

4

CHAPTER



Program Integrity in Medicaid

Recommendations

Program Integrity in Medicaid

- 4.1** The Secretary should ensure that current program integrity efforts make efficient use of federal resources and do not place an undue burden on states or providers. In collaboration with the states, the Secretary should:
- ▶ Create feedback loops to simplify and streamline regulatory requirements;
 - ▶ Determine which current federal program integrity activities are most effective; and
 - ▶ Take steps to eliminate programs that are redundant, outdated, or not cost-effective.

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- 4.2** To enhance the states' abilities to detect and deter fraud and abuse, the Secretary should:
- ▶ Develop methods for better quantifying the effectiveness of program integrity activities;
 - ▶ Assess analytic tools for detecting and deterring fraud and abuse and promote the use of those tools that are most effective;
 - ▶ Improve dissemination of best practices in program integrity; and
 - ▶ Enhance program integrity training programs to provide additional distance learning opportunities and additional courses that address program integrity in managed care.

4

CHAPTER

Program Integrity in Medicaid

Program integrity consists of initiatives to detect and deter fraud, waste, and abuse and improve program administration.¹ These activities are important because they affect the ability of the federal and state governments to ensure that taxpayer dollars are spent appropriately. Fraud, waste, and abuse exist throughout the health care system, not just in Medicaid.

Program integrity efforts help to achieve value in the Medicaid program by ensuring that federal and state dollars are spent appropriately on delivering quality, necessary care and *preventing* fraud, waste, and abuse from taking place. Because fraud is particularly difficult to detect, its precise magnitude is unknown, though analysis has shown that the great majority of Medicaid providers do not engage in such actions (Rosenbaum et al., 2009).

When implemented well, program integrity initiatives help to ensure that:

- ▶ eligibility decisions are made correctly;
- ▶ prospective and enrolled providers meet federal and state participation requirements;
- ▶ services provided to enrollees are medically necessary and appropriate; and
- ▶ provider payments are made in the correct amount and for appropriate services.

This chapter examines how Medicaid programs work to prevent and detect provider fraud and abuse.² In the future, the Commission will address waste and program management as it affects program integrity in Medicaid in more detail, as these areas are not the focus of this chapter.

¹ Program administration can include federal and state program management (e.g., policy development and implementation), as well as ongoing monitoring and oversight.

² A State Children's Health Insurance Program (CHIP) that is part of a Medicaid expansion is likely included in that state's Medicaid program integrity efforts. A separate CHIP program likely enrolls their enrollees in managed care, so some program integrity activities are carried out by the health plan.

Key points addressed in this chapter include:

- ▶ A variety of program integrity statutory provisions and administration initiatives have been implemented over time. Yet, identification of provisions and initiatives that may no longer be effective is necessary.
- ▶ More than a dozen agencies at the federal and state levels are involved in program integrity. With so many agencies involved in these activities, their success and efficiency depend on effective coordination.
- ▶ Balance between program integrity activities and other management responsibilities is an important consideration. Initiatives that are not effective or timely may lead to federal and state funds being spent on services that may be unnecessary or were never delivered, while those that are too aggressive may place an undue burden on providers.
- ▶ The availability, timeliness, and accuracy of data used in program integrity activities may make it difficult to quantify and compare the value, success, and cost-effectiveness of these initiatives.

This chapter provides information about:

- ▶ federal and state oversight;
- ▶ federal and state coordination;
- ▶ challenges in quantifying program integrity outcomes; and
- ▶ how managed care plans address program integrity.

In addition, this chapter features two Annexes. Annex 1 includes a list of key legislative milestones and statutory requirements related to program integrity. Annex 2 includes more detailed information about the roles and activities of federal and state agencies with program integrity responsibilities.

The Commission's program integrity

recommendations. Based on issues identified in this chapter, the Commission makes two recommendations regarding Medicaid program integrity. The first recommendation is intended to ensure that current program integrity efforts make efficient use of federal resources and do not place an undue burden on states or providers. The Commission recommends that the Secretary of the U.S. Department of Health and Human Services (the Secretary) determine which current federal program integrity activities are most effective and take steps to eliminate programs that are redundant, outdated, or not cost-effective. The second recommendation is intended to enhance the states' abilities to detect and deter fraud and abuse. The Commission recommends that the Secretary develop methods for better quantifying the effectiveness of program integrity activities, assess analytic tools for detecting and deterring fraud and abuse, promote the use of those tools that are most effective, and enhance program integrity training initiatives.

Defining fraud, waste, and abuse. Fraud and abuse are both defined in Medicaid regulations (Box 4-1). Fraud involves an intentional deception, such as billing for services that were never provided. Abuse includes taking advantage of loopholes or bending the rules, such as improper billing practices.

Although not the focus of this chapter, it is important to understand how waste differs from fraud and abuse. Waste, which is not defined in federal Medicaid regulations, includes inappropriate utilization of services and misuse of resources. An example is the duplication of tests that can occur when providers do not share information with each other. Waste is not a criminal or intentional act, but results in unnecessary expenditures to the Medicaid program that might be prevented.

Errors made by providers on submitted claims are also a program integrity issue, which may

BOX 4-1. Regulatory Definitions of Fraud and Abuse

Medicaid regulations define fraud and abuse as follows:

- ▶ **Fraud:** “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.”
- ▶ **Abuse:** “Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.”

Source: 42 CFR 433.304 and 42 CFR 455.2

occur because of the complexity of the billing process.^{3,4} Catching and correcting these errors can be another important component of safeguarding program integrity.

Program Oversight

Many federal and state agencies have oversight authority for the Medicaid program, and these agencies’ key Medicaid program integrity initiatives are included in Annex 2. Some of these activities relate directly to the administration of the Medicaid program (e.g., implementing Medicaid policy, addressing provider concerns, monitoring managed care plans), while others assess the administration of the program and identify areas where problems exist (e.g., federal and state audits and investigations). Some oversight programs focus on preventing fraud and abuse through effective program management, while others focus on addressing problems after they occur through investigations, recoveries, and enforcement actions.

At the federal level, the Deficit Reduction Act of 2005 (DRA, P.L. 109-107) gave the Centers for Medicare & Medicaid Services (CMS) significant new funding and responsibility for Medicaid program integrity.⁵ Other federal agencies, including the U.S. Department of Health and Human Services (HHS), the HHS Office of Inspector General (OIG), the U.S. Department of Justice (DOJ), and the Government Accountability Office (GAO) are also involved in this work. These agencies have different roles, and this differentiation may help the agencies carry out their responsibilities impartially, avoiding conflicts of interest.

Similarly, at the state level, program integrity may be shared by the state Medicaid agency and other state agencies. A state must have a Medicaid Fraud Control Unit (MFCU), which has certain responsibilities defined in law.⁶ Other agencies that may be involved in Medicaid program integrity activities include the survey and certification agency, state OIG, Office of the Attorney General,

³ For information about claims submission, see MACPAC 2011a.

⁴ For more information about unintentional errors, see the presentation of William Hazel, MD before the Commission (Hazel 2011).

⁵ For fiscal year 2004, the year before the enactment of the DRA, CMS allocated eight staff nationally and an additional budget of \$26,000 for overseeing the states’ Medicaid program integrity activities (GAO 2004).

⁶ A state may be exempt from this requirement if it can show that such efforts would not be cost-effective because minimal fraud exists, and enrollees will be protected from abuse and neglect without such a unit. For more information about MFCUs, see Annex 2.

other law enforcement agencies, and Office of the State Auditor.

The way in which states design the management structure of their program integrity responsibilities may be influenced by the federal matching rates they receive for these activities (Table 4-1). For example, general state administrative costs, which fund program management functions aimed at preventing fraud and abuse, are matched at 50 percent, while the activities of a state's MFCU, aimed at detecting fraud and abuse after they have occurred, are matched at 75 percent. Regardless of how these programs are structured, states have to find the right balance for their program integrity initiatives to ensure that delivery of care to enrollees is not negatively impacted.

Depending on their specific mission and scope, federal and state agencies may use a number of tools to identify and address fraud and abuse in the Medicaid program. Specific methods can include:

- ▶ data mining to identify possible fraud and abuse for further examination;
- ▶ audits to determine compliance with federal and state rules and regulations or to identify fraud and abuse;
- ▶ investigations of suspected fraud and abuse;
- ▶ enforcement actions (e.g., provider termination, provider exclusion) against those who have committed fraud;
- ▶ technical assistance and education for state staff so they are able to prevent and identify fraud and abuse; and
- ▶ outreach to and education of the provider and enrollee communities (e.g., how to report suspected fraud, explaining Medicaid rules and requirements).

Many oversight activities focus on identifying improper payments made to providers for services rendered.⁷ When an improper payment is identified, the state must return the federal share

TABLE 4-1. Federal Matching Rates for Activities Related to Program Integrity

State Administrative Costs (day-to-day program operations)	50 percent
Medicaid Fraud Control Unit (MFCU)	
▶ First 3 years	90 percent
▶ After 3 years	75 percent
Medicaid Management Information System (MMIS)	
▶ Design, development, and upgrade	90 percent
▶ Operation	75 percent
Medical Professionals	75 percent
Medical and Utilization Review (prospective, concurrent, or retrospective)	75 percent

⁷ "Improper payments" refer to payments that should not have been made or that were made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements, and include any payments to an ineligible recipient, any duplicate payments, any payments for services not received, any payments incorrectly denied, and any payments that do not account for credits or applicable discounts (42 CFR 431.958).

to CMS. States may use their share of the recovery in any manner otherwise lawful for the use of state funds.

Federal and State Coordination

Many federal and state agencies are involved in program integrity activities, and interagency coordination plays an important role in these initiatives. Success in this area can prevent duplication of government activities and lessen administrative burden on providers. Because program integrity initiatives have developed over time, they have not always been examined as a whole to evaluate which are duplicative, which could be improved, and which may place an unnecessary burden on states or providers.

One example of the need for coordination involves audits, which consume resources of the federal or state agency conducting the audit, as well as of the state agency or provider being audited.⁸ Different oversight agencies may conduct audits at the same time, sometimes on similar or identical topics. They are most often conducted through a field or desk audit, though in some instances, providers may conduct a self-audit. When multiple agencies are involved in similar examinations, coordination would help to ensure that program integrity efforts are conducted in a more efficient manner.

Providers have informed the Commission that, over the course of a year, they may be subject to multiple Medicaid and Medicare audits, as well as other state audits. Each audit may examine a different area regarding the provision of services, as well as aspects of business operations, which can contribute to the volume of reviews and create burden for providers.

Many audits identify errors made by providers when submitting claims for payment. Providers have indicated that the complexity of the billing process and the length of the provider manual can lead to inadvertent errors. The Commission has been advised by providers that feedback loops to the appropriate federal or state entity regarding administrative requirements would help to eliminate and prevent problems.

Federal and state coordination has many elements. Successful coordination can be difficult to achieve, as many agencies have differing mandates and goals. For example, a state Medicaid agency's priority may be to ensure service delivery for beneficiaries, a MFCU's priority may be to prosecute Medicaid fraud, and an auditor's priority may be to verify proper documentation that a service was provided. Such differing roles can complicate coordination processes, as each agency may measure success in its own way and may not consider issues important to other agencies. In addition, feedback loops that help to correct identified problems and prevent them from happening again may be absent or insufficient.

The following summarizes coordination activities among various agencies. Table 4-2 identifies the federal and state agencies that are involved in various aspects of program integrity.

Coordination among federal agencies

HHS and DOJ: Health Care Fraud and Abuse Control (HCFAC) Program. Created in 1996, the HCFAC program was designed to coordinate federal, state, and local law enforcement activities related to health care fraud and abuse across *all* health plan types, both public and private. This program funds federal health care law

⁸ State staff educate federal auditors on their state's policies, procedures, and data, taking state resources and time away from other program activities.

BOX 4-2. Federal and State False Claims Acts

The False Claims Act. The federal False Claims Act (FCA) (31 U.S.C. §§3729-3733) imposes liability on any person who defrauds the federal government and enables private parties to bring an action on behalf of the federal government and to share in a percentage of the money recovered from an FCA action or settlement. States may also have their own FCAs. To encourage this, Section 1909 of the Social Security Act allows a state that has a qualifying FCA to receive an increase of 10 percentage points in its share of any amounts recovered under these laws.⁹ Currently, 16 states have an FCA that qualifies for this enhanced match on recoveries.

Whistleblower provisions. The FCA contains *qui tam*, or whistleblower, provisions. This mechanism allows citizens with evidence of fraud relating to government contracts and programs to sue on behalf of the government in order to recover the stolen funds. In these cases, the whistleblower, also referred to as a relator, may be awarded a portion of the funds recovered, typically between 15 and 25 percent. A *qui tam* suit initially remains under seal for at least 60 days during which the DOJ can investigate and decide whether to join the action.

enforcement activities at HHS through the OIG, the Administration on Aging, and the Office of the General Counsel; and at DOJ through the United States Attorneys' Offices, and Criminal, Civil, and Civil Rights Divisions. These activities include investigations, audits, inspections, and evaluations related to the delivery and payment of health care services. HHS and DOJ jointly issue an annual report quantifying the results of the previous year's fraud and abuse initiatives. In fiscal year (FY) 2011 the Secretary and the Attorney General certified \$297.7 million in mandatory funding as necessary for the program, and Congress appropriated an additional \$310.4 million in discretionary funding (OIG 2012).

HHS and DOJ: Health Care Fraud Prevention and Enforcement Action Team (HEAT).

Created in 2009, HEAT coordinates activities across government agencies to prevent fraud in Medicare and Medicaid and enforce current anti-fraud laws around the country. This includes information and data sharing between HHS and DOJ to improve the efficiency in investigating

and prosecuting complex health care fraud cases. It is comprised of top-level law enforcement agents, prosecutors, attorneys, auditors, evaluators, and other staff from DOJ and HHS and their operating divisions. It is funded through the HCFAC program.

CMS: Center for Program Integrity (CPI).

Created in 2010, CPI oversees all CMS interactions and collaborations with federal and state partners (e.g., DOJ, OIG, state Medicaid offices, state program integrity offices, state law enforcement agencies, other federal entities, and across CMS Centers and Offices) to detect, deter, monitor, and combat fraud and abuse, as well as take action against those that commit or participate in fraudulent or other unlawful activities. The Medicaid Integrity Program, run by the Medicaid Integrity Group, is located within the CPI.

⁹ For example, if a state's federal matching rate is normally 50 percent and if it has a qualifying state FCA, then the state's share of the recovered amount would be 60 percent. To qualify for this incentive, a state's FCA must be at least as stringent as the federal FCA.

TABLE 4-2. Federal and State Agencies and Offices Involved in Medicaid Program Integrity¹

When interpreting this table, a • indicates that the agency plays a role in the program or activity listed. A ✓ indicates the agency has ad hoc or intermittent involvement in the listed program or activity, or provides oversight or guidance to other agencies involved in the listed program or activity. For example, nine agencies are involved in the Health Care Fraud and Abuse Control Program.

Program or Activity	Department of Health and Human Services				Department of Justice					State Agencies				Other	
	Centers for Medicare & Medicaid Services, including the CPI	Office of Inspector General	Administration on Aging	Office of the General Counsel	US Attorney	Civil Division	Civil Rights Division	Criminal Division	Federal Bureau of Investigation	State Medicaid Agency ²	Medicaid Fraud Control Unit ³	State Office of the Inspector General ⁴	State Auditor	Government Accountability Office ⁵	Providers ⁶
Health Care Fraud and Abuse Control Program (HCFAC) ⁷	•	•	•	•	•	•	•	•	•						
Health Care Fraud Prevention and Enforcement Action Team (HEAT) ⁸	•	•		•	•	•		•	•	✓	✓	✓			
Review Medicaid Integrity Contractors (MICs) ⁹	•									•	✓	•			
Audit MICs ⁹	•									•	✓	•			•
Education MICs ⁹	•									•					•
Medicare-Medicaid Data Match (Medi-Medi) Program ¹⁰	•	•			•					•		•			
Audits	•	•								•		•	•	•	•
Payment Error Rate Measurement (PERM) Program ¹¹	•									•					•
Medicaid Eligibility Quality Control Program (MEQC)	✓									•					•
Recovery Audit Contractors (RACs)	✓									•					•
Provider exclusions		•								•					
Provider terminations	•									•					
Provider enrollment moratoria	•	✓								•					
Prosecution	•	•		•	•	•	•	•		•	•	•			
Investigations	•	•							•	•	•	•	•	•	

Notes: Many of the agencies, programs, and activities listed in this table are described in Annex 2 to this chapter.

1 Other agencies may be involved in specific program integrity activities under certain circumstances that are not included in this table. For example, the Drug Enforcement Agency (DEA) may be involved in investigations regarding prescription drugs.

2 In some states, certain activities listed in this table as being performed by the state Medicaid agency may be delegated to another state agency, such as a sister agency that administers certain Medicaid services or a surveillance and utilization review unit that is not a part of the Medicaid agency.

3 In some states, activities listed in this table as being performed by the Medicaid Fraud Control Unit (MFCU) may be performed by another office or agency. For example, in states where MFCUs do not have statewide prosecutorial authority, prosecutions are handled by other state or federal law enforcement agencies.

4 Some states address certain Medicaid program integrity issues through the state's Office of Inspector General, while others have an Office of the Medicaid Inspector General that is dedicated to addressing Medicaid issues.

5 The GAO also undertakes policy work, which could include evaluating programs listed in this table, when directed by the Congress.

6 Providers are included in this table to show where there are instances in which they must provide information to the federal or state governments for certain program integrity activities.

7 The Health Care Fraud and Abuse Control Program (HCFAC) also funds certain activities in the Office of the Assistant Secretary for Planning and Evaluation, Food and Drug Administration Pharmaceutical Fraud Program, and Office of the Assistant Secretary for Public Affairs.

8 The Health Care Fraud Prevention and Enforcement Action Team (HEAT) is part of HCFAC. While most of its efforts are focused on the Medicare program, it does address fraud in Medicaid.

9 The Medicaid Integrity Group (MIG) uses Medicaid Integrity Contractors (MICs) to review, audit, and educate providers, as required in statute. See Annex 2 for more information about the roles of the three types of MICs.

10 CMS uses Zone Program Integrity Contractors (ZPICs) to coordinate the Medicare-Medicaid Data Match Program (Medi-Medi Program) with states.

11 Under the Payment Error Rate Measurement (PERM) program, CMS contractors conduct the reviews associated with fee-for-service claims data and managed care capitation payments, while states conduct the eligibility reviews, although a CMS contractor calculates the state and national eligibility error rate.

Coordination between federal and state governments

CMS: Medicaid Integrity Program (MIP).

Created as part of the DRA, the MIP attempts to coordinate audits conducted by Medicaid Integrity Contractors (MICs) with program integrity work performed by other agencies.¹⁰ It also provides training for state program integrity staff through the Medicaid Integrity Institute (MII) and conducts state program integrity reviews to help states improve their program integrity activities and disseminate best practices. In addition, the MIP provides technical assistance on a variety of issues (e.g., provider fraud, provider enrollment and exclusion, billing issues, regulations) and supports various state special projects to address issues that arise. To enhance coordination with states, the Medicaid Integrity Group (MIG), which operates the MIP, has indicated it is redesigning its national provider audit program to improve coordination with states on data, policies, and audit measures (GAO 2011c).

The MII was established by CMS in late 2007 in partnership with the DOJ. Located at the DOJ's National Advocacy Center in Columbia, South Carolina, it provides training to state staff on a variety of program integrity issues at no cost to the state. Currently, the MII has trained over 2,200 state staff (Brice-Smith 2011a). In FY 2011, the MII trained about 860 people and expended \$1.7 million.

The MII curriculum is developed by CMS after consultation with the MII Advisory Committee, which includes state program integrity directors,

state Medicaid directors, state MFCU directors, and MII staff. The courses, which are usually several days in length, are taught by experts in the field. They cover topics such as fraud investigation, data mining and analysis, case development, and emerging trends in specific areas (e.g., managed care, pharmacy, benefit design issues), as well as those intended to help prepare the state for new initiatives, such as the coding updates in the International Classification of Diseases, 10th Edition (ICD-10).

Those trained at the MII include program integrity employees (e.g., first-line investigators and clinicians, program managers and specialists, non-clinical case reviewers, directors, and audit staff). Other state Medicaid employees (e.g., those who work on contracts, enrollment, policy, and programs) who would benefit from understanding program integrity functions and goals may also attend. Staff from MFCUs and law enforcement agencies may also be invited to participate.

Based on discussions with states,¹¹ areas that could be further expanded include distance learning to allow state staff to attend courses remotely, the inclusion of more advanced topics, and providing introductory courses for more state staff.

CMS and states: Medicare-Medicaid Data Match Program (Medi-Medi Program).

At the federal level, CMS combines and compares Medicare and Medicaid claims data to determine billing and payment abnormalities and to detect potential fraud and abuse patterns that previously were invisible to either program when examined independently.¹² Currently, 14 states participate

¹⁰ These can include the state Medicaid agency, law enforcement, and Medicare contractors. If another stakeholder is conducting an audit of the provider, the MIP may cancel or postpone its audit.

¹¹ MACPAC spoke with representatives from a number of states. These individuals indicated that the MII was valuable.

¹² Zone Program Integrity Contractors (ZPICs), which identify overpayments and aberrant providers in the Medicare program, coordinate the Medi-Medi Program in participating states. Through this program, they may also make referrals to state agencies regarding Medicaid providers.

in the program.¹³ In instances where Medicaid overpayments are identified, the state is responsible for taking action to recover the identified funds and handle any appeals that arise from such actions.

While certain states are satisfied with this program, others have identified problems. Reasons for this dissatisfaction include the lack of understanding of the Medicaid program among some of the contractors working on this program, as well as a focus on law enforcement referrals, rather than a wider range of program integrity issues. Better coordination of Medicare and Medicaid program integrity efforts could help to enhance the ability of both programs to identify broader patterns of fraud and abuse. For example, states report that while Medicaid data are shared with Medicare, there is no reciprocal data-sharing from Medicare to Medicaid. The Commission plans to examine the Medi-Medi program and other aspects of Medicare and Medicaid coordination.

OIG and states: Provider exclusion. Under OIG authority (42 CFR 1001), providers may be excluded for a number of different reasons. The type of exclusion depends on the offense and can be mandatory or permissive (where the Secretary has discretion to exclude a provider). The OIG maintains an online database (List of Excluded Individuals/Entities) available to states and providers to identify excluded individuals and entities. States must exclude any specified provider from participation in the Medicaid program if the provider was suspended, excluded, or terminated from Medicare or another state's Medicaid program (§1902(a)(39) of the Social Security Act (the Act)). States may also initiate their own provider exclusions from Medicaid (42 CFR 1002) for any reason the Secretary could use to exclude a provider from Medicare, Medicaid, or any other

federal health care program. States may take this action regardless of whether the OIG has excluded the provider, though they must notify the OIG of any such actions taken.

In addition, states must have an information reporting system that allows them to report state actions to the federal government. This includes:

- ▶ formal proceedings concluded against a health care practitioner or entity by a state licensing or certification agency that result in an adverse action; and
- ▶ any final adverse action taken against a health care provider, supplier, or practitioner by a state law or fraud enforcement agency (§1921 of the Act).

CMS and states: Provider enrollment

moratorium. CMS is able to impose a temporary enrollment moratorium on new Medicare providers if it determines that there is significant potential for fraud, waste, and abuse with respect to a particular provider type, geographic area, or both. States are required to comply with this moratorium, except when such steps would adversely affect Medicaid beneficiaries' access to care (§1902(kk)(4) of the Act). If a state is able to demonstrate this, it can still enroll new providers, despite the identified concern. States also have the option to impose their own temporary enrollment moratoria, numerical caps, or other limits on providers to combat fraud, waste, and abuse, provided that certain conditions are met (42 CFR 455.470).

Coordination within states

A number of state-level agencies have a role in program integrity in Medicaid, and the extent to which they are able to work together or coordinate their activities can affect their ability to address

¹³ The following states participate in the Medi-Medi Program: Arkansas, California, Colorado, Florida, Georgia, Mississippi, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Texas, and Utah.

fraud, waste, and abuse in the program effectively. Certain efforts are required in law, such as referring all cases of suspected provider fraud to the MFCU and providing the MFCU with access to and copies of all requested records, data, and other information kept by providers to which the Medicaid agency has access (42 CFR 455.21). Other activities that may or may not be required under state law can include sharing information and using interagency meetings to track emerging trends and avoid duplicating efforts. See Program Integrity in Managed Care for information about the coordination between Medicaid managed care plans and states.

Successful cooperation and coordination within a state can be complicated by the differing mandates and goals of various agencies (e.g., service delivery versus enforcement actions, recovering every dollar made in overpayment—regardless of the cost involved in getting the full recovery—versus maximizing limited state resources to recover the largest of overpayments). Because states have different approaches and structures in place to address program integrity, coordination approaches will also vary.

Challenges in Quantifying Program Integrity Effectiveness

Although there are estimates of the magnitude of the problem of health care fraud, no one really knows its full extent. For example, while reports from the Federal Bureau of Investigation (FBI) indicate fraudulent billing makes up roughly 3 to 10 percent of total health care spending across both public and private programs (FBI 2009), the broad range of this estimate suggests that the

magnitude is largely unknown. Within Medicaid, this is due in part to the system being designed primarily to pay honest providers efficiently,¹⁴ not to catch those committing fraud.

The most commonly cited numbers regarding program integrity initiatives pertain to the amounts of financial recoveries¹⁵ and settlements, as well as the number of investigations and prosecutions. Initiatives and policies that *prevent* fraud and abuse may actually be more effective, but their success is hard to measure because of the difficulty of quantifying something that was avoided. This makes it extremely difficult to determine the return on investment of program integrity efforts and to quantify which are most successful and effective in detecting and deterring fraud and abuse. The ability to quantify results can play a key role in determining the allocation of program integrity resources, between those addressing program integrity problems *after* they have taken place and those devoted to *preventing* them from happening.

Data used in program integrity activities

Data are used in a number of ways in program integrity activities (Table 4-3). For example, auditors with appropriate credentials may examine clinical records to determine if a service was medically necessary, program administrators or contractors may run algorithms on claims data to identify areas of possible fraud and abuse, and state staff may use licensing information to determine whether a provider is qualified to enroll in the program. To be most effective and useful, these data must be complete, accurate, and timely.

Although data may provide useful information by helping to quantify the results of program integrity

¹⁴ Section 1902(a)(37) of the Act requires states to pay Medicaid claims in a timely manner for services furnished by health care practitioners through individual or group practices or through shared health facilities.

¹⁵ Recoveries are often a percentage of the total amount of fraudulent payments made.

efforts or to identify possible fraud and abuse in the program, there are certain issues that must be considered when interpreting program integrity information. They include:

Medicaid Statistical Information System (MSIS) data can be incomplete and dated for use in program integrity activities. MSIS is

the only source of nationwide Medicaid claims and beneficiary eligibility information collected by CMS from the states. Although these data are used at the national level to help detect fraud, waste, and abuse in the program, this source does not capture many data elements that can help identify these problems. The database is also subject to significant time lags (OIG 2009). CMS is

TABLE 4-3. Sources of the Data Used in Program Integrity Activities

Data Type	Information
Eligibility data	Includes all information and supporting documents that are the basis for determining a person's eligibility for Medicaid, such as income, assets, date of birth, disability, and address. These data are used in audits such as the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) programs.
Claims data	A claim is a request for payment for services provided; it must include sufficient information so that the state can make the proper payment.* For example, states must require the National Provider Identifier (NPI) of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional (§1902(kk)(7)(B) of the Act). Data from claims can be used for data mining and identifying possible trends of fraud and abuse. Providers may have up to a year to submit claims for payment, as well as an additional year to make any adjustments to that claim. As a result, data can change over time.
Medicaid Statistical Information System (MSIS) data	Compiled by CMS from state reporting, this source includes eligibility-related information on each person enrolled in Medicaid, as well as a record of each paid claim for most services an enrollee receives. CMS uses these data for its algorithms that help to determine which providers to audit.
Other payer data	Includes information about providers that have been excluded from other programs (e.g., Medicare, other states' Medicaid programs, private insurers), as well as third-party liability information. States must have laws that require third-party insurers and other payers to furnish information to the state on eligibility and benefits under their plans, which strengthens the states' ability to recover payments made that should have been the responsibility of the third party.
Provider enrollment data	Includes information about providers, such as licensing information, whether the provider has a certificate of need (in the event one is required), and office location (to verify they have a legitimate business).
Provider operating data	Includes items such as cost reports, which are audited by states if provider payment is based on costs of services or on a fee plus cost of materials.

*For information about claims submission, see MACPAC's MACBasic: *The Medicaid fee-for-service provider payment process* (MACPAC 2011a).

BOX 4-3. Understanding Payment Error Rate Measurement (PERM) Results

The PERM program conducts audits of a random sample of state payment and eligibility records to assess whether state Medicaid payments and eligibility determinations are made in accordance with federal and state requirements and policies. PERM results are a calculated error rate, not a fraud rate. See Annex 2 for background information about PERM.

These audits identify improper payments, which include any payment made on behalf of an ineligible recipient, any duplicate payment, any payment for services not received, any payment incorrectly denied, and any payment that does not account for credits or applicable discounts. The payment error rate is the absolute value of all improper payments (both overpayments and underpayments), although almost all of the payments in error are overpayments. In FY 2011, the national error rate was 8.1 percent, or \$21.9 billion (federal share only), with error rates for fee-for-service payments at 2.7 percent, managed care payments at 0.3 percent, and eligibility at 6.1 percent.

The 2011 reporting cycle is the first year an updated method was used to measure eligibility errors in an attempt to reflect federal and state policies more accurately. As a result, comparisons should not be made to previous years' eligibility error rates. In addition, although there are certain general trends in error data that emerge, there are significant differences in state-specific error rates, owing in part to how states implement and administer their programs.

The most commonly occurring errors identified through PERM are due to missing documentation. Such documentation may not actually be missing, but rather may not have been delivered by the provider in time to be included in the audit. Such cases are considered to be improper payments, a characterization that artificially inflates the reported improper payment rate for the program. In addition to providing potentially misleading results, PERM is often seen by states and providers as being an administrative burden.

Although PERM estimates a national payment error rate across the Medicaid program, the only funds that can be recovered are from claims that were actually sampled during the audit. As a result, the overpayments that are subject to recovery make up a small fraction of the total amount projected to be in error for the nation for each PERM cycle.

working with 10 volunteer states on a pilot project, Transformed-MSIS, to improve the data captured in the database (Brice-Smith 2011a).

CMS data initiatives may improve the quality of data used in program integrity activities.

In 2006, CMS began to centralize and make more accessible the data needed for analyses that could identify possible fraud and abuse and to improve the analytical tools available to analysts conducting this work. The GAO has reviewed

two of these initiatives—the Integrated Data Repository (IDR), which is intended to provide a single source of data related to Medicare and Medicaid claims,¹⁶ and the One Program Integrity (One PI) system, a web-based portal and suite of analytical software tools used to extract data from the IDR and to allow staff to conduct complex analyses of these data. In its report, GAO notes that although implementation is behind schedule, CMS has shown some progress toward meeting the programs' goals. The GAO also indicates that

¹⁶ Under Section 6402 of the Patient Protection and Affordable Care Act (P.L. 111-148, as amended), CMS is required to include claims and payment data from specific programs, including Medicaid, in the IDR.

the current implementation of the IDR and One PI will not allow the agency to identify, measure, and track the financial benefits that will be achieved by reducing improper payments (GAO 2011a). In addition, the data for this system would come from MSIS, a data source with a number of shortcomings that are highlighted above.

As part of a broader data initiative, CMS has established a Medicaid and CHIP Business Information Solutions (MACBIS) council that is overseeing a project to transform the agency's data strategy and environment (Plewes 2010, Thompson 2010), which included a review of existing Medicaid and CHIP data sources and their uses (Borden et al. 2010). Ultimately, CMS expects to improve overall data quality and availability, including those used in program integrity activities (Brice-Smith 2011b).

There may be weaknesses in HHS' and DOJ's reporting of recoveries. Information provided in the HCFAC's annual report for FY 2011 indicates that almost \$600 million in federal Medicaid money was transferred to the U.S. Treasury as a result of the program's activities for that fiscal year. For this same period, nearly \$4.1 billion for all investigations was deposited with the Department of the Treasury and CMS (i.e., the Medicare Trust Fund), transferred to other federal agencies administering health care programs, or paid to private persons (e.g., those who file suits on behalf of the federal government under the *qui tam* provisions of the False Claims Act). A GAO audit for FY 2008 and 2009, however, found that there were problems with the numbers reported and that neither HHS nor DOJ provide sufficient controls to ensure the HCFAC report is accurate and supported (GAO 2011b). Both agencies are

currently taking steps to address the issues cited in the report.

Reporting on recoveries and on other performance measures is not consistent across states.

CMS uses its State Program Integrity Assessment tool to collect information on state Medicaid program integrity initiatives. This state-reported information shows that states track recoveries that result from various projects, including data mining, provider audits, settlements/judgments, overpayments and other collections, and MFCU investigations and prosecutions. Some states also include estimates of costs avoided. States choose which tracking metrics they use and the methodologies used in these calculations, complicating any possible cross-state comparisons.

Program Integrity in Managed Care

When using Medicaid managed care for service delivery, states cannot delegate to plans their federally mandated responsibility to ensure appropriate payment, access, and quality. States use their contracts with plans to require them to comply with a range of both federal and state requirements, including guarding against fraud, waste, and abuse.

In 2009, 47 percent of Medicaid enrollees were enrolled in comprehensive risk-based managed care plans and, in FY 2008, 18 percent of Medicaid benefit spending was on comprehensive risk-based managed care (MACPAC 2011b).¹⁷ With states increasingly moving enrollees into managed care, it is important to understand program integrity challenges and opportunities in this area. The

¹⁷ Historically, Medicaid managed care has covered families with children and pregnant women, populations that are relatively low-cost compared to other covered Medicaid populations. In addition, states may make fee-for-service payments on behalf of individuals enrolled in these plans if they carve out certain services from the managed care plan contract. The cost of providing these services is reflected in the amount of benefit spending under fee-for-service, not managed care.

Commission plans to examine these efforts in more detail in the future.

Tracking and implementing program integrity

While plans design their program integrity activities to address the requirements of the states in which they operate, addressing possible fraud and abuse committed by providers also helps to improve the effectiveness of their business operations. Plans operating in multiple states or with multiple lines of business (e.g., Medicaid, Medicare, private insurance) may develop program integrity programs that coordinate requirements across states and lines of business.

Tactics used by plans to identify possible fraud, waste, and abuse can be similar to those used by states. They use outside vendors, conduct these activities internally, or a combination of both. Reviews of post-payment reports can identify outliers among providers and anomalies that require further investigation. Plans also commonly use telephone hotlines for enrollees, employees, and providers to identify problems. These activities help identify instances when providers bill for services never performed, over-bill for services provided, or bill for tests, services, and products that are medically unnecessary. Plans have implemented formal compliance programs, which include installing compliance officers, conducting compliance training to educate employees about fraud and abuse laws, and having policies and procedures in place for staff to follow for reporting potential compliance issues.

Coordination between states and managed care plans

State agencies may coordinate certain fraud and abuse activities with managed care plans and may regularly communicate with plans on emerging trends and regulatory updates. Plans submit

information (e.g., provider exclusions) to state regulators as required, though it is the states' responsibility to act on this information, when appropriate. States must determine how they address recoveries in managed care, including issues such as the adequate length of time for plans to make recoveries and when the state or its contractors should recover improper payments (Gordon 2011). The extent to which coordination occurs varies and is based on the processes put in place by a state to address these issues.

As states continue to expand into Medicaid managed care and search for ways to promote program integrity, it is important that state staff be trained to address program integrity issues specific to this delivery system, that staffing is adequate to properly oversee the contracts that are in place, and that states implement appropriate strategies for coordinating with plans to identify and take actions against providers who intentionally defraud the Medicaid program.

Program Integrity in Statute

As new statutory provisions have been added over time, there has not been a focused evaluation to determine which are most valuable and which are duplicative or unnecessarily burdensome. Moving forward, it is important to conduct such evaluations so the statute can be updated, as needed, to eliminate duplicative or ineffective programs and ensure that effective programs have adequate resources.

For example, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) requires coordination of the Medicaid Eligibility Quality Control (MEQC) and PERM programs and allows for data substitutions between these two programs. It should be assessed whether these efforts are adequate to address the overlap of these two programs.

BOX 4-4. Health Information Technology (HIT)

Technology provides the health care system with a number of tools to prevent fraud, waste, and abuse in the system through efficient program administration and to conduct prepayment and post-payment reviews of suspicious claims.¹⁸ To truly improve program integrity, however, these issues must be incorporated into the product's design.

Tools to Identify Possible Fraud and Abuse. There are a variety of HIT tools that can be used to both prevent questionable payments from happening and identify paid claims that require further investigation. States use coding policies and edits to identify claims with common errors that should not be paid, and these efforts have recently been increased with the implementation of the National Correct Coding Initiative. States and the federal government also use data mining techniques (conducted either “in house” or by contractors) on paid claims to identify possible fraud or to target payment audits.

Predictive Analytics. There are initiatives to begin to move towards predictive analytics, a system that uses algorithms and models to examine claims in real time to flag suspicious billing,¹⁹ similar to that which is used by the credit card industry.²⁰ This could help to decrease the cycle of “pay and chase,” where claims are paid and then states attempt to recover inappropriate payments. These tools can help prevent bad actors from enrolling as Medicaid providers by identifying background information on potentially fraudulent actors and questionable affiliations. They also analyze claims before they are paid to identify emerging trends in potentially fraudulent activities, with flagged claims undergoing further scrutiny before any payment is released.

CMS is currently examining ways to apply advanced data analytics technology to the Medicaid Integrity Program (Brice-Smith 2011b), but because states are responsible for Medicaid claims payment, they ultimately will play a key role in the success of any such initiatives. Some states already have started to take steps to move in this direction.

Prevent waste. HIT can help to prevent waste and improve the quality of care provided. Examples of this, which are used throughout the health care system, include:

- ▶ Clinical decision support can help providers make evidence-based decisions around appropriate care;
- ▶ Health information exchange can decrease unnecessary or duplicative procedures;
- ▶ Electronic health records can provide a complete record of clinical care, help with continuity of care, and decrease duplication of tests and procedures;
- ▶ Computerized physician order entry can decrease delays in order completion, reduce errors related to handwriting or transcription, and provide error-checking for duplicate or incorrect doses or tests; and
- ▶ Bar code medication administration can help ensure that the right patient gets the right medication, in the right dose, at the right time, and through the right route.

¹⁸ While technology is a tool that can help to address a number of program integrity issues, it should be noted that HIT is not a panacea and can also be used by providers to commit fraud and abuse.

¹⁹ The system builds profiles of providers, networks, billing patterns, and enrollee utilization. These profiles are then used to create risk scores to estimate the likelihood of fraud and flag potentially fraudulent claims and billing patterns before a claim is paid.

²⁰ The Small Business Jobs Act of 2010 (P.L. 111-240) mandated that CMS implement a predictive analytics system to analyze Medicare claims to detect patterns that present a high risk of fraudulent activity. In 2014, CMS must report to the Congress on the cost-effectiveness and feasibility of expanding the use of predictive analytics to analyze Medicaid and CHIP claims. Reportedly, over 30 states are proceeding with legislation on the use of these tools, even though their effectiveness in Medicaid has yet to be determined.

The Patient Protection and Affordable Care Act (PPACA, P.L. 111-148, as amended), includes provisions regarding Medicaid Recovery Audit Contractors (RACs). It should be evaluated whether RACs are implemented in such a way to complement and coordinate other audits already in place. The PPACA also includes provisions regarding the suspension of Medicaid payments based upon pending investigations of credible allegations of fraud. It should be assessed whether these provisions limit the cycle of “pay and chase.”

Looking Forward

The Commission plans to continue to examine program integrity activities, including examining the coordination of these initiatives across the Medicare and Medicaid programs, approaches to program management as they relate to program integrity, and problems of waste in the Medicaid program. The Commission will also continue to examine program integrity issues related to managed care, as well as the Medi-Medi and PERM programs.

Commission Recommendations

Recommendation 4.1

The Secretary should ensure that current program integrity efforts make efficient use of federal resources and do not place an undue burden on states or providers. In collaboration with the states, the Secretary should:

- ▶ **Create feedback loops to simplify and streamline regulatory requirements;**
- ▶ **Determine which current federal program integrity activities are most effective; and**
- ▶ **Take steps to eliminate programs that are redundant, outdated, or not cost-effective.**

Rationale

Federal and state government agencies and providers are required by law to participate in various program integrity activities. There may be overlap and duplication of activities at times because newer initiatives sometimes repeat efforts already underway in existing programs. This recommendation would help address this problem by promoting administrative simplification—successful initiatives that should be expanded would be identified, while programs that are redundant, outdated, or not cost-effective would be eliminated.

Simplify and streamline regulatory requirements. When CMS identifies an area where a regulation or process could be simplified, updating relevant regulatory requirements or sub-regulatory manuals could ensure that relevant processes and requirements would prevent identified problems from recurring. For example, the Commission has heard from state Medicaid agencies that they are frequently audited by a

number of federal and other state agencies. Likewise, providers have indicated that they are frequently audited by a number of federal and state agencies. At the federal level, the Medicaid Integrity Group has attempted to prevent duplicative activities that place undue burden on providers by coordinating the audits its Medicaid Integrity Contractors conduct with other agencies with audit responsibilities. It is also working to redesign its national provider audit program to improve coordination with states on data, policies, and audit measures. The Commission encourages the Secretary to promote similar efforts.

In addition, the Commission has heard from providers that unintentional errors could occur when they submit claims for payment because of the complexity of the processes in place. Simplification of processes and development of feedback loops could help to identify problems more readily by referring them to the appropriate entity in a more timely manner.

The Commission strongly supports the promotion of program management efforts that prevent fraud and abuse from taking place, as effective management is a key component of ensuring the integrity of the Medicaid program.

Determine which programs are most effective and which should be eliminated because they are redundant, outdated, or are not cost-effective. As the chapter indicates, the Deficit Reduction Act of 2005 (P.L. 109-171) provided significant funding at the federal level for Medicaid program integrity. Given that many of these initiatives are relatively recent, assessing which are most effective could help determine those that should be enhanced or expanded to take full advantage of their success.

In addition, federal and state agencies and providers must participate in numerous program integrity initiatives. Because many program

integrity provisions have been added over the years, there may be activities or programs that are duplicative or no longer effective. Identifying and eliminating these programs and activities could reduce administrative waste at the federal, state, and provider levels and allow resources and funding to be invested in program integrity efforts that are more effective.

Implications

Federal spending: There is no immediate and direct impact on the federal budget.

State spending: There is no immediate and direct impact on state budgets.

Beneficiaries: Although there would be no direct effects, reduction in state burden could redirect state and provider resources to Medicaid enrollees. If the reduction in administrative burden encouraged more providers to participate in the program, this could also improve access to care for enrollees.

Providers: Providers could gain efficiencies through administrative simplification and streamlining. Reduction in state burden could also free up state resources that could be directed to support Medicaid providers. Reduction in administrative burden on providers could possibly encourage more providers to participate in the program.

Recommendation 4.2

To enhance the states' abilities to detect and deter fraud and abuse, the Secretary should:

- ▶ **Develop methods for better quantifying the effectiveness of program integrity activities;**
- ▶ **Assess analytic tools for detecting and deterring fraud and abuse and promote the use of those tools that are most effective;**

- **Improve dissemination of best practices in program integrity; and**
- **Enhance program integrity training programs to provide additional distance learning opportunities and additional courses that address program integrity in managed care.**

Rationale

Quantifying the impact of program integrity activities. States currently track and calculate program integrity performance metrics in a variety of different ways, complicating any possible cross-state comparisons. In addition, program integrity activities that *prevent* fraud and abuse are difficult to measure because they are an attempt to quantify something that was avoided. The ability to demonstrate the value of initiatives can play a key role in determining the allocation of program integrity resources, between those addressing program integrity problems *after* they have taken place and those devoted to *preventing* them from happening.

Developing methods to better quantify the impact of program integrity activities could provide states with tools they might use to report on program integrity activities and could help federal and state governments make better decisions about where to focus their efforts. In particular, providing states with guidance on ways to show the impact of activities that *prevent* fraud and abuse from taking place could help demonstrate the value of prevention activities. The Commission believes improving program management (and allocating sufficient resources to do so) is a key component of ensuring the integrity of the Medicaid program.

Analytic tools. There are many analytic tools that can help states prevent and identify possible fraud and abuse in the Medicaid program. Guidance issued by CMS could help states choose which tools to purchase for their specific program

integrity needs. For example, guidance could include information about strengths of a specific tool or the types of analyses for which it would be best suited. Through this process, CMS could do once what each state must now do individually. CMS could help to negotiate a more competitive price at which states could, at their discretion, buy these products so that they could take advantage of economies of scale.

Dissemination of best practices. The Medicaid Integrity Group conducts a comprehensive review of each state's program integrity operations once every three years and releases an annual summary report of best practices based on comprehensive reviews conducted. The Commission would like to encourage the dissemination of this type of information and the use of additional communication outlets to ensure that it reaches all relevant stakeholders. For example, the HHS OIG recently issued a report (OEI-01-09-00550) that includes a recommendation that CMS could share best practices regarding ways to address fraud and abuse in Medicaid managed care through the Medicaid Integrity Institute (MII).

Enhancing program integrity training.

Feedback from states has indicated that training received at the MII has helped them better address program integrity issues. As discussed in this chapter, the MII provides training to state employees at no cost to states and covers topics on a variety of issues. Expanding training programs to include additional distance learning opportunities could allow a broader group of state staff to take advantage of the MII's training opportunities without the need to travel. It would also make these opportunities available to staff whose states do not permit travel, even when it is at no cost to the state. Enhanced training could:

- Allow state staff whose primary focus is not program integrity to understand basic information about this topic and how their

job responsibilities affect the integrity of the program (e.g., training sessions that are a few hours in length that cover program integrity issues that are important for policy staff, eligibility staff, or program delivery staff to understand). This could also help with the dissemination of best practices, making such information available to a wider audience so that it could be more easily incorporated into laws; policies; and program design, management, and operation;

- ▶ Allow state staff to participate in self-paced learning; and
- ▶ Provide guidance to state staff on how to improve education and outreach to providers (e.g., to help providers understand billing procedures or program changes) and ensure that program policies and rules are as clear and simple as possible.

In 2009, 47 percent of Medicaid enrollees were enrolled in comprehensive risk-based managed care and 71 percent were enrolled in some form of managed care. States are continuing to move additional populations of Medicaid enrollees into managed care. Therefore, it is important that states be able to address program integrity issues in this area. Providing additional information to states about how to address program integrity issues in managed care, including best practices, would help states ensure they have effective program integrity initiatives in place.

Implications

Federal spending: There is no immediate and direct impact on the federal budget.

State spending: There is no immediate and direct impact on state budgets.

Beneficiaries: Although there would be no direct effects, reduction in state burden could free up

resources that could be directed to Medicaid enrollees.

Providers: Enhanced program integrity activities could prevent paying claims to providers committing fraud, as well as result in additional provider terminations and exclusions. Reduction in state administrative burden could also make state resources available that could be directed to support Medicaid providers.

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Chapter 4 Annex 1

Key Legislative Milestones and Statutory Provisions in Program Integrity

TABLE 4-A1. Key Legislative Milestones in Program Integrity

Year	
1965	Medicaid was enacted (P.L. 89-97) as Title XIX of the Social Security Act (the Act) to provide health coverage for certain groups of low-income people; established Medicaid as an individual entitlement with federal-state financing. Medicare was also enacted as Title XVIII of the Act. During its first decade, Medicaid operated with few fraud controls and without any specific state or federal law enforcement agencies responsible for monitoring criminal activity within the program.
1977	The Medicare-Medicaid Anti-Fraud and Abuse Amendments (P.L. 95-142) provided special federal funding for the start-up of state Medicaid Fraud Control Units (MFCUs).
1980	The Mental Health Systems Act (P.L. 96-398) required most states to develop a computerized Medicaid Management Information System (MMIS). The Medicare and Medicaid Amendments of 1980 (P.L. 96-400) provided the authority in Section 1128 of the Act to exclude individuals and entities from participation in Medicare and Medicaid for fraud against the programs. The Omnibus Reconciliation Act of 1980 (P.L. 96-499) provided permanent federal funding for MFCUs beyond the initial three-year start-up period.
1981	The Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) provided the authority for the imposition of civil money penalties as an intermediate sanction for fraud or abuse.
1986	False Claims Act Amendments (P.L. 99-562) made significant changes to the False Claims Act (FCA), including rewards for whistleblowers and fines for fraudulent activity.
1987	The Medicare and Medicaid Patient and Program Protection Act of 1987 (P.L. 100-93) strengthened authorities to sanction and exclude providers from the program and established criminal penalties for fraud against Medicare, Medicaid, and other federal health care programs.
1989	Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) placed limitations on physician self-referrals, commonly referred to as the “Stark law.”

TABLE 4-A1, Continued

Year	
1993	Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) significantly amended the Stark law, with rules commonly referred to as “Stark II,” and required each state to have a MFCU unless the state could demonstrate to the satisfaction of the Secretary that it has a minimal amount of Medicaid fraud and Medicaid enrollees would be protected from abuse and neglect.
1996	The Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) defined numerous offenses relating to health care and set civil and criminal penalties for them. It also created several programs to control fraud and abuse within the health care system, including HCFAC and the Medicare Integrity Program (which was the model for the Medicaid Integrity Program that was created through the Deficit Reduction Act of 2005, described below).
1997	The Balanced Budget Act of 1997 (P.L. 105-33) allowed states to contract with a limited number of managed care plans; applied federal conflict-of-interest standards to state officials involved in Medicaid managed care contracting; required prior approval by HHS of all Medicaid managed care contracts that are over \$1 million; and added conditions of participation for managed care plans that include areas of fraud and abuse, quality assurance, protections against patient billing, information and disclosure, and marketing.
2002	The Improper Payments Information Act of 2002 (P.L. 107-300) required every federal agency to report on improper payments and efforts to combat them; CMS created the Payment Error Rate Measurement (PERM) program to comply with the statute.
2005	The Deficit Reduction Act of 2005 (P.L. 109-171) established the Medicaid Integrity Program (MIP) and the Medicare-Medicaid data match program, strengthened third-party liability, and included provisions encouraging states to enact their own False Claims Acts.
2009	The Fraud Enforcement and Recovery Act (P.L. 111-21) further strengthened the FCA by broadening the range of conduct that can be subject to false claims prosecution by including the presenting of a false claim (even if not paid) and the knowing use of false records or statements related to a false claim. The Children’s Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) provided states with the option to verify U.S. citizenship through data matches with the Social Security Administration, enrollment simplification, and required coordination of Medicaid Eligibility Quality Control (MEQC) and PERM program efforts, as well as substitution of data between these two programs.
2010	The Patient Protection and Affordable Care Act (P.L. 111-148, as amended) included provisions regarding provider screening requirements, an integrated data repository for Medicare and Medicaid, Medicaid Recovery Audit Contractors (RACs), provider terminations, credible allegations of fraud, reporting managed care data in MMIS, participating in the National Correct Coding Initiative, the Stark law, and FCA actions. The Small Business Jobs Act of 2010 (P.L. 111-240) mandated that CMS implement a predictive analytics system to analyze Medicare claims to detect patterns that present a high risk of fraudulent activity and that it report to the Congress in 2014 on the cost-effectiveness and feasibility of expanding the use of predictive analytics to Medicaid and CHIP.

TABLE 4-A2. Key Program Integrity Provisions in Statute

Section 1893(g)	Medicare-Medicaid Data Match Program
Section 1902(a)(4) and Section 1903(u)	Medicaid Eligibility Quality Control (MEQC) Program
Section 1902(a)(4)(C)	Conflict-of-interest standards
Section 1902(a)(25)	Third-party liability
1902(a)(30)(A)	Payment methods and procedures to safeguard against unnecessary utilization, consistent with efficiency, economy, and quality, and provide access equal to the general population
Section 1902(a)(37)	Timely, prompt payment (per the matter in Section 1902(a) after (83), the Secretary can waive this requirement if he finds the state has exercised good faith in trying to meet this requirement)
Section 1902(a)(39)	Termination of provider participation under Medicaid if provider is terminated under Medicare or another state's Medicaid program
Section 1902(a)(42)(B)	Recovery Audit Contractors for the Medicaid program
Section 1902(a)(46)(A)	State Income and Eligibility Verification System (also in Section 1137)
Section 1902(a)(46)(B)	Citizenship documentation
Section 1902(a)(61)	A state must effectively operate a MFCU, unless it can show that such efforts would not be cost-effective because minimal fraud exists and enrollees will be protected from abuse and neglect without such a unit
Section 1902(a)(77)	State compliance with provider screening, oversight, and reporting requirements in Section 1902(kk)
Section 1902(a)(79)	Requires billing agents, clearinghouses, and other alternate payees that submit claims on behalf of a provider to register with the state and HHS
Section 1902(a)(80)	Prohibits payment for items and services to any financial institution or entity located outside the U.S.
Section 1902(e)(13)	Express lane eligibility
Section 1902(ee)	Provides states with the option to verify citizenship through the Social Security Administration data match
Section 1902(kk)	Provider and supplier screening, oversight, and reporting requirements
Section 1903(a)(6)	Federal match for MFCU expenses
Section 1903(d)(2)	Allows states one year to return the federal share of most overpayments
Section 1903(i)(2)	Prohibits payments to those excluded from the program
Section 1903(q)	Requirements MFCUs must meet
Section 1903(r)(1)(B)(iv)	National Correct Coding Initiative
Section 1903(r)(1)(F)	Requires states to report expanded set of data elements under MMIS to detect fraud and abuse
Section 1903(x)	Citizenship documentation
Section 1909	State False Claims Act requirements for increased state share of recoveries

Table 4-A2, Continued

Section 1921	Information reporting requirements concerning sanctions taken by state licensing authorities against health care practitioners and providers
Section 1927(g)	Drug use review
Section 1932(d)	Protections against fraud and abuse in managed care
Section 1936	Medicaid Integrity Program
Section 1124	Disclosure of ownership and related information
Section 1126	Disclosure by institutions, organizations, and agencies of owners and certain other individuals who have been convicted of certain offenses
Section 1128	Exclusion of certain individuals and entities from participation in Medicare and state health care programs
Section 1128A	Civil monetary penalties
Section 1128B	Criminal penalties for acts involving federal health care programs
Section 1128C	Fraud and Abuse Control Program
Section 1128D	Guidance regarding application of health care fraud and abuse sanctions
Section 1128E	Health Care Fraud and Abuse Data Collection Program
Section 1128F	Coordination of Medicare and Medicaid surety bond provisions (applies only to home health agencies)
Section 1128G	Transparency reports and reporting of physician ownership or investment interests
Section 1128H	Reporting information relating to drug samples
Section 1128I	Accountability requirements for facilities (skilled nursing facilities and nursing facilities)
Section 1128J	Medicare and Medicaid program integrity provisions
Section 1137	Requirements for state income and eligibility verification systems (also in Section 1902(a)(46)(A))
Section 1156	Obligations of health care practitioners and providers of health care services, sanctions and penalties, hearings and review

Chapter 4 Annex 2

Agencies and Programs Related to Program Integrity

This annex includes additional information about federal and state oversight agencies and activities related to Medicaid program integrity.

Federal Oversight Agencies

Department of Health and Human Services (HHS)

- ▶ **Centers for Medicare & Medicaid Services (CMS).** CMS oversees program integrity efforts that are run through the Center for Program Integrity (CPI) and the Office of Financial Management (OFM). CPI includes the Medicaid Integrity Group, which runs the Medicaid Integrity Program (MIP). The MIP is described below and in the Federal and State Coordination Section of Chapter 4. OFM is responsible for the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) programs, described below.
- ▶ **Office of Inspector General (OIG).** The OIG is an independent organization within HHS that provides oversight of HHS programs, including Medicaid and the State Children's Health Insurance Program. In this role, it conducts audits, investigations, and evaluations, as well as assists in the development of criminal, civil, and administrative enforcement cases. It also provides resources to help the health care industry comply with federal fraud and abuse laws, and to educate the public on these issues, including how to report suspicious activities. In FY 2011, OIG estimated that \$345 million would be obligated to combat fraud, waste, and abuse within all HHS programs, of which approximately \$269 million would support efforts pertaining to both Medicare and Medicaid.

Department of Justice (DOJ). Various divisions and offices within DOJ have a role in ensuring Medicaid program integrity through investigations and enforcement actions. They include the U.S. Attorneys, Civil Division, Civil Rights Division, Criminal Division, and the Federal Bureau of Investigation.

Government Accountability Office (GAO). The GAO, a nonpartisan Congressional agency, investigates how the federal government spends tax dollars, including those spent on the Medicaid program. The agency conducts audits of agency operations to determine whether federal funds are being spent efficiently and effectively, investigations

into allegations of illegal and improper activities, and research and reports assessing the extent to which government programs and policies are meeting their objectives.

State Oversight Agencies

State Medicaid Agency. Each state is responsible for the day-to-day operation of its Medicaid program. This includes not only setting policy and managing the program in such a way as to prevent fraud, waste, and abuse from taking place, but also having systems in place to identify and correct these problems if and when they do occur. While many of these activities take place within the Medicaid agency itself, in some states, some of these responsibilities may be delegated to other state-level agencies, such as the Office of the Inspector General, Office of the Attorney General, Office of the State Auditor, or sister agencies that may administer certain Medicaid services.

Medicaid Fraud Control Unit (MFCU).

A MFCU is a single, identifiable entity of state government, usually located within the office of the state's attorney general (NAMFCU 2012), that is responsible for the following activities:

- ▶ investigating and prosecuting (or referring for prosecution) health care providers that defraud the Medicaid program;
- ▶ reviewing complaints of abuse or neglect of nursing-home residents and complaints of the misappropriation of patients' private funds in these facilities;
- ▶ investigating fraud in the administration of the program; and
- ▶ collecting or referring for collection (to the appropriate state agency) any overpayments it identifies in carrying out its activities (42 CFR 1007).

Each MFCU is certified by the OIG when implemented and then recertified annually thereafter. A MFCU is funded at a 90 percent federal matching rate for the first three years of operation; the match is 75 percent for subsequent years (§1903(a)(6) of the Act). In FY 2010, the combined federal and state grant expenditures for MFCUs totaled \$205.5 million, of which federal funds represented \$153.8 million (OIG 2010).

Other State Agencies. In addition to the organizations listed above, there are a number of other state agencies that can play a role in Medicaid program integrity. There are state agencies (e.g., state survey and certification agencies) that monitor providers to ensure the quality of care they provide, as well as receive and investigate complaints about such providers. Other state law enforcement agencies may be involved in prosecuting Medicaid fraud cases.

Federal and State Activities

Medicaid Integrity Program (MIP). The MIP is a comprehensive federal strategy to prevent and reduce Medicaid provider fraud, waste, and abuse. It funds the Medicaid Integrity Group within the CMS Center for Program Integrity. Under the MIP, CMS has two broad responsibilities:

- ▶ To hire contractors (Medicaid Integrity Contractors, MICs) to: 1) review Medicaid claims data for fraud, waste, or abuse; 2) audit provider claims and identify overpayments; and 3) educate providers and others on Medicaid program integrity issues; and
- ▶ To provide support, education, and technical assistance to states in their efforts to combat Medicaid provider fraud and abuse (CMS 2011).

The MIP was appropriated \$75 million in FY 2010 (CMS 2011).

Medicaid Integrity Contractors (MICs). CMS contracts with three types of MICs. Review MICs analyze claims data to identify potential fraud and abuse; Audit MICs audit providers; and Education MICs educate providers, state staff, enrollees, and others about Medicaid payment integrity and quality of care issues. All processes are intended to ensure that claims are paid only for services that were provided and properly documented, billed using the correct procedure codes for covered services, and paid in accordance with federal and state laws, regulations, and policies. CMS is responsible for the MICs' activities, though states play a role in training contractors on their policies and rules.

Recovery Audit Contractors (RACs). Originally implemented under Medicare, RACs were expanded to include Medicaid under the Patient Protection and Affordable Care Act (P.L. 111-148, as amended). Beginning in 2011, states are required to contract with RACs, which will identify Medicaid fee-for-service underpayments and overpayments and recoup overpayments (§1902(a)(42)(B) of the Act). RACs are paid on a contingency basis for collecting overpayments and in amounts specified by the state for identifying underpayments. States must have an appeals process in place for adverse determinations (this can be the process a state already has in place, provided it is able to handle RAC appeals), report certain information to CMS about the RACs' contract metrics, and coordinate RAC activities with other program integrity organizations (such as federal and state law enforcement). States are responsible for the RAC program.

While some states have expressed concern about the RAC program, others view it as an opportunity to enhance and target their oversight efforts in areas where they otherwise would not have been able because of tight state budgets.

Payment Error Rate Measurement (PERM)

Program. The PERM program is designed to comply with the Improper Payments Information Act of 2002 (P.L. 107-300). In this program, which is managed by the CMS Office of Financial Management, state payment and eligibility records are reviewed to calculate payment error rates using a statistically valid random sample of claims and eligibility determinations. It is conducted annually on a rotating basis in 17 states. CMS contractors conduct the reviews associated with the fee-for-service claims data and managed care capitation payments, while states conduct the eligibility reviews (although a CMS contractor calculates the state and national eligibility error rate). Each state must develop a corrective action plan to reduce improper payments based on the error causes identified and is required to return the federal share of overpayments to CMS (42 CFR 431 Subpart Q). The error rate calculated through PERM is *not* a fraud rate. See Box 4-3 in Chapter 4 for a discussion of issues with PERM results.

Medicaid Eligibility Quality Control (MEQC)

Program. Although processes exist to verify that Medicaid eligibility decisions are made correctly before a person is enrolled in (or disenrolled from) Medicaid, post-eligibility checks are also used to assess whether or not the proper determination was made. The MEQC program requires states to report to CMS an annual estimate of improper Medicaid payments based on eligibility reviews of people enrolled in the program. The threshold for improper payments is set at three percent per fiscal year and, if a state exceeds this amount, the Secretary may withhold payments to the state based on the amount of improper payments that exceeded the threshold (§1903(u) of the Act). However, no state has exceeded this threshold in a number of years.

Because states consistently had error rates below the threshold, CMS offered states the option to develop alternative ways to identify and reduce improper payments through either an MEQC pilot or as part of a Section 1115 demonstration waiver.¹ In FY 2010, 12 states were operating traditional MEQC programs and 39 were operating a pilot or waiver program (D’Annunzio 2010). Because MEQC shares certain characteristics with PERM, when a state is undergoing a PERM audit, it has the option to use the data collected in its PERM review for its MEQC review and vice versa (42 CFR 431.812; 42 CFR 431.980).

State Audit Requirements. In addition to meeting federal audit requirements, where the state agency must ensure appropriate audit of records for payments based on costs of services or on a fee plus cost of materials (§1902(a)(42)(A) of the Act and 42 CFR 447.202), states may also conduct their own audits, with the exact process (e.g., the agency conducting the audit, what is examined during the audit) varying by state.

¹ Section 1115 demonstration waivers allow states to test an “experimental, pilot, or demonstration project likely to assist in promoting the objectives of the programs” covered by the Social Security Act. For more information about these waivers, see the Commission’s March 2011 *Report to the Congress on Medicaid and CHIP*.