procedure code.

Referrals of Suspected Provider Abuse

Separate from the issue of referrals of fraud is the issue of whether and when to refer cases of suspected of provider abuse. While States are under an explicit obligation under 42 CFR section 455.21 to refer instances of suspected fraud, provider abuse referrals are referenced in the regulations only in 42 CFR section 455.15. Therefore, as indicated in that regulation, when the MOU between the PIU and the MFCU provides that the PIU should make referrals of provider abuse (as distinct from fraud) cases, States should refer suspected provider abuse, and consider using the same standard set forth above for fraud referrals (substituting the definition of "abuse" in section 455.2 for the fraud definition). When such a provision is not included in the MOU, the State Medicaid agency should conduct a full investigation.

Include in Every Referral to the MFCU the Information Set Forth in the Referrals Performance Standard

A MFCU referral must contain the minimum criteria set forth in the "Acceptable Referrals from States to MFCUs Performance Standard" released by CMS in October, 2008 in conjunction with this Best Practices document. The following information should be included to assist in facilitating the MFCU's evaluation of a case:

- **Subject** (name, Medicaid provider ID, address, provider type)
- **Source/origin of complaint**
- **Date reported to State:** This is the date on which the PIU received the information that the provider being referred might be engaged in illegal behavior.

If the PIU developed the information on its own, then it should provide the date when the PIU initiated an investigation of the provider. In the event a PIU ranking report or other data analysis revealed the provider, the date of the report should be used.

- **Description of suspected intentional misconduct, with specific details including:**
  - *The category of service.*
  - *Factual explanation of the allegation:* The PIU should provide as much detail as possible concerning the names, positions, and contact information (if available) of all relevant persons; a complete description of the alleged scheme as it is understood by the PIU, including, when possible, one or more examples of specific claims that are believed to be fraudulent; the manner in which the PIU came to learn of the conduct; and the actions taken by the PIU to investigate the allegations.
  - *Specific Medicaid statutes, rules, regulations, or policies violated:* This information should include an explanation of why the conduct of the provider or individual violates the statutes, rules, regulations, or policies.
  - *Date(s) of conduct:* When exact dates are unknown, the PIU should provide its best estimate.
- **Amount paid to the provider for the last three years or during the period of the alleged misconduct, whichever is greater:** This information should also include a claims detail with fields such as TCN, date of service, provider ID, recipient ID, diagnosis code, procedure code, and modifier.
- **All communications between the State Medicaid agency and the provider concerning the conduct at issue:** This section should include any communications that began with a question from the provider, provider enrollment documentation, and any education given to the provider as a result of past problems; as well as advisory bulletins, policy updates, or any other general communication to the provider community regarding the questionable behavior. Letters, emails, and phone logs are all sources of communication.
- **Contact information for State Medicaid agency staff persons with practical knowledge of the workings of the relevant programs**
- **Sample/exposed dollar amount, when available**

Note that prior to referring any case to the MFCU, the PIU should conduct due diligence to verify that the Medicaid program has not issued any policies or guidance, or conveyed through any informal communications to providers any information that might be construed as making the conduct at issue permissible in the eyes of the program.

Example: Texas created a comprehensive referral form that contains all of the information above for each referral. In addition to that information, the form contains a section for background/criminal history checks, utilization reports including top ten procedure codes billed by provider, prior PI audits/reviews, and internet research results. This form is transmitted electronically to the MFCU and has assisted in streamlining the referral process. In State fiscal year 2007, PIU referrals accounted for 44% of the Texas MFCU caseload.

Update the MFCU on Ongoing Investigations

Updating should occur on a regular basis so that both the State Medicaid agency and MFCU have a clear understanding of the cases being pursued. Once a referral has been forwarded and accepted, it is vital that the communications continue so that actions do not occur that could potentially jeopardize a criminal case or collection of an overpayment.

As noted above, ongoing communications between the PIU and the MFCU has a number of benefits to both organizations. It improves the quality of referrals, provides greater certainty as to whether an ongoing investigation will remain on a track for administrative proceeding, allows the PIU to obtain insight from a variety of perspectives, increases the level of trust between the two agencies, and minimizes the likelihood of conflicts.

Updates can occur through a variety of communications methods, including meetings, periodic written reports, and access to databases. The following are two examples of how the MFCU and State Medicaid agency coordinate updates:

Examples: Some States utilize reports generated on a periodic basis by their MFCU to evaluate whether the State is duplicating services or possibly jeopardizing an active investigation. The States also use those reports to ensure that potential new cases would not interfere with ongoing MFCU investigations.

Indiana – The SUR Unit and MFCU developed a shared secure website listing all the SUR-developed cases that the MFCU is currently investigating, allowing both sides to update the list. The ability to see investigations that are active and currently being pursued helps preserve the viability of cases.

Offer Education to the MFCU

Because their primary mission is the investigation and prosecution of fraud in the Medicaid program, MFCU investigators frequently lack programmatic experience. As a result, they may not be aware of the manner in which program regulations have been interpreted, or know who inside the State Medicaid agency is responsible for various functions, or understand a program's daily operations. In other words, they don't always know how their Medicaid program actually works. MFCU investigators can more efficiently pursue their cases if they received training on the ins and outs of their Medicaid program, an outcome that benefits program integrity units, as well. PIU and other State Medicaid agency staff can provide education to the MFCU to improve that unit's efficiency and overall ability to investigate and prosecute Medicaid fraud cases.

Examples: Georgia – The MFCU and the Georgia Department of Community Health OIG (GA-OIG) initiated a cross-training program for new employees. For its part, the GA-OIG developed an internship program with the MFCU that is two weeks in length. Through this program, new MFCU investigators and attorneys are given a basic understanding of the Medicaid program and the program integrity function within the program. As part of this training, MFCU staff receive an overview of the clinical and investigative components of PI and accompany an investigator on an on-site visit.

Florida – The PIU and the MFCU have developed a "train the trainer" approach to investigations. Projects are developed based on discussions between leadership of both entities and data reports are run. Outlier providers identified are examined for inappropriate or illegal indicators. The PIU next trains a select group of MFCU investigators regarding the issue, who then conduct pilot investigations of a limited number of providers to determine the viability of the project. When it proves successful, the trained investigators then educate the remaining investigators. For example, when the PIU initiated a project involving therapy services, analysts and clinicians from the PIU produced ranking reports that identified numerous providers. In concert with a referral to the MFCU, the agencies' employees trained certain MFCU investigators on the therapy program and policies involved. The initial limited MFCU investigation yielded positive results. Additional MFCU staff were then trained by the original investigators, and the project was expanded to many other providers in the same category of service.

Offer to Provide Consultative Services to the MFCU

Health care fraud and abuse cases can be complex and difficult to investigate. When a case involves a quality of care issue or an issue involving a sophisticated medical procedure, medical consultants are often necessary to assist in reviewing records and explaining processes. The PIU and State Medicaid agency can often provide this type of expertise to the MFCU, producing a stronger case and increasing the chances the case will be prosecuted.

Most MFCUs have a limited number of clinicians on staff. Medical expertise is a critical area where the State can assist the MFCU by offering their clinical staff or providing access to skilled professional consultants. For example, one State offers access to its medical consultant database when their MFCU needs a clinician to review medical records or an expert witness to testify in a case.

Additionally, the PIU can provide MFCUs with assistance regarding medical policy or policy clarification inquiries. A State with an in-house medical policy department can be a valuable resource to a MFCU with questions regarding the operational intentions of Medicaid policy and regulation. When no such department exists, the PIU can help the MFCU by locating the individuals in its State Medicaid agency who can answer the MFCU's inquiries.

Reconcile Your Program Activities with the MFCU

Reconciliation of activities prevents the flow of conflicting data to the Federal oversight agencies, and enables a more accurate accounting of return on investment. As such it is an important part of coordination efforts between a PIU and MFCU.

Example: In Ohio, the PIU and MFCU perform quarterly and annual reconciliations of program activities to assure a full accounting of all activities directly related to the detection and prevention of fraud, waste, and abuse within Medicaid. This process includes a reconciliation of case referrals, cases accepted/declined, convictions, recoveries, status of multi-state investigations and settlements, and other performance indicators identified by the PIU and MFCU.

Conclusion

CMS hopes that States find this information useful in their continued interactions with their respective Medicaid Fraud Control Units. We also encourage States to offer to one another and the MIG other suggestions on developing and maintaining positive working relationships with their MFCUs. Any comments or suggestions for future revisions of this best practices document should be directed to Jason Weinstock, Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, Medicaid Integrity Group, 7500 Security Boulevard, Mailstop B2-15-24, Baltimore, Maryland, or to jason.weinstock@cms.hhs.gov.