

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Center for Medicaid and State Operations

December 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 2003. This National Report summarizes Observations and “Benchmark” practices gathered during the six reviews conducted in Arkansas, Colorado, Kansas, Louisiana, Michigan, and Rhode Island.

The Alliance has now completed a grand total of thirty reviews in twenty-nine states, (one state was a re-review). These reviews are designed to help states strengthen their program integrity operations by providing constructive observations and identifying areas of regulatory weakness or non-compliance. Each state's review focused on the functional areas related to its ability to prevent, identify and deter inappropriate Medicaid payments.

We hope this National 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. This report, as well as all previous National Reports, is available on our Web Site at: <http://www.cms.hhs.gov/states/fraud> under “Reports”. If you have any questions concerning this report, you may contact Mark Rogers, Regional Liaison, in the Atlanta Regional Office at (404)-562-7321.

Sincerely,

/s/

Paul Miner
Technical Director
Medicaid Fraud and Abuse

Enclosure

Review of State Medicaid Program Integrity Procedures
National Report
Fiscal Year 2003



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 Arkansas, Colorado, Kansas, Louisiana, Michigan, and Rhode Island in fiscal year (FY) 2003. The objectives were: (1) to determine how each state identified, received and processed potential provider fraud and abuse information involving the Medicaid Program and, (2) to determine if the State Agencies' PI policies and procedures complied with Federal statutory and regulatory requirements. The Alliance also identified "Benchmark Practices" that could be shared with other states in order to enhance their programs.

The findings from this year's 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 State Agencies reviewed did not comply with all Federal requirements. Three State Agencies did not meet the requirements at 42 CFR 455.104, which states that the Medicaid agency must require participating and applicant providers (other than individual practitioners and groups) and fiscal agents (*i.e.* "disclosing entities") to disclose information related to ownership and controlling interests. One State Medicaid Agency was not satisfying the requirement at 42 CFR 455.105 that providers consent in their agreements with the state to furnish, upon request, information related to business transactions as specified at 42 CFR 455.105(b)(1)-(2). Four states did not comply with the requirement at 42 CFR 455.106 that, before the state enters into or renews an agreement with a provider, the provider must disclose the identity of any person, who has been convicted of a crime related to a federal health care program.

One State Agency failed to comply with provisions of section 1902(a)(39),(41) of the Act, that requires the state to ensure that it does not do business with excluded parties, defined as those providers listed on the Office of the Inspector General's List of Excluded Individuals/Entities (LEIE), the Medicare Exclusion Database (MED), or other similar listing. The State Agency only reviewed the MED periodically and never reviewed the LEIE when enrolling providers.

Program Integrity/ Surveillance and Utilization Control Subsystem (SURS)

Three states were in compliance in the area of SURS/claims review oversight. Four State Agencies did not make use of their authority under BBA §4724(d) to decline to do business with individuals or entities convicted of felonies that are not necessarily related to government health insurance programs. This provision can be a powerful tool to keep some unwanted providers out of a state's Medicaid program. One of the states that exercised the authority granted under the provision did so by passing a state law and using a provider enrollment broker.

Managed Care

Two of the six states reviewed did not have managed care in their Medicaid Program. The four of the six State Agencies that have managed care were in compliance with the regulations in the managed care area. Two of the State Agencies could benefit from increased monitoring of Managed Care Organization (MCO's) contracts for fraud & abuse activities such as insuring that MCO's are

checking the LEIE and collecting ownership and control information. One state was advised to include the MCO's in the monthly meetings that involve the MFCU and other parties as a way to exchange information regarding potential F&A issues in managed care. It was recommended in one state that the managed care contracts be amended to require that all MCO's collect ownership and criminal conviction information and check for exclusions. These requirements should also be assessed during the state's annual reviews of their MCO's. One state requires any provider enrolled in one of the Managed Care Plans (MCP's) to provide services to all Medicaid beneficiaries.

Medicaid Fraud Control Unit (MFCU)

All of the State Agencies conducted preliminary investigations and referred cases involving potential fraud to the MFCU and other appropriate law enforcement agencies as required by the regulations. We found that although all states followed the regulations, some states had a better working relationship with their MFCU than did others. In three of the states the fraud analysts and the program integrity staff meet monthly or at least quarterly, with the MFCU. The purpose of the meeting is to exchange case updates, discuss fraud issues, address pending issues and discuss the status and disposition of cases. In one state the CMS review team recommended that the State Agency make greater use of both regularly scheduled and ad hoc meetings with the MFCU to clarify any unmet needs with respect to state-initiated sanctions and federal program integrity requirements. In another state the MFCU assists the PI unit "triage" fraud or abuse complaints, and assists in determining whether matters are worthy of a formal referral or if alternative actions should be taken. In yet another state the MFCU has been very active in presenting the State Medicaid Agency with recommendations for changes that may stop abusive or fraudulent practices.

Conclusion

Although the majority of the State Medicaid Agency PI Units reviewed were in compliance with Federal law there were a few areas in which non-compliance was found in the areas of 1902(a) (39) of the Social Security Act, 42 CFR 455.104, 42 CFR 455.13, 42 CFR, 455.14, 42 CFR 455.15, 42 CFR 455.23, and Section 4724(f) of the Balanced Budget Act (BBA). Most of the State Agencies assessed indicated that they had made positive modifications in their programs as a result of the CMS PI review. These State Agencies will undoubtedly increase their ability to identify fraud and abuse in their Medicaid programs and improve their capacity to reduce the amount of inappropriately paid Medicaid monies by instituting the appropriate corrective actions.

Introduction

In December 2002, the Medicaid Alliance for Program Safeguards (the Alliance) began its fourth year of reviewing the State Agencies' Program Integrity (PI) Units. The reviews were performed 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. A national team composed of Alliance staff from the Central Office and/or Regional Offices performed these reviews. In FY 2003, the Alliance reviewed the following six States: Arkansas, Colorado, Kansas, Louisiana, Michigan, and Rhode Island.

The inspection goals were to: (1) determine if every state reviewed 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 inspection teams also looked for substantial practices that could be shared to help states augment their PI activities.

This National Report is a compendium of data from the six individual PI reviews conducted in FY 2003. 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 Medicaid Agency was found to be out of compliance with regulatory requirements. In addition, this Report also discusses other "Observations" Observations include noteworthy State Medicaid Agency procedures that do not rise to the level of Benchmark Practices or Findings. 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 significant part of an effective and capable Medicaid program. Verification and/or use of the information disclosed during the application process provides a State Medicaid 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 after the fact. Fraudulent providers frequently declare insolvency 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 safety measures to prevent dishonest organizations and/or individuals from becoming Medicaid providers.

Since provider enrollment is such a critical part of ensuring fiscal integrity, a priority of the national review teams was to analyze each state's 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 susceptibility to fraudulent and/or abusive providers by disenrolling inactive providers and performing periodic re-enrollment

All of the states utilized a provider enrollment broker to enroll providers into their Medicaid program. State Medicaid Agencies retained the final authority for accepting providers into their program. The broker in one state processes approximately 2,500 provider applications yearly. Disclosure information is computerized, and both the state and the enrollment broker's provider enrollment staff have access to the computerized files. The State Medicaid Agency's staff then uses the information obtained via the disclosures and through review of the List of Excluded Individuals and Entities (LEIE) or it is equitable to base its final decision on whether or not the applicant should be permitted to become a Medicaid provider. During a review, PI staff were able to point out an example of an applicant who had been denied permission to become a Medicaid provider because of its history of sanctions for fraudulent/abusive claims.

The review team found that the one State Agency did not question the lack of information on the provider enrollment form or conduct a search for related exclusions before completing the enrollment process and assigning a provider number. The information sent to the enrollment broker for input into the MMIS did not include ownership information, and was not checked by the enrollment broker for entity exclusions.

In another state, the PI unit has developed and implemented policies and procedures that mandate potential Medicaid providers to disclose all of the information required by 42 CFR 455.104-106. As part of its oversight role, the State Medicaid Agency's PI unit monitors the enrollment broker to ensure that it consistently obtains and validates the ownership and control information. The Medicaid provider application is not processed unless the potential provider discloses all of the required information.

Benchmark Practices

One state passed a Medical Assistance Program Integrity Law (MAPIL) in 1997. This law has a significant impact on all Medicaid providers in the state. Provisions in MAPIL establish the provider agreement as a contract between the State Department of Health and the provider. The law requires that by entering into the contract, the provider must meet certain terms and conditions. Some of the other conditions that MAPIL requires providers to meet include, but are not limited to:

1. Provider assurance that the buyer and the seller of a provider are liable for any civil judgments or administrative sanctions;
2. Providers must maintain all records for five years;
3. Providers must post a letter of credit or bond as required;
4. Providers must notify the State Medicaid Agency of any change in ownership.

Another noted benchmark practice in one state requires providers enrolled in one of states Managed Care Plans to provide services to Fee-For-Service (FFS) Medicaid beneficiaries. This is an excellent way to ensure access to services for all Medicaid recipients.

Exclusions and Excluded Providers

One of several ways 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 list of the names of individuals and providers who have been excluded from participation in Federally funded programs such as Medicare, Medicaid or Title XX programs).

Providers on this list should not be allowed to become, or continue to remain Medicaid providers. Three states did not have a process in place to ensure that excluded providers or entities were not allowed to participate in federally funded programs. Three states had a process in place to ensure that their computer system compared the LEIE data against 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 appeared on the list. The states that did check for excluded parties often did not check for disclosure and ownership information, such as the names of owners and managers.

Three states that did not check for excluded providers and entities indicated that they were working toward implementing 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 abusive providers from entering and remaining enrolled in the Medicaid program.

Although four states reviewed were in compliance with Section 1902(a) (39) of the Social Security Act, which delineates 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 have the propensity to move their business enterprises to any place in the United States, it is important that a State Medicaid Agency compare its roster of existing Medicaid provider applicants against the entire LEIE.

Benchmark Practices

Some State Agencies have developed Internet 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 Medicaid Agency 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).

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. Five of the states reviewed confirmed 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.

States check provider licenses to ensure that they have a beginning and end date to show when the license is valid. One state has their enrollment broker access the state's Division of Regulatory Agencies (DORA) via the Internet as an added check on the validity of a license. The status of the

license is reviewed to see if there are any actions that may limit or prevent the state from granting entrance into their Medicaid program. Out of state provider applications are handled like those for in-state providers. However, out-of-state licenses may not have a beginning and/or ending date, and licensure boards in other states are not typically checked to determine the status of licenses.

Another state, as part of the provider enrollment process, entered all information from the application into the state's Provider Enrollment Database (PED). Each provider is required to submit a physical address, rather than a post office box. The PED includes an automated in-state license verification that will confirm or deny the existence of a medical license for the provider applicant. However, this system will not alert the Medicaid agency if there is a sanction or restriction on that license. If all information is complete, the Agency issues a provider number and enrolls the provider into the program. The enrollment period is not limited, but is subject to being terminated for cause or for inactivity. Out-of-state providers that are not located close to this particular state's borders will be given a miscellaneous transaction number when they render services to a Medicaid recipient from this state. The assigned number will be valid for three days prior to and following the date of service.

Benchmark Practices

In one of the states reviewed, in order to participate in the Medicaid program, any required license must be current and in good standing. The fiscal agent requires that a copy of the medical license be enclosed with the provider application. Further, they check with the state-licensing department to ensure that the license is valid and does not contain any restrictions that would impact the provider's ability and eligibility to render services to Medicaid recipients. The fiscal agent receives notification of sanctions and other actions taken by the medical boards from the Department of Health. Additionally, out-of-state providers are required to update their licenses annually.

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 state did not meet the requirements of 42 CFR 455.105. Neither the state's provider enrollment agreement, nor any other provider application material, required providers to furnish within thirty days of a request, information about (1) ownership of any subcontractor with whom the provider has had business transactions of more than \$25,000 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 requirement 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.

Four of the states reviewed 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 a new provider agreement 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 approach to collection and use of provider conviction information fluctuates from state to state. Some states ask for 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 for the reason that: (1) not having and utilizing the information can allow 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)).

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

Three methods that states used to help eliminate inappropriate providers from their Medicaid programs were observed. These methods included, the use of criminal background checks, tracking inactive billers, and systematically re-enrolling providers.

Criminal Background Checks

The data provided through criminal background checks can be an important tool in shielding a vulnerable population from known felons. Currently there is no consistency among states as to when the State Agencies perform or how they make use of the information from background checks. Some 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 one state reviewed, inactive providers are subject to an additional safeguard. If a provider does not bill for Medicaid services for a 24-month period, the State Agency will terminate its provider number. There is an edit in the MMIS that automatically tracks and calculates this period of inactivity. The provider must re-enroll if it wants to begin billing again.

Re-Enrollment

Re-enrollment of existing providers can cleanse provider files of non-billers, and build an information base that can be used to identify related organizations and potentially problematic providers, as well as update licensure and ownership information. Also, re-enrolling providers every two or three years decreases billing address information errors and recovers the time wasted tracking down lost providers and perhaps de-activating them due to billing inactivity. There is a lot of variation as to when states perform re-enrollment. Some states re-enroll providers only when the state changes its 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. One state reviewed only re-enrolled Primary Care Physicians.

Program Integrity/SURS

The Surveillance and Utilization Control Subsystem (SURS) is the name used for the division whose responsibilities include Program Integrity (PI) duties such as identifying and investigating potential fraud and abuse. The sampling methodologies and techniques used vary between states as each has the power to devise and implement the types of fraud and abuse identification systems that are most effective for them.

In our current economic climate, it is vital that states aggressively identify and reduce Medicaid fraud and abuse in order to ensure that Medicaid services do not have to be reduced needlessly due to a lack of state funds. Aggressive SURS units can and do save money for their programs. Although the Federal government does not mandate the type of sampling methodologies that states use, the PI review teams monitored to determine if the States' Medicaid program had implemented and complied with the mandatory regulatory activities defined 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. Five 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 State Medicaid Agencies to have methods and criteria to identify, investigate and refer suspected fraud;
- (2) 42 CFR 455.14 requires that, when a State Medicaid Agency receives a complaint of fraud and abuse or identifies questionable practices, the State 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 State 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);
- (4) 42 CFR 455.23 allows State 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) Section 4724(f) of the Balanced Budget Act (BBA) requires that State Medicaid Agencies have a means to receive and compile data on beneficiary complaints of alleged fraud, waste and abuse in Medicaid.

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

Some State Agencies have set up data warehouses that include several years of data, and facilitate improved claims analysis. Other states enhance their use of random samples for preliminary fraud and abuse identification with advanced software. The software detects peculiar billing patterns, allowing for staff to identify particular providers for closer inspection. Since it is not easy 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 at <http://cms.hhs.gov/states/fraud>, under "Reports".

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' PI units participated in multi-agency task forces and special projects within their State Medicaid Agencies. Each of the states utilized their SUR/PI 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 reviewed met the requirement that State Agencies have a system for verifying with beneficiaries whether or not the services billed by providers were received. Four 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. The EOBs are also used to educate beneficiaries and identify possible fraud and abuse among various provider types. For example, three state's SURS units sent out EOB statements to recipients each month. These states have the ability to change the provider type targeted so that different providers can be checked, each month. This flexibility allows SURS to scrutinize a particular service type if questions about billing improprieties arise. States often mail randomly selected EOBs each month. This helps providers understand that any invoice they submit is potentially subject to review.

Reassignment of Provider Claims

Federal regulations at 42 CFR 447.10 implement 1902(a)(32) of the Social Security Act, 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. All six states were in compliance with this regulation.

Benchmark Practices

Contingency Based Contracts

The use of contingency-based contracts can provide innovative fraud and abuse and credit balance solutions. The contractor provides data analysis using algorithms and data mining based on a vulnerability analysis agreed to by the state. The contractor's fee is based on a percentage of the dollars it recovers.

Development of Procedure Manual

In another state, the SURS unit has developed a procedure manual that is very detailed in its explanation of case development, correspondence procedures, and ordering reports and claims information. The manual contains a detailed section on quality control and is used in the training of new employees and, on an ongoing basis, current staff. Updates appeared to be made as needed.

Centralized Case Development

One state funneled all case development issues through a centralized location (PI Director). This practice provides for better control of case workload, especially in terms of development and referrals to the MFCU.

Suspect Provider Database

In one state the fiscal agent maintains a Suspect Provider Database (SPD) that is utilized by the fraud analyst to update provider eligibility files, update quarterly reporting, and as a research tool if Managed Care contract inquiries or provider history inquiries are received. The SPD is utilized as a resource to determine if negative or punitive action has been taken against a provider. Any action taken against a provider that provides a historical overview of Professional Board actions, exclusion, or termination activity, is added to the database.

PI/SURS/MFCU/Relationships

The inspection team noted that in one state the PI and MFCU Chiefs meet monthly to discuss the status of cases under review. MFCU staff also is present at Quality Assurance Team meetings where cases are discussed internally at SURS. At this point in the review process, cases get selected for review and/or referred to the MFCU. The MFCU also uses this opportunity to educate SURS staff as to why a case is not ready for referral.

In another state the MFCU also asks SURS to research certain scams identified by the MFCU through fraud alerts and other sources. Recently, during the fiscal agent change-over, the MFCU outlined to the SURS and PI staff how they operate and what makes a good case referral. Potential case referrals are discussed as needed to help ensure case quality.

The MFCUs in most of the states had a mix of healthcare and former law enforcement professionals. In one of the states reviewed the staff possessed a great variety of skills and experience. The investigators are former police officers, with one being a registered nurse. The auditors' backgrounds include banking, former law enforcement security officers, and one with a background in Medicare. The diversity of talent positions this office serves well, to develop and dispose of fraudulent cases.

Managed Care

Over the years Medicaid Managed Care has been implemented in many states through Section 1115 Waivers. Since managed care organizations receive capitated payments for services rendered, this means that individual providers do not bill Medicaid directly. This lack of direct involvement between the Managed Care provider and the State Medicaid Agency may provide excluded providers an opportunity to participate in a Federally funded program. Thus, it is important that State agencies that contract with Managed Care Organizations (MCO's) include mechanisms within the contract to address fraud & abuse. One way would be to require all MCO's to access the Medicare Exclusions Database (MED),LEIE or the Excluded Parties Listing Sysytem (EPLS) before enrolling providers in their network.

Benchmark Practices

Program Administration

One state reviewed MCO contracts throughout a four-year cycle. The first year review protocol includes all components of the contract, while the second, third and fourth year reviews concentrate on targeted areas. The state and MCO's routinely meet every other month to discuss concerns and issues. This allows the state to monitor how their MCO's conduct provider enrollment and detect fraud and abuse.

Managed Care Assessment Tool

One state upgraded its on-site review tool, used to perform compliance reviews at their MCO's. The upgraded tool incorporates a more comprehensive PI section. PI staff will be using this tool annually during visits to each of their 18 MCO's. This is an excellent method for educating MCO's and ensuring that they are meeting their obligations under their contract, as well complying with state and Federal law. This tool describes numerous contract requirements and how compliance will be monitored. For example, the site visit includes a review of the MCO's methods of prevention, detection, and elimination of fraud and abuse, cooperation with the attorney general's office, complaint processing, and credentialing.

Encounter Data

One State Medicaid Agency negotiated full access to the MCO's encounter data during their contract development. Further, the state recently made encounter data available to analysts at their desktop, and is in the process of implementing software that enables analysts to mine the data similar to their CS-SURS and Bi/Query capability. These steps are very beneficial for provider oversight in the state's large managed care population and for ensuring the integrity of their program.

There was adequate documentation supporting the referral of cases suspected of fraud and abuse to the Medicaid Fraud Control Units (MFCU) in all six of the states. This is in compliance with Federal regulations at 42 CFR 455.14, which 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.

Medicaid Fraud Control Units (MFCUs)

MFCU/State Relations and Cooperation - 42 CFR 455.21

State 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.

The six states reviewed have policies and procedures in place that allow the State Medicaid Agency to send referrals to the MFCU. Most of the states made multiple referrals throughout the course of the year. States that referred fewer cases cited budgetary and staffing constraints. 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. It was noted that the MFCU's subject to this review all stated that they receive virtually no referrals from MCO's.

Benchmark Practices

MFCU Investigators and Fiscal Agent

One state's MFCU investigators spent a day at the fiscal agent and the fiscal agent staff spent a day at the MFCU offices to gain a better understanding of what each staff does. This approach allows the MFCU investigators to explain in detail what they look for when developing cases.

MFCU Member of the Northeast (NE) Law Enforcement Association

The MFCU in one state is a member of the Law Enforcement Association. This association meets semi-annually and consists of representatives of MFCUs in the area, US Attorneys' offices, and State Police. These meetings generate a lot of sharing of ideas for identification of fraudulent practices and they result in numerous referrals.

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. These include regularly scheduled meetings between the State Medicaid 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

Only one of the six State Medicaid Agency PI unit's functions was in complete compliance with Federal law. Three units were in substantial compliance and did not meet a portion of the disclosure requirements, while 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 Medicaid 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 PI reviews 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 to address areas of non-compliance noted during the onsite review. States can access this report and others by logging onto our web site at www.cms.hhs.gov/Medicaid/states/fraud. If additional clarification of any ideal expressed in this report is needed, please contact your CMS Regional Medicaid Fraud and Abuse Coordinator for assistance.