Overview of Missouri Medicaid Audit and Compliance

Presentation Before the MO HealthNet Oversight Committee

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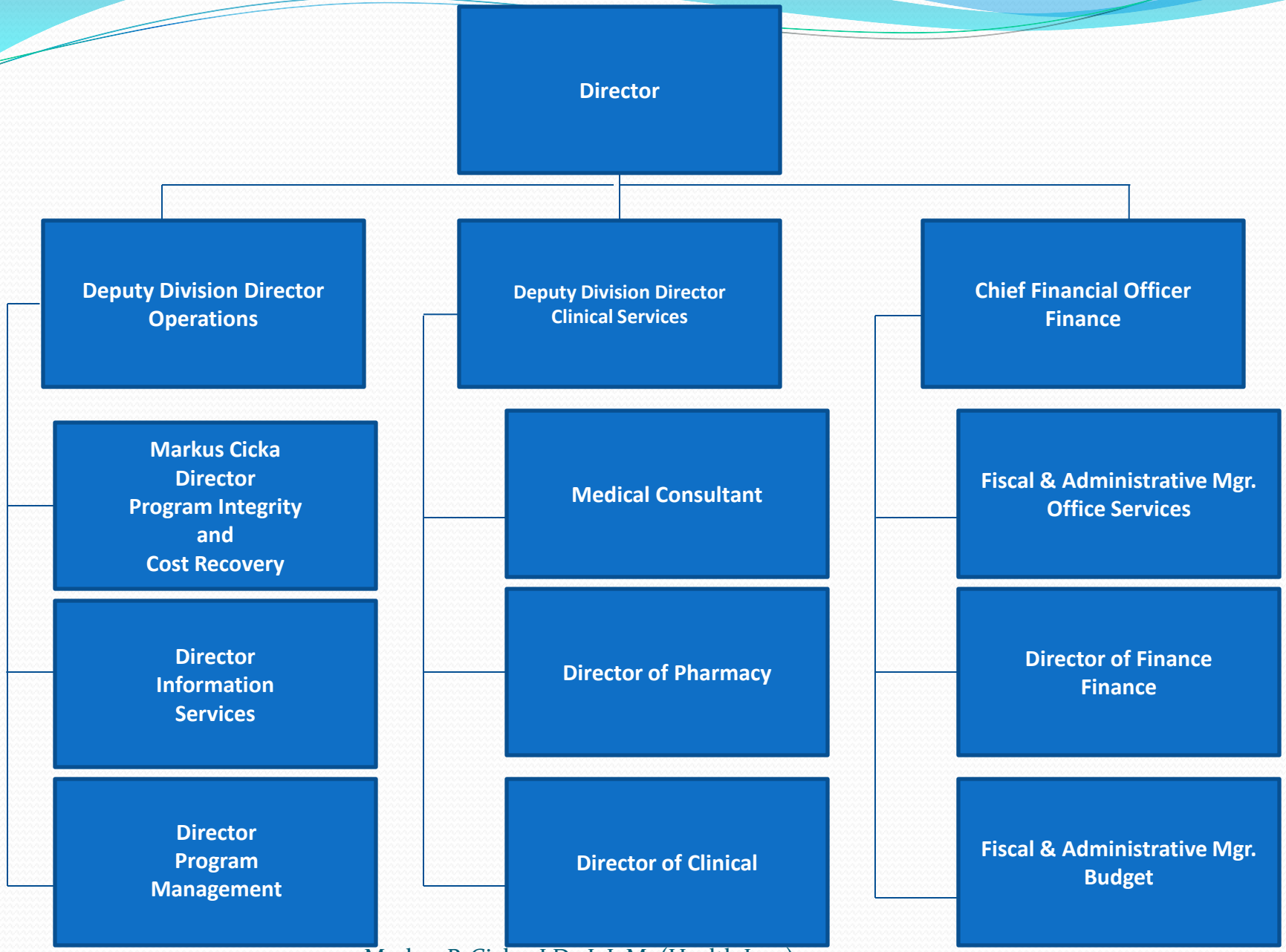
Embedded in Medicaid

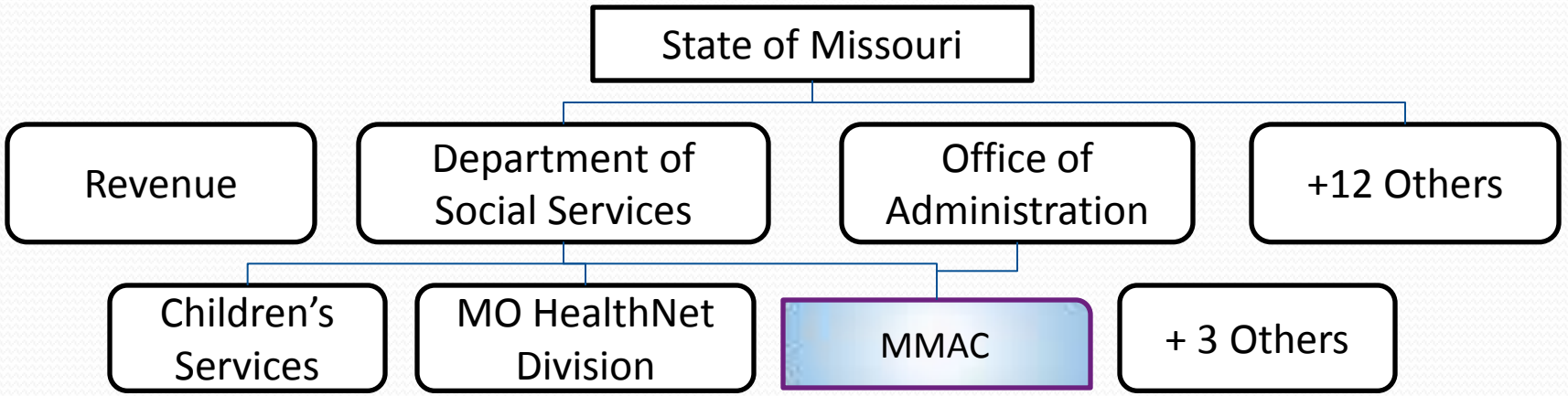
- In December, 2009, Program Integrity was located within the MO HealthNet Division of Missouri's Department of Social Services.
- Also at that time, Missouri Medicaid dollars were flowing into, and being disbursed by, three entities within Missouri's State government:
  - the Missouri Department of Social Services;
  - the Missouri Department of Health and Senior Services; and
  - the Missouri Department of Mental Health.
- In addition, the Provider Enrollment Unit was located within the Missouri Department of Social Services, MO HealthNet Division.

MO HealthNet Division in December, 2009

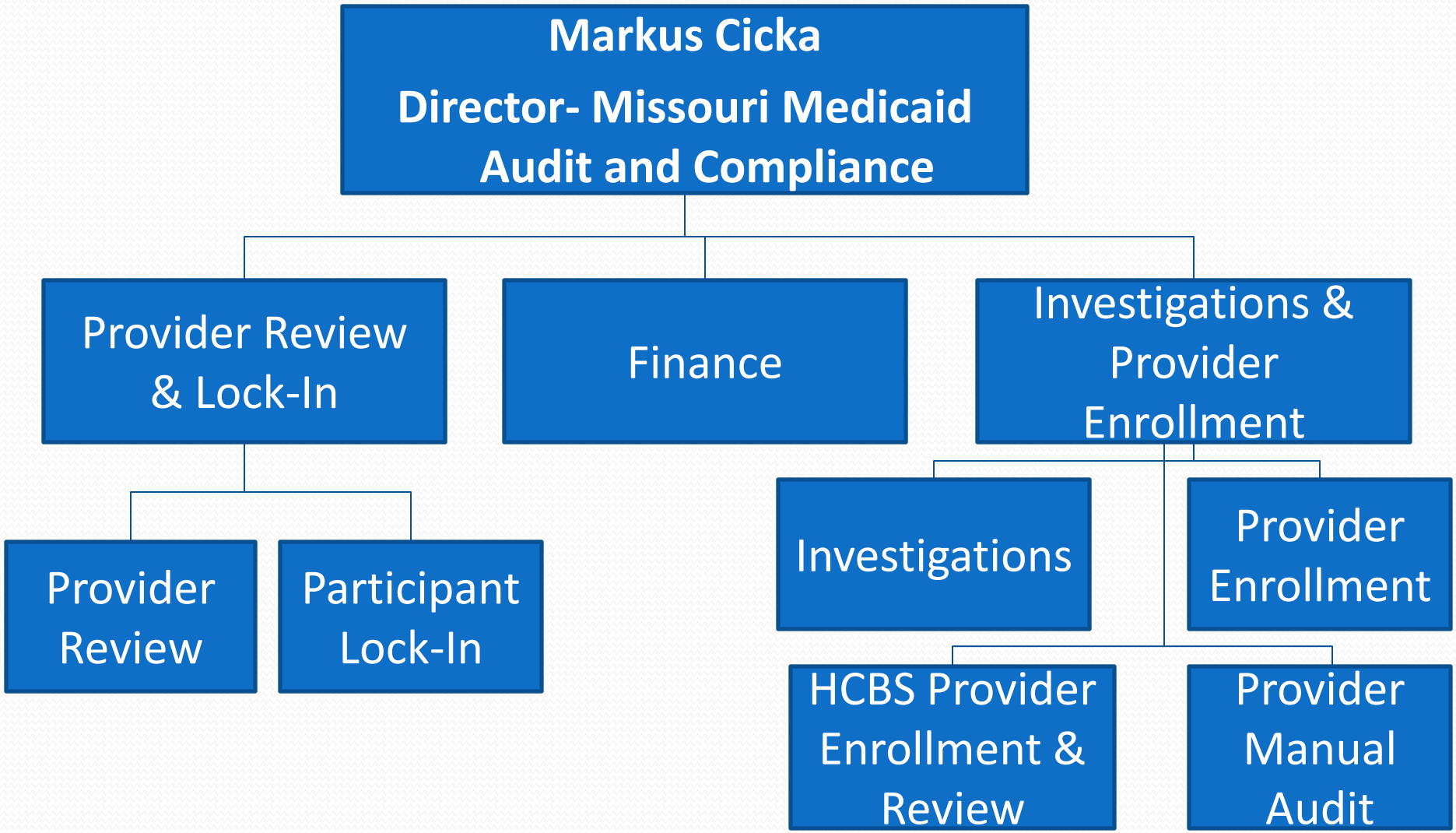


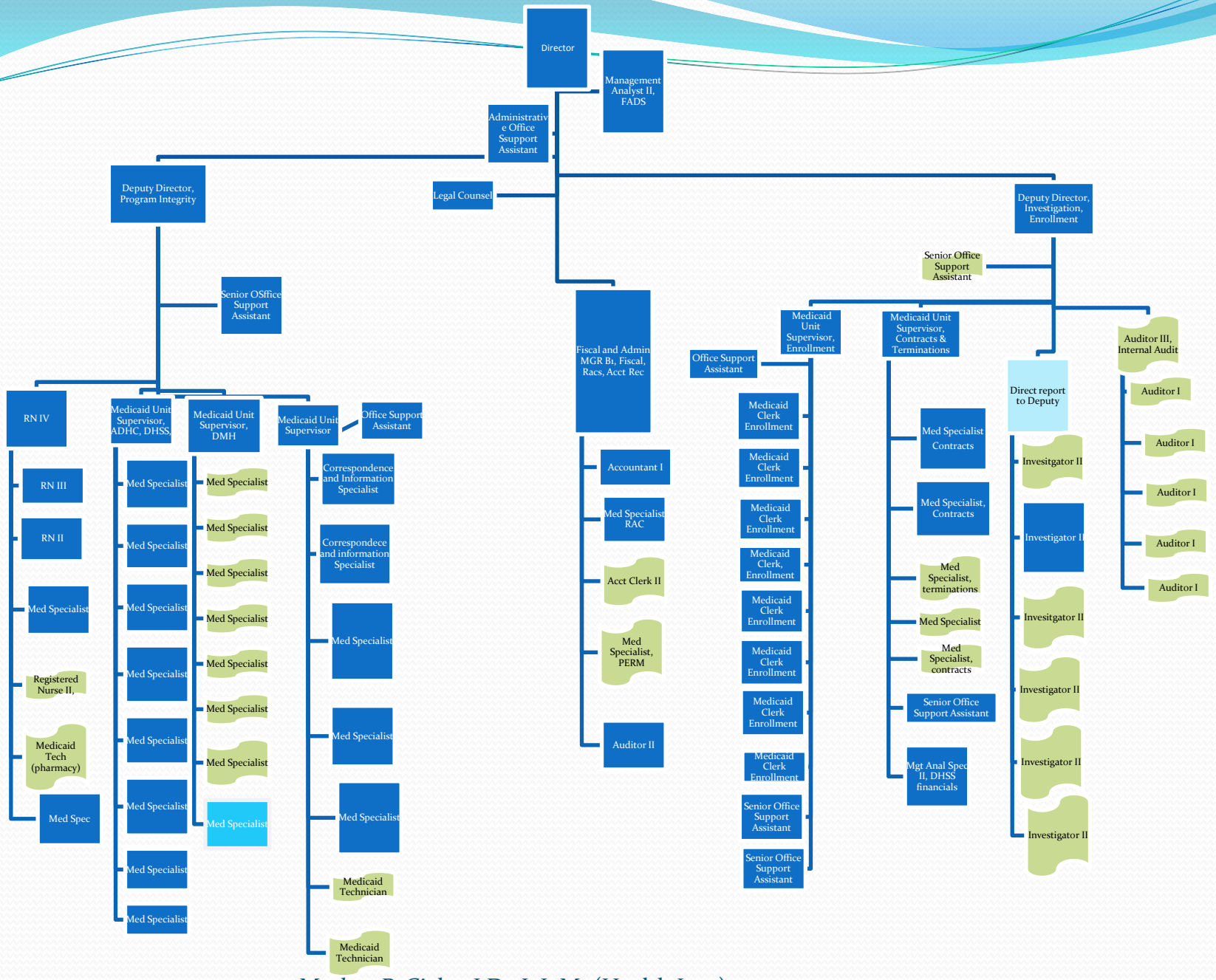
INDEPENDENT PLACEMENT

Organizational Structure of Missouri Medicaid Audit and Compliance Today



Missouri Medicaid Audit and Compliance in January, 2011




Director
Management Analyst II, FADS
Administrative Office Ssupport Assistant
Deputy Director, Program Integrity
Legal Counsel
Deputy Director, Investigation, Enrollment
Senior OSffice Support Assistant
Fiscal and Admin MGR Bi, Fiscal, Racs, Acct Rec
Senior Office Support Assistant
RN IV
Medicaid Unit Supervisor, ADHC, DHSS
Medicaid Unit Supervisor, DMH
Medicaid Unit Supervisor
Office Support Assistant
Medicaid Unit Supervisor, Enrollment
Medicaid Unit Supervisor, Contracts & Terminations
Auditor III, Internal Audit
Office Support Assistant
Direct report to Deputy
RN III
RN II
Med Specialist
Registered Nurse II,
Medicaid Tech (pharmacy)
Med Spec
Med Specialist
Med Specialist
Med Specialist
Med Specialist
Med Specialist
Med Specialist
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Medicaid Technician
Medicaid Technician
Accountant I
Med Specialist RAC
Acct Clerk II
Med Specialist, PERM
Auditor II
Medicaid Clerk Enrollment
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Medicaid Clerk Enrollment
Medicaid Clerk, Enrollment
Medicaid Clerk Enrollment
Medicaid Clerk Enrollment
Medicaid Clerk Enrollment
Medicaid Clerk Enrollment
Senior Office Support Assistant
Senior Office Support Assistant
Med Specialist Contracts
Med Specialist, Contracts
Med Specialist, terminations
Med Specialist
Med Specialist, contracts
Senior Office Support Assistant
Mgt Anal Spec II, DHSS financials
Investigator II
Investigator II
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Investigator II
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Auditor I
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Missouri Medicaid Audit and Compliance Unit

The Missouri Medicaid Audit and Compliance Unit (MMAC) is responsible for the oversight and the auditing of compliance of the Missouri Medicaid providers and participants. The MMAC is charged with the responsibility of detecting, investigating, and preventing fraud, waste and abuse of the Missouri Medicaid Title XIX Program.

MMAC is divided into four major organizational components:

- Administration Section
- Financial Section
- Provider Review and Lock-In Section; and
- Investigations and Provider Enrollment Section.

Financial Section

- The Financial Section has charge of the Recovery Audit Contractor (RAC) program and internal compliance with outside assessment review of the Missouri Medicaid Title XIX Program.
- The state of Missouri has two annual reviews of the Title XIX Program responsibility for which is charged to the Financial Services Section.
- This section is also tasked with auditing managed care organizations and other providers and developing Medicaid fraud and abuse standards for managed care organizations.

Provider Review & Lock-In Section

Provider Review Group

- The Provider Review Group is responsible for reviewing and monitoring statewide utilization and program compliance of Medicaid fee-for-service providers.
- The Group conducts post-payment reviews and researches complaints. Following a review, the Group may issue provider sanctions in accordance with applicable federal and state laws and regulations, including, but not limited to, educational letters, recovery of improperly paid funds, and request for a corrective action plan.
- The Group is responsible for detecting and identifying patterns of provider fraud, reviewing provider records, claims and payments to determine whether fraud, waste and abuse exists.

Provider Review Group (cont')

- The Group is responsible for referring suspected fraud cases to the MMAC Investigations Group for further and full investigations.

Provider Review Group (cont')
Claims processing

Upon a provider submitting a claim electronically, the claim goes through a series of edits, including:

- Data validity
- Participant eligibility and third party liability
- Provider eligibility and pricing
- History checking including medical criteria
- Prior authorization
- Certification
- Pre-payment review (medical consultant review)

Provider Review Group (cont')
Post-Payment Review

- Providers are selected to be reviewed from either referral, exception reports, and/or other system generated reports.

- Referrals concerning possible misutilization may be received from providers, participants, consultants, employees, and staff from other agencies.

- Exception reports are produced on providers that have exceptional patterns of utilization, or that deviate from established norms.

Provider Review Group (cont')

- A review of claims reimbursed is performed on each of the selected providers or project in order to determine program compliance.

- This review is completed by either desk review or field review.

- The appropriateness and quality of service are also considered for the claims being reviewed. If a question regarding the quality of service, medical necessity or medical interpretation exists, the case is referred to the Division's State Consultants for review.

Provider Review Group (cont') Sanctions/Administrative Actions

The outcome of a provider review may include one more of the following administrative actions:

- Determination of overpayment.
  - If an overpayment is identified, a certified mailing is sent to the provider outlining all errors noted in the review and informing the provider of the total amount overpaid.
  - The provider is also notified of any repayment options available to them.
- Withholding of payments.
- Transfer to closed-end agreement.
- Provider education.

Provider Review Group (cont') Sanctions/Administrative Actions

- Pre-payment review.
  - A means by which a provider's claims are reviewed by the State Consultant prior to payment to determine reasonableness and appropriateness of services and charges. The Consultant monitors all claims submitted by the provider for services rendered to MO HealthNet-eligible participants and payment is denied for all incorrectly billed services.
- Referral to another State agency
- Suspension
- Termination

Provider Review Group (cont') Sanctions/Administrative Actions

- Referrals
  - If the review findings question the provider's license or certification, an appropriate referral is made to Professional Registration.
  - If the review findings question the provider's Bureau of Narcotic and Dangerous Drugs prescribing privileges, the appropriate referral is made to the Bureau.
  - If a question of potential fraud exists, the case is referred to the Office of the Attorney General-Medicaid Fraud Control Unit.
  - PI staff also review and monitor the utilization of participants. If participants are found to abuse a program, such as emergency room visits for non-emergency situations, the staff will lock the participant into a specific provider and monitor the utilization very closely.

Participant Lock-In Group

- The Participant Lock-In Group is responsible for reviewing and monitoring statewide utilization and program compliance of Medicaid fee-for-services participants.
- The Group conducts reviews of participant activity regarding the number of physicians and pharmacies visited to determine whether the probability of fraud, waste and abuse exits.
- The Group is responsible for referring suspected participant fraud cases to the MMAC Investigations Group for further and full investigation.

Participant Lock-In Group (cont')

- The Group is responsible for monitoring participants who are participating in fraud, waste and abuse of the Medicaid Title XIX program by mandating that such participants receive Medicaid services through certain providers or pharmacies and ensuring those participants utilize their Medicaid benefits with only those providers or pharmacies.

Investigations & Provider Enrollment Section

- The Investigations and Provider Enrollment Section is divided into the following groups:
  - Investigations Group;
  - Provider Enrollment Group;
  - Home and Community Based Provider Enrollment and Review Group; and
  - Provider Manual Audits Group

Investigations Group

- The Investigations Group is responsible for receiving and fully investigating allegations of Missouri Medicaid Title XIX program fraud against both providers and participants from multiple sources.
- The Group provides assistance to other state Departments and/or Divisions to detect fraud, waste and abuse of the Missouri Medicaid Title XIX Program.
- After conducting a thorough investigation, including obtaining and reviewing provider and medical records, interviewing providers, participants, and any other applicable individuals, and obtaining and reviewing any other records, document, and information deemed necessary to complete a full investigation, the Group is responsible for determining whether referrals to any appropriate law enforcement agencies are warranted.

Investigations Group (cont')

- The law enforcement agencies may include, but are not limited to, local law enforcement agencies, the Medicaid Fraud Control Unit (MFCU) within the Missouri Office of Attorney General, and the FBI.

Provider Enrollment Group

- The Provider Enrollment Group is responsible for reviewing applications for Medicaid Title XIX providers.
- The applications may include, but are not limited to, new provider applications, re-enrolling provider applications, revalidation provider applications, and change of ownership provider applications.
- The Group screens all provider applications to determine whether there exists a history of provider sanctions, fraud, previous professional licensing sanctions or terminations, previous termination as a Medicare or Medicaid provider, and whether the provider is in compliance with federal and state laws and regulations required to become a Medicaid Title XIX provider.

Provider Enrollment Group (cont')

- The Group is responsible for determining whether to accept or deny a provider application pursuant to applicable federal and state laws and regulations
- The Group maintains updates and changes to the provider enrollment files and processes the direct deposit application fees and application fee hardship waiver requests.
- The Group responds to provider inquiries and notifies providers when their application is processed and when a provider number is issued.

Home & Community Based Provider Enrollment and Review Group

- The Home and Community Based Provider Enrollment and Review Group is responsible for reviewing applications for Medicaid Title XIX Home and Community Based Providers providing services to the Department of Health and Senior Services' clients.
- The applications may include, but are not limited to new provider applications to determine whether there exits a history of provider sanctions, fraud, previous terminations as a Department of Health and Senior Services, Medicare, or Medicaid provider, and whether the provider is in compliance with federal and state laws and regulations required to become a Medicaid Title XIX provider.

Home & Community Based Provider Enrollment and Review Group (cont')

- The Group is responsible for determining whether to accept or deny a provider application based on the information available and pursuant to applicable federal and state laws and regulations.
- The Group maintains updates and changes to the provider enrollment files and processes the direct deposit applications, the application fees and application fee hardship waiver requests.
- The Group responds to provider inquiries and notifies providers when their application is processed and when a provider number is issued.

Home & Community Based Provider Enrollment and Review Group (Cont')

- The Group may also conduct on-site and desk reviews of providers as deemed necessary to ensure providers are in compliance with federal and state laws and regulations.
- The Group will issue sanctions as deemed necessary.

Provider Manual Audits Group

- The Provider Manual Audits Group is responsible for performing reviews of provider manuals to ensure the manuals accurately incorporate necessary changes related to policy and federal and state laws and regulations.

- The Group works with the Department of Social Services, the Department of Health and Senior Services, and the Department of Mental Health to ensure the proper maintenance of manuals that regulate the management of the Missouri Medicaid Title XIX program.

Implications to Program integrity Efforts of Organizational Location

- Decrease lag time in updating and implementing MMIS edits
- Increased combined Program Integrity and Provider Enrollment staff from approximately 35 to approximately 80.
- Staff includes more analysts, investigators, internal auditors and home/community based contract reviewers
- Investigators now utilized to investigate provider and participant fraud
- On-site audits becoming more routine and prevalent
- Provider Enrollment fully integrated into MMAC

- Provider Enrollment now focused on compliance with federal regulations regarding screenings, terminations and exclusions
- Moving toward re-enrolling/re-validating providers on a cyclical basis
- Internal auditors ensure update of policy, procedures and regulations by all departments receiving Medicaid funds. Increased efforts to identify fraudulent providers and participants while continuing efforts at reducing unintentional billing errors.
- Enhanced ability to carry-out audit and compliance of other state organizations serving Medicaid recipients

THANK YOU