

Department of Health & Human Services
Centers for Medicare & Medicaid Services
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Atlanta, Georgia 30303-8909



February 2003

Dear Program Integrity Director:

The Medicaid Alliance for Program Safeguards (Alliance) has conducted a series of program integrity reviews at Medicaid State Agencies. Enclosed you will find our *Review of State Medicaid Program Integrity Procedures National Report* (National Report) for Fiscal Year 2002. This National Report summarizes Observations and “Benchmark” practices gathered during the eight reviews conducted in Alabama, Arkansas, Florida, Idaho, Massachusetts, Ohio, Washington, and West Virginia.

The Alliance completed on-site reviews in eight States per year in FYs 2000-2002, for a total of twenty-four States, and is currently engaged in six more reviews in FY 2003. The reviews are designed to help States strengthen their program integrity operations by providing constructive observations and identifying areas of regulatory weakness or non-compliance. Your State's review focused on the functional areas related to its ability to prevent, identify and deter inappropriate Medicaid payments. Comments from your staff played a significant role in the preparation of your State's report.

We hope this National Report will assist your State, and all States, in assessing where your State is positioned along the fraud and abuse prevention continuum and in selecting appropriate enhancements that fit your needs. This report, as well as all previous National Reports, are available on our Web Site under the heading “Reports” at: <http://www.cms.hhs.gov/states/fraud>. If you have any questions concerning this report, you may contact Mark Rogers in the Atlanta Regional Office at (404)-562-7350.

Sincerely,

/s/

Rose Crum-Johnson
Southern Consortium Administrator

Enclosure

cc: Mike Lewis, Acting Commissioner, SMD
Bruce Lieberman, MFCU Director



Review of State Medicaid Program Integrity Procedures

National Report

Fiscal Year 2002



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

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Executive Summary

The Medicaid Alliance for Program Safeguards (the Alliance) conducted program integrity (PI) reviews in Alabama, Arkansas, Florida, Idaho, Massachusetts, Ohio, Washington, and West Virginia in fiscal year (FY) 2002. The objectives were: (1) to determine how each State identified, received and processed potential provider fraud and abuse information and, (2) to determine if the State Agencies' program integrity policies and procedures complied with Federal statutory and regulatory requirements. Teams also identified "Benchmark Practices" that could be shared with other States in order to enhance their programs.

The findings from the reviews are discussed in this National Report, which is organized into four functional areas: Provider Enrollment, Program Integrity/Surveillance and Utilization Review Subsystem, Managed Care, and Medicaid Fraud Control Unit. The applicable Findings, Benchmark Practices and observations are discussed in each section of the main report.

Provider Enrollment: Four of the eight State Agencies reviewed did not comply with all of the requirements. The four State Agencies did not meet the requirements of 42 CFR 455.104. One of the four did not comply with 42 CFR 455.105. Two of the four also did not request the information required by 42 CFR 455.106.

Program Integrity/ Surveillance and Utilization Control Subsystem (SURS): Seven States were in compliance in the area of SURS/claims review oversight. One State Agency did not comply with the requirements at: 42 CFR 455.13; 42 CFR 455.14; 42 CFR 455.15; 42 CFR 455.23; 42 CFR 447.10; and section 4724(f) of the BBA.

Managed Care: All of the State Agencies were in compliance with the regulations in the managed care area.

Medicaid Fraud Control Unit (MFCU): Seven of the eight State Agencies conducted preliminary investigations and referred cases to the MFCU and other appropriate law enforcement agencies as required by the regulations. There was a finding of non-compliance with 42 CFR 455.15 at one State Agency.

Conclusion

Although the majority of the State Agency PI Units reviewed were in substantial compliance with Federal law there were a few areas in which non-compliance was found. All of the State Agencies assessed indicated that they had made positive modifications in their programs as a result of their PI review. The State Agencies may increase their ability to identify fraud and abuse in their Medicaid programs and improve their capacity to reduce the amount of inappropriately paid Medicare monies by instituting appropriate corrective actions.

Introduction

In December 2001, the Medicaid Alliance for Program Safeguards (the Alliance) began its third year of reviewing the State Agencies' Program Integrity (PI) Units. The reviews were conducted in accordance with the Centers for Medicare & Medicaid Services' (CMS) mandate to provide oversight of the State Agencies' PI functions and support the States' efforts to identify and eliminate Medicaid fraud and abuse. Each PI review was conducted by a national team composed of Medicaid Alliance for Program Safeguard's staff from the Central Office and/or Regional Offices. In FY 2002, the Alliance reviewed the following eight States: Alabama, Arkansas, Florida, Idaho, Massachusetts, Ohio, Washington, and West Virginia.

The PI review teams' objectives were to: (1) determine if the State was in compliance with Federal law by reviewing its policies and procedures; and, (2) to determine how each State identified, obtained and processed potential provider fraud and abuse information. The teams also looked for noteworthy practices that could be shared to help States enhance their program integrity activities.

This National Report is a compendium of data from the eight individual PI reviews conducted in FY 2002. A "Benchmark Practice" is a potentially beneficial tool that other States might consider implementing to improve their program. A "Finding" is an area in which the State Agency was found to be out of compliance with regulatory requirements. In addition, this Report also discusses other observations that might prove to be beneficial to State Agencies wanting to enhance their program integrity oversight. States should be aware; however, that adoption of some of these procedures may require a change in State law.

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

Provider Enrollment

Preventing abusive and/or fraudulent entities and individuals from becoming Medicaid providers is a critical part of an effective and efficient Medicaid program. Verification and/or use of the information disclosed during the application process provides the State Agency with an opportunity to deny enrollment to ineligible or excludable providers. Preventing Medicaid dollars from being inappropriately paid is far more efficient and effective than trying to recover the funds at a later date. Fraudulent providers frequently declare bankruptcy and/or spend the falsely obtained funds before payment can be recovered. Even when a court orders a provider to return the money, the State often receives only pennies on the dollar. Therefore, it is critical that States exercise all possible precautions to prevent dishonest organizations and/or individuals from becoming Medicaid providers.

Since provider enrollment is such a critical part of ensuring fiscal integrity, one of the national review teams' priorities was to analyze the State's program integrity practices as they correspond to Federal law. The areas assessed under provider enrollment include: exclusions, licensure verification, and disclosure. In addition, this report discusses other ways that the States may limit their vulnerability to fraudulent and/or abusive providers by disenrolling inactive providers and performing periodic re-enrollment.

Exclusions and Excluded Providers

One way to reduce inappropriate payments is to ensure that providers reported on the Department of Health and Human Services' Office of Inspector General's List of Excluded Individuals and Entities (LEIE), (a compilation of the names of individuals and providers who have been excluded from participation in Medicare, Medicaid or Title XX programs) are not allowed to become, or continue to be Medicaid providers. One State took the initiative to ensure that their computer system compared the LEIE data to the names of individuals or entities applying to become Medicaid providers as part of the initial credentialing process. The same computerized system was also used to compare the LEIE against the list of existing Medicaid providers to determine if any participating providers appear on the list.

Other States manually compared the LEIE against Medicaid provider applicants and existing Medicaid providers. Although not completed at the time of the PI reviews, several States indicated that they were working toward implementing similar systems for electronic comparison. The Alliance strongly recommends development and implementation of such a system since it serves as a fiscal safeguard and helps prevent fraudulent and abuse providers from becoming and remaining enrolled in the Medicaid program.

Although all eight States reviewed were in compliance with Section 1902(a)(39) of the Social Security Act, which outlines provider exclusion requirements, there were vulnerabilities in the methodology used by several States at the time of the PI reviews. For example, three States looked at the LEIE data for only the names of excluded providers who were based in their State or one of their border States. Since many fraudulent providers are willing and able to move their operations to any place in the United States, it is important that a State Medicaid Agency compare its roster of existing Medicare and Medicaid provider applicants against the entire OIG LEIE. Another State was vulnerable because it compared the LEIE data only for physician providers instead of all Medicaid provider types.

Benchmark Practice/s in the Areas of Exclusions/Excluded Providers

(1) Several of the State Agencies have developed web sites that furnish listings of excluded providers and inform the public of the importance of not doing business with excluded providers. In addition, one State Agency has developed an internal Web page that has links to the LEIE and other databases containing additional information on providers (e.g., the State medical boards and the Health Integrity and Protection Data Bank).

(2) One State's system for comparing the LEIE data with their Medicaid provider applicants was entirely electronic making it possible to better use staff time, which otherwise would have been absorbed by a manual comparison. Further, computerizing such a comparison reduces the potential for human error.

Licensure Verification

The Medicaid program requires providers to have a valid State license for the medical services they are providing. All of the States reviewed checked with the appropriate licensing organizations/boards to verify that providers had valid licenses before enrolling them. Many States classify out-of-state providers who are located near their borders as in-state providers. All of the States used a distance limit to classify providers as out-of-state. Out-of-state providers generally have limits placed on their participation ranging from duration of participation and/or only being paid for providing emergency care.

Benchmark Practice/s in the Area of Licensure Verification

One of the States routinely checked its list of Medicaid providers against data from the State's medical board to determine the status of the provider's license. The State then worked with the medical licensure board to ensure that providers whose licenses were set to expire were terminated from the Medicaid program in a timely and efficient manner. The process works well and helps ensure that unlicensed providers are not treating Medicaid recipients or receiving Medicaid payments.

Disclosure

Four States did not require all Medicaid provider applicants to disclose whether a person with an ownership or controlling interest in the entity was related to any of the other owners. Additionally, they did not require the applicant to report the names of any other disclosing entities in which they had an ownership or controlling interest pursuant to 42 CFR 455.104. One of the four States required that this information be obtained only for long term care facilities. Additionally, two States did not require that the relationship of these individuals as spouse, parent, child or sibling be disclosed.

One of the eight States did not meet the requirements of 42 CFR 455.105. Neither the State's provider enrollment agreement nor any other provider application material required that providers consent, upon request, to furnish within thirty-five days, information about (1) ownership of any subcontractor with whom the provider has had business transactions of more than \$25,00 during the twelve month period prior to the date of the request and (2) significant business transactions with wholly-owned suppliers or with subcontractors for the previous five years. This consent may be useful because it enables the State to obtain critical information about the provider's partners. If the partners have a history of committing fraud, it may be in the State's best interest not to admit the new provider into the Medicaid program.

Two States did not request that provider applicants disclose information about certain criminal convictions as required by 42 CFR 455.106. This regulation states that before a Medicaid Agency enters into or renews a provider agreement, the provider must disclose to the Agency the identity of any person who has an ownership or controlling interest in the provider or is an agent or managing employee of the provider, and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title XX services.

The manner of collection and use of provider conviction information varies from State to State. Some States request this information on their provider enrollment forms. In other States, the provider agreement requires that the provider disclose conviction information about any agent or managing employee of the provider. It is important that States collect and use the information obtained about convictions because: (1) not having and utilizing the information makes it possible for providers whose owners have criminal histories to enter into the Medicaid program; and, (2) if conviction information is not collected, it cannot be conveyed to the OIG as required by regulation (42 CFR 455.106(b)).

Benchmark Practice in the Area of Disclosure

One State required provider applicants to disclose information about all criminal convictions except minor traffic offences. Having this data available allowed the State to more effectively exercise its authority under section 1902(a) (39) of the Act to decline to do business with parties convicted of felonies that conflict with the best interest of the beneficiaries. States also have the option to exercise their authority under 42 CFR 455.106 to refuse to enter into or renew a provider agreement with any party convicted of Medicare, Medicaid or Title XX offenses. By not permitting prospective providers who pose a threat to the fiscal integrity of the program to become Medicaid providers, the State Agency is preemptively able to save monies from being paid to potentially fraudulent/abusive providers. The State Agency also proactively saves money by not having to incur the costs associated with taking legal actions to recover inappropriately paid monies and to exclude providers from participating in the Medicaid program.

Other Methods to Reduce Fraud and Abuse by Controlling the Provider Network

Other methods that States may use to eliminate inappropriate providers from their Medicaid program include use of criminal background checks, tracking inactive billers, and systematically re-enrolling providers.

Criminal Background Checks

Although the data they provide can be a valuable tool in protecting a vulnerable population from known felons, there was no uniformity among States with respect to when the State Agencies' conducted or how they utilized the information from background checks. Several State Agencies never performed background checks while others required them only for individuals who provide Medicaid services to vulnerable adults or children (e.g., adult family home care, children's foster home providers, etc.).

Benchmark Practice in the Area of Criminal Background Checks

One State's provider application asks all providers if they have been convicted of a felony, or had any disciplinary action taken against their business or professional license. In addition, most new providers must undergo fingerprinting and criminal history background checks prior to enrollment. The enrollment application asks for information about all managers, billing agents, officers, directors and principal owners. Physicians are not subject to this requirement due to the State's requirement for licensure background checks. Fingerprint cards are sent to the State's Department of Law Enforcement where a criminal history check is performed. The fingerprints are then sent to the FBI where the National Criminal Information Center's database is searched to

determine if the applicant has a criminal history record. The cost of the screening for each individual disclosed in the application is paid for by the provider.

Inactive Billers

Several States should be commended for purging inactive providers from their Medicaid provider rolls. These State Agencies deactivate providers who have not billed Medicaid for a pre-established time period (ranging from two to three years depending upon the State). One State had recently taken the initiative to gain legislative authority to terminate over 48,000 inactive providers in their Medicaid program. The legislation gives the State the authority to "notify any provider who has not submitted claims or transacted any business with the department for a period of twenty-four months of a proposed termination. That termination becomes effective if the provider fails to notify the department within forty-five days from the date of notification that it wants to continue the provider agreement."

Re-Enrollment

Re-enrollment of existing providers benefits the State Agency because it reminds the providers of their obligations and alerts them to any policy changes. It also enables the State to ensure that it has valid licensure and ownership information for their providers. In addition, re-enrolling providers every two or three years reduces billing address information errors and recovers the time otherwise wasted tracking down lost providers and possibly de-activating them due to billing inactivity. There is a lot of variation in when States perform re-enrollment. Some States re-enroll providers only when there is a change in their provider enrollment contractor. Other States re-enroll providers at pre-established intervals such as every five years. Other States do not have a system for re-enrolling providers on a regularly scheduled basis.

Program Integrity/SURS

The Surveillance and Utilization Control Subsystem (SURS) is a commonly used name for the section whose responsibilities include PI duties such as identifying and investigating potential fraud and abuse. The sample methodologies and techniques used vary between States as each has the authority to design and implement the types of fraud and abuse identification systems that are most effective for them.

In these lean budgetary times, it is especially critical that States aggressively identify and reduce Medicaid fraud and abuse in order to ensure that Medicaid services do not have to be reduced unnecessarily due to a lack of funds. Aggressive SURS units can and do save money for their programs. Although the Federal government does not mandate the type of sampling methodologies the State must use, the program integrity review teams did monitor to determine if the State's Medicaid program had implemented and complied with the mandatory regulatory activities outlined in Federal law. These include the requirements to have: (1) methods for identification, investigation, and referrals as outlined in 42 CFR 455.13 - 16; (2) recipient verification procedures as stated in 42 CFR 455.20; and, (3) SURS' recipient verification process

(including managed care) pursuant to 42 CFR 455.20. Seven of the eight States were in compliance with all of the regulations listed above. The one State that was not in compliance did not meet the following requirements:

(1) 42 CFR 455.13 requires Medicaid agencies to have methods and criteria to identify, investigate and refer suspected fraud;

(2) 42 CFR 455.14 requires that, when a Medicaid agency receives a complaint of fraud and abuse or identifies questionable practices, the Medicaid agency must conduct a preliminary investigation to determine whether there is a sufficient basis for a full investigation;

(3) 42 CFR 455.15 requires that full investigations of potential provider fraud and abuse be conducted on the basis of the Medicaid agency's preliminary investigation, identification of fraud, and determination of a sufficient basis to refer potential fraud cases to the Medicaid Fraud Control Unit (MFCU);

(3a) 42 CFR 455.15(a)(1) requires that, if a preliminary investigation gives a Medicaid agency reason to believe provider fraud or abuse has occurred, the State must refer the case to the MFCU under the terms of the State's agreement with the MFCU;

(3b) 42 CFR 455.15(b) requires Medicaid agencies to report suspected beneficiary fraud to a law enforcement agency;

(4) 42 CFR 455.23 allows Medicaid agencies to withhold provider payments based on reliable evidence of fraud and sets out specific notice requirements at 42 CFR 455.23(b)(1)-(4);

(5) 42 CFR 447.10 under which the Medicaid agency must prevent prohibited reassignments of claims by ensuring that payments are made to providers or reassigned as specified under 447.10(e)-(g); and,

(6) 4724(f) of the Balance Budget Act (BBA) requires that Medicaid agencies have a means to receive and compile data on beneficiary complaints of alleged fraud, waste and abuse in Medicaid.

The absence of written policies, procedures and supporting documentation demonstrating how the State's PI Unit had identified, investigated and reduced abuse and fraud was the cause for the review team's findings of non-compliance. Since the program integrity team's onsite visit, the State has indicated via correspondence and conference calls, that it is developing and implementing new policies in order to come in to compliance with the regulations. The Alliance is planning a follow-up visit.

Methods for Identification, Investigation and Referral of Fraud and Abuse to the Appropriate Agencies as Required by 42 CFR 455.13 - 16

Several of the State Agencies have established data warehouses, which include multiple years of data, and allow for better claims analysis. In addition, some States supplement their use of random samples for preliminary fraud and abuse identification with sophisticated software. The software detects aberrant billing patterns and identifies particular providers for closer scrutiny. Since it is difficult to recover the full amount of payments made to fraudulent providers, it is vital that dishonest providers be identified as quickly as possible in order to minimize the losses to the Medicaid program. For a detailed look at which information systems software is being used by various States, see the CMS report, *Resource Guide of State Fraud & Abuse Systems*, available on the Medicaid Alliance for Program Safeguards' Web site under the heading "Reports" at <http://cms.hhs.gov/states/fraud>.

In addition to using data analysis, all of the States had a toll-free hotline to encourage their beneficiaries and providers to refer possible fraud and abuse. All of the States' Program Integrity Units participated in multi-agency task forces and special projects within their State Agencies. Each of the States utilized their SURs staff in numerous ways including data analysis to identify possible fraud and abuse by the providers, medical chart reviews, recouping settlements and overpayments, imposing sanctions, conducting field investigations in the staff members' areas of expertise, and furnishing provider education activities.

Compliance with Recipient Verification Procedures as outlined in 42 CFR 455.20

All of the States met the requirement that State Agencies have a system for verifying with recipients whether or not the services billed by providers were received. Most States sent out Explanation of Benefits (EOBs) to a targeted sample of recipients selected by the type of claims being reviewed. Recipients were requested to respond if they had not received the services indicated on the bill. In most situations, SURs staff then contacted the beneficiary via telephone to follow-up on any beneficiary responses indicating that the services were not provided.

Reassignment of Provider Claims

Federal regulations at 42 CFR 447.10 implement 1902(a)(32) of the Social Security Act, and prohibit States from making payments for Medicaid services to anyone other than a provider, except as specified in the regulation. 42 CFR 447.10 also specifies who may receive payments, and requires that these specifications be reflected in the State plan. Although several requests for the documentation were made, one of the eight States did not produce the requested State plan provision or any alternative form documenting that it was in compliance with these requirements.

Benchmark Practices In the SURS Area

- (1) Using contractors to provide wide-ranging and targeted high tech fraud and abuse detection software, which allows the State to gain the benefits of using sophisticated data analysis tools without having to supply the programming skills and technical support in-house:

(2) Creating a Deputy Inspector General position to enable the coordination of fraud and abuse policy throughout the State Agency. The new position allows the State to deal with fraud and abuse in all aspects of its Medicaid program:

(3) Having program integrity staff work with the State's legislators to pass legislation to tighten loopholes and to add tools to reduce fraud and abuse. Proposals being worked on include: (a) transferring an overpayment liability to new owners until the debt is paid; (b) placing liens against a provider's professional assets and (c) eliminating the current physician exemption for overpayment withholding. The web address for the Medicaid Fraud Statute web site is: <http://cms.hhs.gov/states/fraud>.

(4) Having the PI/SURS unit collaborate with their State's medical and other allied professional associations to furnish training and information to providers. The goal is to teach providers the coverage and coding requirements in order to reduce the occurrence of accidental coding and billing errors and encourage them to recognize and report fraud and abuse. Several States also feature new provider and provider-type-specific training information on their websites.

(5) Using "Explanation of Benefits Statements" (EOBs) to educate beneficiaries and identify possible fraud and abuse among various provider types. For example, one State's SURS unit sends out EOB statements to 6000 recipients each month. This State has the ability to change the provider type targeted so the targets can be changed each month. This flexibility allows SURS to scrutinize a particular service type if questions about billing improprieties arise. Four hundred randomly selected EOBs are also mailed each month. This helps providers understand that any invoice they submit is potentially subject to review.

(6) Pursuing different ventures to improve funding for PI. For example, one State was able to pass legislation allowing its PI Unit to retain a portion of the State's share of fraud and abuse recoveries and to use the monies to expand program integrity staff and activities.

(7) Having the flexibility to modify the PI Units/SURS structure as needed to maximize effectiveness. One State was authorized to hire additional staff provided they were specifically used to recover overpayments, increase efficiency, improve quality of care, and avoid unnecessary spending. The State is focusing on areas where it can help contain costs and increase payment accuracy.

Managed Care

All of the States had a managed care component that was separate from the Program Integrity Unit. There were variations in the amount of interaction between the PI/SURS and managed care staff. The old perception that States did not have to be concerned about fraud and abuse in managed care because the State paid a capped fee per beneficiary to the managed care organizations, is gradually changing.

Most States included managed care service encounter data in their claims systems. However, the States' PI Unit did not routinely analyze the data to determine if there were trends indicating the possibility of fraud and/or abuse. In most situations, it was the managed care component that was responsible for verifying that services billed for were actually received.

Most of the States could benefit from their managed care components taking a more active stance in fraud and abuse identification and prevention. Methods for improving the managed care component's involvement in fraud and abuse identification and prevention activities include: (1) ensuring that each managed care organization's contract requires it to establish and operate an effective system for identifying and reducing fraud and abuse; (2) developing and maintaining a strong relationship between managed care and program integrity staff; (3) implementing a system so the managed care organization refers fraud and abuse to the program integrity unit; (4) ensuring that any entity or provider excluded by the HHS OIG is prevented from entering into the managed care program when they initially apply for participation, or are removed from payment status if already participating; and, (5) utilizing the CMS publication: *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care*, which is available under the heading "Reports" on the Alliance's Web site at: <http://cms.hhs.gov/states/fraud>.

Benchmark Practices in the Area of Managed Care

One State added fraud and abuse as a component to its Performance Improvement Agreements (PIAs) for managed care providers (MCPs) during fiscal year 2002. The implementation of the PIAs required the MCPs to submit a written fraud and abuse plan and the related policies and procedures they had put in place including procedures for identifying, detecting, and investigating double billing and procedures to prevent and detect improper coding. The State was then able to monitor the MCP's progress in meeting its PIAs.

Medicaid Fraud Control Unit

Sections 1903(a)(6), 1903(b)(3) and 1903(q) of the Social Security Act, as amended by the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95-142) form the legal basis for establishment of a State Medicaid Fraud Control Unit (MFCU). The statute authorizes the Secretary to pay a State ninety percent of the costs of establishing and operating a MFCU for the purpose of eliminating provider fraud in the State Medicaid program. The MFCU is responsible for investigating and prosecuting fraud throughout the State's entire Medicaid program. The law allows the State to be flexible in how it organizes the MFCU. However, it does mandate that the MFCU be: (1) a single identifiable entity of the State government; (2) be independent of the Medicaid Agency and, (3) be certified by the Secretary.

Although the Office of the Inspector General (OIG) has oversight responsibility for the MFCUs, there are also specific Federal regulations applicable to both the MFCU and the Medicaid Agency. These regulations mandate cooperation and coordination between the MFCU and the Medicaid Agency (including an inter-agency agreement). This inter-agency relationship was the focus of the program integrity teams' reviews at the MFCU offices.

There was documentation supporting the referral of cases of suspected fraud and abuse for seven of the eight States reviewed. One State's PI Unit indicated that instead of sending a referral documenting possible fraud and/or abuse it sent the MFCU a copy of the Request for Repayment letter that the SURS unit sent to the provider when they discovered inappropriately paid claims. The Agency failed to comply with regulations requiring documentation of appropriate identification, preliminary investigation and referrals of suspected fraud and abuse to the MFCU (42 CFR 455.14 and 42 CFR 455.15). Federal regulations at 42 CFR 455.14 require Medicaid agencies to conduct preliminary investigations of complaints of provider fraud or abuse to determine whether there is a sufficient basis for a full investigation. 42 CFR 455.15 requires that, when a Medicaid agency suspects provider fraud based on the findings of a preliminary investigation, the Medicaid agency must refer the case to the MFCU for full investigation.

State Agencies' Responsibility for Case Referral – 42 CFR 455.21

All eight States had policies and procedures in place that enabled them to send referrals to the MFCU. Many of the States made multiple referrals throughout the course of the year. The MFCUs commonly request that the State Agency PI/SURS Units not delay administrative sanctions against a provider who has been referred to the MFCU until the MFCU has decided whether or not they wish to pursue a case. Some PI/SURS Units expressed frustration with the amount of time taken by the MFCUs before they elect to accept, or return cases to the PI/SURS Units. It is critical that the MFCU and PI/SURS Unit regularly meet and/or exchange information on the status of the referred cases to ensure the cases are processed as efficiently and effectively as possible.

MFCU/State Relations and Cooperation - 42 CFR 455.21

The States' Medicaid PI efforts are most effective when there is continuous productive interaction and information sharing between Medicaid Agencies and MFCUs. When possible, PI/SURS and MFCU investigators should have a system that enables them to work together and share information on their respective operations. Interagency training is also beneficial. For example, the PI/SURS Unit may share training on payment criteria and data mining techniques with the MFCU, while the MFCU provides the PI/SURS Unit with training on investigative and case management techniques. When possible, both units should participate in task force operations.

Task Force Participation

In addition to working together on specific cases involving one or more providers, most States have some form of regular health care fraud task force meetings. Many of the States held regularly scheduled meetings between the State Agency PI staff, the MFCU, the State Attorney General's Office, and the State Health Care Task Force to discuss specific cases. The FBI and the U.S. Attorneys' offices were also invited. Several of the States also attended the annual Federal Health Care Task Force meetings.

Conclusion

Four of the eight State Agency PI Units reviewed were in complete compliance with Federal law. Three Units were in substantial compliance and did not meet a portion of the disclosure requirements. One PI Unit was not in substantial compliance and had findings in several different areas. In addition to doing a good job meeting the PI regulations many of the State Agencies had developed and implemented one or more "Benchmark Practices" that enhanced their program's ability to identify and/or reduce Medicaid fraud and abuse.

The Alliance commends the State Agencies for their willingness to utilize the information obtained from their Program Integrity Review to improve their programs. All of the States indicated that they had made or planned to make modifications in their PI Units in order to incorporate suggestions for improvement and/or to address areas of non-compliance noted during the onsite review.