



HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING - WITH REAL-WORLD PERSPECTIVE.

MO HealthNet Program Integrity Findings and Recommendations

April 30, 2010 (revised 5/14/2010)

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About This Report

- The purpose of this report is to present our observations and recommendations regarding MO HealthNet Program Integrity activities.
- This report focuses on organizational recommendations, as well as recommendations to improve PI operations related to cost avoidance and recoveries. We also provide recommendations to continue developing a collaborative relationship with MFCU, best practices from other states, and our perspective on creating a new Office of Medicaid Program Integrity.
- This report is a deliverable under MO HealthNet's contract with The Lewin Group. All opinions and recommendations reflect those of The Lewin Group, not MO HealthNet nor any of its sister agencies.
- This report responds to the provision of SB 577 (section 208.955.2(11)), which requires the MO HealthNet Oversight Committee to conduct a study to determine whether the State should establish an office of inspector general.

Medicaid Program Integrity - 2010 Landscape

- Medicaid Program Integrity (PI) has evolved from the old Surveillance and Utilization Review Services (SURS) model, which focused on the mechanical completion of outlier audits to comply with standard Centers for Medicare & Medicaid Services (CMS) guidelines
- Over the past 15 years, a heightened understanding that health care fraud, waste and abuse costs all healthcare payers, including taxpayers, billions of dollars annually has repurposed PI at the federal and state level
- Medicaid Program Integrity Programs are now evaluated differently
 - How and what does it contribute to cost avoidance opportunities?
 - How many dollars does it collect retrospectively?
 - How effectively does it contribute to the effort to catch those committing fraud and keep them out of the system?
- During periods of budgetary challenge, PI is often even more highly scrutinized and may even be viewed as a revenue center and be called upon to help plug holes in state budgets

Federal Program Integrity Further Challenge and Strain the Resources of State PI Programs

- Existing efforts include the following:
 - Medicaid Integrity Group (MIG) - Created by CMS in 2006 to implement the Medicaid Integrity Program (MIP), a national strategy to detect and prevent Medicaid fraud and abuse, and to support state efforts through technical assistance and oversight
 - Payment Error Rate Measurement (PERM) - CMS program to measure improper payments in the Medicaid program and CHIP through medical records and data processing reviews
 - Medicare-Medicaid Data Match Program (Medi-Medi) - Program to identify payment anomalies and potential fraud and abuse by combining Medicaid and Medicare data
- The Patient Protection and Affordable Care Act includes new program integrity initiatives including:
 - Recovery Audit Contractors (RACs) - Requires states to contract with RACs to identify and recoup overpayments
 - Expanded data reporting - Requires states to submit an expanded set of data elements to CMS from the MMIS

Project Methodology

- The Lewin Team developed observations, findings and recommendations for this report by reviewing current operations in MO HealthNet, comparing observed operations to known best practices, and reporting areas for program improvement. Specifically, the Lewin Team:
 - Performed onsite interviews with key MO HealthNet staff; reviewed organizational structure, program integrity workflow processes, and staffing levels
 - Assessed MO HealthNet's ability to cost avoid; focused efforts on five program areas with the greatest potential for improper payments
 - Reviewed existing activities to understand the current PI processes and to develop options for the State to measure PI activity results
 - Explored existing interactions and coordination between MO HealthNet and the Medicaid Fraud Control Unit (MFCU) to identify opportunities for improvement
 - Identified known best practices from other states and the commercial insurance industry and compared these to activities performed by MO HealthNet; evaluated advantages and disadvantages of establishing a separate Office of the Medicaid Inspector General

Elements of a High-Functioning Program Integrity Operation

- Maintain a high profile within the Human Services Organization to demonstrate that program integrity is an enterprise-wide responsibility
 - Program Integrity is not just a discrete team within the agency, but part of the entire human services organization - intertwined with program, policy, claims processing, rate-setting, and provider enrollment
- Maintain a high profile externally as well as internally
 - Focus on high dollar provider types, but cast a broad net so that all providers know they are being scrutinized
 - Maximize quality and quantity of interactions with critical external partners - law enforcement, MCOs, provider groups, legislature
 - Report on successes
- Focus on high yield, high impact activities by establishing goals and a work plan
- Maximize access to data and invest in useful technology
- Maximize and develop internal subject matter expertise and leverage expertise throughout the organization
- Recognize that quality of care is an important and integral component of program integrity

While Not a High-Performing Program, MO HealthNet's Program Integrity Unit Is Moving in the Right Direction

- Current PI operations in Missouri are about average compared with other programs
- Ongoing operational improvements will lead to higher performance
 - With the development of the dashboards, staff are refocusing their efforts on data driven analytics
 - Staff do a good job of handling multiple priorities
 - Staff do a good job of tracking their workloads individually without any centralized assignment or tracking system
 - Efforts are underway to increase communication between unit leadership, supervisors and staff to better prioritize workloads and address back log
 - Augmentation of staff by hiring of investigators is a positive step that should yield multiple benefits
 - Increased PI focus on managed care is positive and in line with past recommendations from the Missouri State Auditor and CMS best practices
 - Provider self-audit program allows for increased recoveries with limited use of State resources
- Additional investment would be required to truly become high-performing

High Level Summary of Recommendations

1. Elevate the profile of Program Integrity in the organization through ongoing communication and collaboration
2. Increase staff with clinical expertise and maximize their use across programs
3. Emphasize field-based audits and investigations
4. Emphasize knowledge transfer and cross training within Program Integrity to enhance efficiency
5. Ensure that systems are designed to avoid improper payments rather than paying and recovering
6. Strengthen provider enrollment processes to limit high-risk provider types

Organization and Staffing

- *Limited clinical resources and staff members that specialize in particular provider types and programs limit the PI unit's ability to prioritize work effectively; however, a newly hired Director is working to change this status quo*
- *We recommend an increase in clinical staff, an organizational structure that promotes cross-training, and an overall elevation of Program Integrity's profile in the organization through enhanced collaboration*

With the PI Director Position Recently Filled, Steps are Being Taken to Improve Operations

- PI supervisors are meeting weekly to review active cases, referral, and work loads
- Supervisors also meet bi-weekly with staff to review case loads
- Quarterly meetings with MFCU are now bi-weekly
 - There is a general agreement (between MFCU and PI) that the relationship between MFCU and PI has meaningfully improved over the past few months
- Staff are being encouraged to participate in on site audits and to attend the Medicaid Integrity Institute
- Scope of reviews has recently been expanded to include Medicaid managed care organizations (MCOs)
- PI managers are reviewing current organizational structure and considering reorganization
- With prior authorization, staff are now permitted to travel overnight to conduct program integrity reviews

Reorganize Unit Based on Logical Groupings

- Current division of labor appears to have developed over time from the combination of SURS and FADS into PI
- The existing structure can result in program silos
 - Staff report that cases are “worked” a little bit differently under each supervisor
 - Lack of conformity and cross-training limits ability to reassign work
 - If a staff member is not available, work in his/her area may be on-hold
 - Staff focus on individual responsibilities in designated program areas, instead of shifting priorities to achieve larger program goals
- Organize the work of each supervisor into logical groupings of responsibility to enhance knowledge sharing
 - Georgia PI includes: Medical Provider, Hospital, Waiver, Non-Institutional, and Pharmacy
 - North Carolina has Provider Medical Review, Home Care, Pharmacy, Behavioral Health, Third-Party Recovery, Quality Assurance, and Special Projects
 - Pennsylvania’s Division of Provider Review includes Outpatient, Pharmacy, Inpatient, IT/Data Support, and Managed Care

Develop Structure and Uniform Processes to Maximize Audits and Analytic Work

- If review units are organized logically, staff within each unit should be able to assist and cover for each other when needed
 - For example, if there is a major problem with a particular provider type (an edit was not set to deny) a team of workers could support the review and follow-up with the providers
- When an individual is out of the office for an extended period of time then workloads could shift to cover these areas
- Individual PI staff members seem to complete all phases of a review from review of the dashboard or creation of a Special Project and subsequent review to creation of the overpayment letters and tracking recoveries
 - Clerical functions performed by auditors detracts from time spent working on cases and conducting analysis
- Clerical support staff could centralize letter creation, tracking of recoveries, and obtaining documentation from providers
 - These functions could also be largely automated through the use of case tracking system
 - While there is an upfront cost (time or funding) to create this system, staff will be able to work “smarter” when it is completed

Continue to Improve Productivity by Prioritizing Projects / Provider Reviews

- PI leadership is meeting regularly to prioritize work on higher dollar cases or known issues
 - This needs to be communicated to all staff
- A detailed work plan of effort for the year should be developed, updated, and distributed to all staff on a regular basis
 - Include both Cost Avoidance and Recovery amounts and level of effort
 - Ensure each provider group is addressed on a cyclical basis
 - Identify resources to scan the wider area of fraud and abuse in other states and nationally
 - Major issues can be addressed on a more timely basis

Following Reorganization Based on Logical Groupings, MO HealthNet Should Evaluate Staffing Levels

- Quantifying suggested staff increases is challenging; however, targeted staff increases to the Program Integrity Unit would likely benefit MO HealthNet
- Following reorganization, MO HealthNet should evaluate staffing level by evaluating workflow, assessing bottlenecks, assessing workplan goals
 - In assessing workflow, consider staff both inside and outside the Program Integrity Unit, such as other program staff that interface with PI (e.g., administrative law judges who hear appeals)
 - Special projects requiring staff with particular skill sets may justify staff additions
- When requesting staff, develop detailed work plan describing gaps in current staff skills and workflow, functions of new staff, and projected cost savings
- As an alternative to additional staff, some functions may be contracted (e.g., some states are relying increasingly more on vendors to supplement staff with nurses and other clinicians and investigators)

Regardless of Overall Decision on Increased Staffing, Increase Number of Staff With Clinical Expertise

- Program Integrity units typically have a significant clinical presence, and in some cases primarily consist of medical professionals
 - Nurses are matched with 75% FMAP, compared to the typical 50% administrative match, which reduces their net cost to the State
 - Clinicians are qualified to evaluate standards of care, as well as documentation and coding issues, helping the PI unit to focus on quality of care issues
- MO HealthNet's PI Unit has only three nurses (one currently on leave)
 - Staff sometimes rely on clinicians from other parts of agency
- It is also important to maximize the use of nurses that are available
 - PI nurses are assigned to work cases that do not necessarily rely on clinical knowledge (though program areas that nurses work tend to be more clinically intensive), and are sometimes consulted by other staff on clinical issues
 - Primary focus of nurses attention is not on quality of care issues
 - If a decision is made to use clinical staff to primarily support clinical issues throughout PI, they will not be able to maintain their existing caseload
- Determine if there are nurses or other medical professionals throughout MO HealthNet that could support PI activities

Establish Routine Process of Communication and Sharing of Knowledge and Best Practices

- Knowledge sharing has historically been lacking, but is improving through increased supervisor and staff meetings
 - There is now a weekly supervisor meeting to review upcoming cases, and supervisors meet with staff every other week to review case loads
 - This needs to be expanded to sharing at the staff (auditor) level as well
- Provide a forum for knowledge sharing within PI and expand to introducing MFCU knowledge, Clinical Services, MMIS, etc.
 - This can be accomplished through regularly scheduled “brown bags”
- Additional knowledge will encourage workers to identify possible areas for review and sharing of knowledge will help make the workers proud of their work
 - Examples include sharing dashboard experiences across provider types and examples of special projects that might benefit other areas

Foster Better Communication and Shared Responsibility Between PI and Program Areas

- A significant proportion of spending is outside of PI's purview
 - Clinical Services has invested significant technological resources to jury approval of pharmacy claims. PI has focused efforts on other program areas that are less tightly managed
 - Pharmacy claim review by PI is limited and generally only as a result of a referral from the Board of Pharmacy and MHD program areas; there is not a pharmacy dashboard
 - Many traditional PI functions for LTC and mental health programs are administered by DHSS and DMH
- Initiate a regular meeting between PI staff and corresponding program areas
 - Staff in PI and corresponding program areas should understand exactly what responsibilities belong to each
 - This could lead to identification of areas where there are gaps and additional work is warranted
 - This includes area administered by DHSS and DMH (and possible also professional boards)
- MO HealthNet leaders should ensure that critical PI functions are being handled by one of the units.
 - Typically PI staff are better able to focus on PI without competing service delivery issues

Consider Development of an Electronic Filing System of Provider Reviews

- There does not appear to be a well-developed electronic system to maintain records of provider review
 - Workers' desks and cubicles are piled with papers, which can make it difficult to locate information on a particular case or provider
 - Current systems requires manual uploading of paper-based information into Access database and ability to share data is limited
- An electronic system would track all audit efforts for a particular provider
 - This would allow anyone to know when the last review was done on an provider, what letters were mailed, what overpayment was collected, etc.
 - Also allows for audit trail to track access and progress
- System should include all active providers, pulled directly from the Provider File
 - Inclusion of all providers will allow reports to be run that identify audit work against all of the MO providers and will spot deficiencies
- At a minimum, a more robust case tracking system should be initiated to support current and future reviews (historic information could be added over time)

Summary of Recommendations: *Organization and Staffing*

- Reorganize unit based on logical groupings
- Develop structure and uniform processes to maximize audits and analytic work
- Continue to improve productivity by prioritizing projects/provider reviews
- Evaluate staffing levels by evaluating workflow, assessing bottlenecks, assessing workplan goals
- Increase number of staff with clinical expertise
- Establish routine process of communication and sharing of knowledge and best practices
- Foster better communication and shared-responsibility between PI and program areas
- Consider development of an electronic filing system of provider reviews

Cost Avoidance Activities

- *Cost avoidance efforts rely largely on an internally developed system of edits that can be difficult to update, as well as prior authorization controls administered by program staff (outside of Program Integrity).*
- *We recommend the MO HealthNet continually review and analyze the effectiveness of existing edits and the expected ROI from an investment in front end technology (such as commercial editing system) as well as increased collaboration between Program Integrity staff and clinical program areas.*
- *Adoption of the provider enrollment recommendations described on slides 36-46 would also significantly enhance cost avoidance efforts*

General Recommendations

- Billing policies should be more clear in what they limit
 - Clearly written policies that provide direct guidance to providers are an important tool in cost avoidance
 - PI should play an active role in policy development
- Edits should be more clearly documented so that they can be better understood by non-technical reviewers
- Develop dashboards for high dollar areas that currently do not have them (e.g., physician, pharmacy)
 - The dashboards (for subject matter areas that have dashboards) are generally comprehensive and describe significant retroactive findings that have potential for front end edits
 - Dashboards are utilized to facilitate retrospective recovery, but these types of analytics also often identify holes that can be plugged
- Make sure that analytics that have broad application across program areas are applied as widely as possible, not just to specific policies
 - Example - The lab and radiology dashboard contains an algorithm looking at fee for service claims for recipients enrolled in managed care. This analytic should be applied across all applicable fee for service claims

Develop a Consistent Referral Process for Edit Development/Modification and Testing

- MO HealthNet should identify issues revealed by dashboards and make corrections through edit development or modification
- There should be a systematic process for these, and other edit modifications
- Referrals to program office for additional edits are infrequent and rarely appear to be followed-up on
 - Audit staff indicate that some requests for edit modifications go unanswered and unaddressed
 - Existing PI tracking of referrals indicates that program areas will “look at the issue and get back to PI”
 - There rarely appears to be a documented response to the issue or any record of a system modification
 - Ensure that process includes monitoring whether responses are received from program areas/MMIS on a timely basis

Continually Evaluate Potential Benefits of a Commercial Edit System

- Existing edits have been built into MMIS overtime rather than using a commercial edit system
 - Decision so-far has been to continue updating system with edits developed in the MMIS system with staff direction
- MMIS is working on updated edit logic (not complete yet) as part of system re-engineering
 - Historically, edit detail had not existed
- A number of commercial editing systems are available
 - Contractors are often better able to monitor developments in cost avoidance and maintain more up-to-date edits
 - Systems can “overlay” existing MMIS and do not require that claims data be run through a separate external contractor system
 - Contractors will run a sample of claims through their systems to determine potential ROI
- If/when MO HealthNet decides that the business case exits, issue an RFP and ensure that Missouri is getting maximum return on the investment

Several Areas Were Identified for a Front-End Vulnerability Assessment

- A high-level scan of expenditures, edits, and policies was conducted to identify five areas for additional analysis
 - Areas selected, based on expenditures and potential for vulnerability include:
 - Pharmacy
 - Physicians/Clinics
 - Lab/Radiology
 - Outpatient Hospital
 - Medical Supplies
- We considered other areas of high spending but did not pursue them in this engagement
 - Inpatient hospital and nursing facilities are reimbursed a per-diem rate, limiting the ability to assess vulnerability through this review process
 - Waiver services are administered by other agencies, limiting direct MO HealthNet oversight

Pharmacy Cost Avoidance Activity Is Limited

- Although Pharmacy is a large program area in terms of dollars spent (15% in SFY09), there is very little focused attention given to pharmacy by PI
 - There is no pharmacy dashboard, but several individual algorithms
 - PI has a nurse to review pharmacy services, but no clinical staff with specific pharmacy training (e.g. pharmacist or pharmacy technician)
- Pharmacy cost avoidance consists primarily of prior authorization and DUR edits
- On-going activity consists primarily of daily review by Pharmacy Services (not PI) of a “top 50” list of claims paid above the allowed amount and PI staff work on referrals
 - Claims that are found to have been overpaid are adjusted in the MMIS
 - Savings from those adjustments are reported back to PI and tracked as recoveries
- There is little apparent tracking or analysis of information from the Top 50 report
 - Example - Are there providers (pharmacy or prescribers) or billings that show up repeatedly indicating a need for more comprehensive analytics?
 - Is 50 the correct number of claims to review? Are there providers consistently just outside the Top 50?

Create a Pharmacy Dashboard

- Pharmacy billing errors are generally easy to identify using algorithms and analytics because the standard pharmacy data set is more granular than medical or institutional claims
- POS systems are designed to adjudicate claims quickly which can be at the expense of accuracy
 - Vulnerable to key stroke errors
- A well-designed pharmacy dashboard would enhance cost avoidance and recovery efforts
 - Identify all overpaid claims subject to common billing errors
 - Identify prescribers and pharmacies that are the primary cause of errors
 - Utilize results of analytics to
 - Create new prior authorizations, DUR edits, MMIS edits
 - Identify outlier providers for referral, education, termination or pre-payment review
 - Initiate recovery

Expand/Leverage “Top 50” Report

- Although as utilized the “Top 50” Report results in meaningful documented recoveries (>\$1.0 million to date in SFY10), information from that report is not utilized or measured to enhance overall cost avoidance or recovery efforts
- Use the results of the report to “farm” for algorithm ideas
 - Analyze common key stroke, quantity and billed amount errors that show up on this report and incorporate them into analytics identifying a broader range of claims
- Evaluate the level of effort utilized to create and work the current Top 50 report to determine whether it would justify additional resources to expand the scope of the review

Physician/Clinic Review Identified Several Existing Vulnerabilities

- Physician/Clinic Services are another area that appear to receive little focused review by PI
- There is currently no PI dashboard for these services even though they account for almost 6 percent of SFY09 expenditures
 - PI reports that development of a Physician dashboard is under consideration
- There are several explicit service limitations in the billing manual that do not appear to have corresponding MMIS edits and which could be reviewed using a dashboard. For example:
 - One E&M (evaluation and management) per day, unless as approved by medical consultant
 - Critical care codes: unbundling of routine services
 - No more than nine units of infusion therapy in an office setting
 - RHC and FQHC may not bill for vaccine administration

Focus Additional PI Attention on Physician/ Clinical Services

- Develop the Physician/Clinical Services Dashboard
- Dashboard should be seeded with algorithms designed to determine effectiveness of current cost avoidance activities (policies and edits), including National Correct Coding Initiative (CCI) edits
 - CCI code pairs are nationally recommended edits updated quarterly by CMS, but current MMIS only updates its edits annually
 - Many states that have implemented CCI continue to see “leakage” of claims. Retrospective analytics will help to determine where the weaknesses are so that they can be remedied
- Physician/Clinical services receive particular focus in front-end claims editing systems
 - Those systems are strongly focused on CPT coding practices and are strongly informed by the tremendous volume of documented coding guidance that exists with respect to CPT coding

Lab/Radiology Has Several Existing Vulnerabilities

- Lab/Radiology has a dashboard that evaluates claim payment activity against duplicate claims as well as payment rules and existing edits
- Indicates significant paid claims activity for services that are contrary to rules, including some which appear to have edits
 - Professional and Technical component double-billing
 - Lab/Radiology with no corresponding medical service
 - Out of Scope Procedures (Edit 136)
 - Labs on Managed Care Recipients (Edit 233, set to *pay for all claims*)
 - No Referring Physician (Edit 020)
 - Unallowed Place of Service (Edit 065)
- MO HealthNet should
 - Evaluate why particular claims continue to be paid, in light of existing edits that appear designed to block payment (e.g. Are they all due to transparent approvals through CyberAccess?)
 - Develop edits to prevent overpayments identified by the dashboard that are being paid contrary to the rules

Outpatient Hospital Services Has Existing Vulnerabilities

- The current dashboard demonstrates that vulnerabilities are not being captured by edits, even in some cases where there are clear rules
 - Excessive observation codes
 - Multiple revenue codes/same day
 - Unbundled codes and panel codes
 - >1 Ultrasound per day
 - Ultrasound not allowed with particular CPT Codes
 - Medically unlikely edits
 - Overlapping inpatient/outpatient
 - Inpatient one day stay
- Determine why vulnerabilities identified on current dashboard are not effectively being edited by the MMIS
 - Analytics should determine effectiveness of CCI (see similar recommendation on slide 31 re: Physician/Clinical)

Medical Supplies Has Several Existing Vulnerabilities

- Payment for medical supplies is a common area of vulnerability
 - Limits are often difficult to interpret and edit (e.g., does a “monthly supply mean every 30 days or every calendar month?)
 - Tremendous opportunity for unbundling - items sold as kits can usually be billed for as individual items (e.g., ostomy and tracheostomy kits)
 - Similar items can be billed for when limits are hit (e.g., if the limit for medium-sized diapers is reached, can a provider seek reimbursement for a larger size?)
- Although there is a dashboard for DME, it does not cover medical supplies
- Although the policy contains specific limits for many supplies, there does not appear to be front-end editing based upon the specific HCPCS code

Medical Supply Recommendations

- Add analytics related to supplies to the dashboards, reviewing items such as
 - Unbundling, claims exceeding limits (for same or similar products)
 - Analytics should look on a per recipient basis to make sure that limits are not being exceeded by providers who have multiple provider numbers or by recipients who utilize multiple providers
- Conduct outlier and other provider-based analysis of providers whose billing patterns exceed the norm (e.g., providers who bill for the highest quantity of supplies as compared to their peers)
- Analytics would support a number of cost avoidance (and recovery) efforts
 - Provide leads to investigators and referrals for MFCU, resulting in sanctions, disenrollment, pre-payment review, etc.
 - Identify edits to the MMIS that would have a significant impact
 - Identify provider and recipient education opportunities
 - On site visits of outlier DME providers would be worthwhile assignment for new investigators

Summary of Recommendations: *Cost Avoidance*

- Develop a consistent referral process for edit development/ modification and testing
- Use dashboard results to identify and correct front-end vulnerabilities through edits
- Continually evaluate potential benefits of a commercial edit system
- Create a pharmacy and medical supply dashboards to identify additional areas that warrant edits and to aid in recoveries
- Expand/leverage “Top 50” report
- Focus additional PI attention on physician/clinical services
- Update lab/radiology edits to enforce policies
- Review outpatient policies that are not being enforced by edits and correct, if necessary

Provider Enrollment

- *Provider enrollment staff rely on several effective practices for limiting the number of inactive providers on the provider file, but system limitations prevent the capture of some important information. On-site reviews of providers are not routinely performed.*
- *Provider enrollment should coordinate further with Medicare and border states regarding problematic providers, and onsite reviews of high-risk provider types should be conducted. Provider file should be updated to include licensure and ownership information and credential verification should be automated.*

Several Provider Enrollment Processes Help Enforce Program Integrity

- Out-of-state providers (from non-contiguous states) are only enrolled if the patient has been prior approved OR the patient is receiving life-threatening services
 - This ensures that Missouri patients are not travelling to obtain services in other states beyond the immediate border
- If a provider is inactive (no claims for previous two years as of the first check in November), the provider is removed as an active provider
 - Inactive providers are required to re-enroll to resume providing services
- If mail to a provider is returned, claims for that provider are suspended. If the provider does not contact Provider Enrollment within 180 days, the provider's claims are denied
 - The action to deny a claim if there is no response from the provider reduces the number of providers who are not actively participating in the program
 - Similar practices have been deemed "noteworthy" by CMS
- DME, Hospice, Home Health, FQHC, and Rural Health providers are required to be enrolled in Medicare as a condition of enrollment in MoHealthNet
 - Enrollment in Medicare helps to ensure that providers are billing Medicare where a patient has dual eligibility
 - Medicare also conducts on-site reviews of enrolled providers

Provider Enrollment and Program Integrity Collaboration Could Be Enhanced Further

- Staff from these units could, for example, conduct joint reviews of federal exclusions, or collaborate to perform on-site reviews of providers
- “At-will” provider contracts would allow MO HealthNet to terminate provider contracts for failure to comply with rules, clinical policy, regulations and guidance, failure to provide documentation of services rendered and billed, and questionable quality of care and billing practices
 - North Carolina and New York are examples of states that use at-will contracting
 - While “any willing provider” may still be eligible for enrollment, their contract may be terminated by the State “at will”

Requiring Periodic Re-Enrollment Would Further Limit the Number of Inactive Providers

- Retaining inactive providers on the provider file reduces the effectiveness of reporting and sampling based on “enrolled” providers
- Lack of re-enrollment processes does not allow MO HealthNet to capture updated provider information
- Current process requires the provider to take a positive action to update their record
 - This is likely to occur only if the outcome is favorable to the provider
- CMS has identified this as a “noteworthy” practice
- Periodic re-enrollment process would most likely require additional staff resources and is often perceived negatively by providers

Require Pharmacy Providers to Enroll in Medicare

- Pharmacy providers are not currently required to be enrolled in Medicare (like DME, Hospice, Home Health, FQHC, and Rural Health providers are)
 - Enrollment in Medicare would assist in claiming when a patient is dually eligible.
 - Any Medicare reviews would provide additional scrutiny to the provider serving overall as a deterrent effect

Provider File Should be Updated to Include Licensure and Ownership Information (1/2)

- License information is collected by the Provider Enrollment process but only the effective date is keyed on the Provider File
 - Expiration date is not captured, allowing unlicensed providers to potentially be paid
 - Collection of an expiration date on the Provider File would allow Provider Enrollment to inactivate providers whose license is no longer in effect
- Once the Provider File is expanded to allow data capture, Provider Enrollment would need to obtain this data which could be accomplished through a mass mailing and/or reenrollment activity
 - Also consider a one-time data match with license agency to obtain license information that could be loaded to the file
 - If it is not possible to add a field to the Provider File, another means to obtain the expiration data would be to establish a data exchange with the entity in Missouri that maintains the license information (Department of Insurance, Financial Institutions, and Professional Registration for professionals, DHSS for hospitals and nursing facilities)
 - Periodic match on NPI would allow Provider Enrollment to remove providers with no valid license
 - If licensing agencies do not currently capture NPI, it is strongly recommended that they begin to

Provider File Should be Updated to Include Licensure and Ownership Information (2/2)

- Ownership information is collected on the Enrollment application but it is not carried through to the Provider File
 - There is no way to connect the provider of service to the owner
 - This information is often requested in resolving cases of bankruptcy
- The Provider File should be expanded to allow collection of ownership information in a manner that allows identification of the owners of each provider that can be obtained through the specific provider as well as allowing all owners to be identified

Coordination with Bordering States Would Enhance Provider Enrollment Integrity

- Currently, interaction with bordering states is limited to occasional requests from states for excluded provider data
 - MO HealthNet is not prepared to respond to such requests because a list of providers excluded in MO is not readily available
 - These requests have been increasing in frequency
- MO HealthNet should develop a data field on the Provider File or maintain a separate database of that information and should publish the list on its website
- MO HealthNet should establish relationships with bordering states to share information regarding providers under investigation

Automate Provider License Verification

- MO HealthNet should investigate either the purchase of a software package or development of an internal system to automate the verification of licenses
 - Texas purchased software that automates license verification and ensures that Medicaid does not allow payments to non-qualified health care providers
 - The software allows the State to match a provider's information against the State Master File, the List of Excluded Individuals/Entities, the Texas State Provider exclusion list, the Texas Medicaid Do Not Enroll List, and the Open Investigations list
 - Effectiveness will be impacted by the ability to link the providers using a common identifier

Conduct Onsite Reviews of DME, Pharmacy, Home Health, and Other “High-Risk” Providers

- Numerous states conduct an on-site review (address verification, inventory checks) of new providers, and many also conduct reviews of existing providers
 - Reliance on Medicare may not provide sufficient protection
- Georgia surveys participants that receive power wheelchairs to verify that the chair that is billed for matched the chair actually received
- Illinois initiated a New Provider verification system in 2001 for NEMT and DME providers including site visits and analysis of billing patterns. In 2009 the IL program was “overhauled” including:¹
 - Increased focus on owners, officials, and day-to-day operators
 - Follow-up investigations based on suspicious behavior during the 180 day probation period
 - Adoption of early detection methodologies that include review of trips through prior approvals and inclusion of fraud detection routines
 - Fraud routines developed by the OIG Fraud Science Team to support the predictive
 - Modeling system have been incorporated into the analysis and include evaluation of the provider’s duplicate services, rejected services, recipient characteristics, interrelationships with other providers and dates of service patterns

¹ Illinois Dept. of Healthcare and Family Services OIG Annual Report, 2009 accessed at <http://www.state.il.us/agency/oig/docs/2009%20OIG%20Annual%20Report%20Final%20Print%20Version.pdf>

Summary of Recommendations: *Provider Enrollment*

- Provider enrollment and program integrity collaboration could be enhanced further
- Requiring periodic re-enrollment would further limit the number of inactive providers
- Provider enrollment should coordinate further with Medicare
- Provider file should be updated to include licensure and ownership information
- Coordination with bordering states would enhance provider enrollment integrity
- Excluded provider lists should be maintained and made available on the State's website
- Automate provider license verification
- Conduct onsite reviews of DME, pharmacy, home health, and other "high-risk" providers

Cost Recovery

- *Cost recovery activities are driven by contractor-generated “Dashboard” reports that generate cases for program integrity staff to work. Internal analytic capabilities are limited.*
- *We recommend that dashboards cover all major provider types and that the vendor contract be monitored closely for compliance. We also recommend that internal analytic capacity be increased.*

Dashboards Should Include All Areas of Significant Expenditures Including Pharmacy, Inpatient, and Physicians

- Dashboards do not currently exist for these provider types
 - Most provider groups are covered to some extent by “general” dashboards; however, it is not clear how much staff assigned to specific programs are aware of the general dashboards
 - “General” algorithms can provide important participant level information across provider types and their utility should be shared with all staff
- Work should be prioritized based upon potential return (financial, programmatic)
 - Staff are routinely behind on working dashboards and keep getting new ones
 - Perception is that they must work all of the old ones first or risk being accused of “ignoring” them (e.g. by state auditor)
 - Backlogs should be evaluated to determine if they warrant review and, if so, additional staff should be considered
- Additional analytics such as outlier analyses may help to focus review of providers
- Special Projects can be run but require preapproval and an estimated ROI (which is often not known) before approval
 - Review approval process to make sure that it is not too restrictive

Enhance Collaboration Between Program Integrity and Data Analytics Contractor

- Dashboards are requested by PI staff, but typically created by the contractor
 - Contractor brings significant expertise and experience from other states
- PI and other staff involvement in the initial development of dashboards should be maximized to make the initial results as useful as possible
 - Ensure that MO HealthNet staff are able to contribute actual MO experience to the development of dashboard algorithms rather than relying on “off-the-shelf” algorithms
- Changes reportedly take a month to program

Build Increased Capacity for Ad Hoc Analytics Among PI Staff

- A basic requirement of an effective program integrity unit is the ability to investigate cases through the use of electronic data mining tools
- Data analytics should become ingrained into the culture of Program Integrity
- Ensure that more than one staff person can be counted on for ad hoc query development
 - Hands-on, interactive training should be provided to all program integrity staff

Continue to Develop and Expand On-Site Audit Capabilities

- An on-site presence increases the “sentinel effect” and lets providers know that PI extends beyond the “I-70 corridor”
- Historically, on-site activities have been very limited, and travel budgets restricted, with nearly all reviews conducted as “desk-audits”
- Two new investigators have been hired with the ability to travel
 - Most documentation is obtained from providers who do their own copying and supplying of information
 - In some cases, providers may delay in providing documentation, or only produce it after an administrative hearing officer becomes involved
 - All PI staff are now being encouraged to conduct on-site reviews periodically which is critical to expanding on-site efforts
- On-site activity should occur in any case where there is reason to believe that documentation does not exist (lest it be created in response to a request) as well as to permit program activities and participants to be viewed

Use the Investigators On a “Pool” Basis

- Currently the new investigators are working on reviewing managed care organizations and other PI projects
- Use them on cases where it is difficult to obtain documentation and/or there is reason to believe the provider may be creating documentation as the occasion arises
- Consider hiring additional investigators to allow for more on-site reviews and case preparation
 - Consider assigning investigator positions under each supervisor

Increase Role of PI Staff in Reviewing Clinical Areas Such As Pharmacies and Physicians

- SmartPA is a robust prior authorization system that limits potential for abuse; however, there is still a significant post-payment role that PI can perform
 - For example, implement review of general provider documentation to support the actual pharmacy claim
 - This could be accomplished by requesting copies of prescriptions for a random number of patients from each pharmacy for a defined period of time and then comparing the claim information to the prescription
 - The number of pharmacy providers to be reviewed can be determined based on the availability of staff to complete the review. It is worth noting however that conducting the review will result in a deterrent effect on providers
 - PI could also review prescribing patterns
- At this time, there is no formal retrospective monitoring of authorizations requested or review of prescribing patterns other than cases generated from referrals
 - A report of high volume prescribers should be developed that includes type and quantity of services
 - If possible the report should also include a designation of the patient to acknowledge any involvement in the lock-in program
 - Providers who prescribe high volumes of typically abused drugs should be reviewed for compliance with the program

Emphasize Cost Avoidance Benefits as TPL Contractor Shifts Away from Cost Recovery

- Revised TPL contract, effective July 2010, shifts contractor's TPL focus from cost recovery ("pay and chase") to more efficient cost avoidance practices
- For the annual Governor's Report, this change will result in fewer dollars reported from TPL as "recovered" and more dollars reported as "cost avoided"
 - MO HealthNet should specifically note that this change has occurred in the annual Governor's Report, highlighting the efficiencies of cost avoidance over cost recovery
 - Conventional wisdom dictates that programs can only recover 15% for every dollar that could be cost avoided

Summary of Recommendations: *Cost Recovery*

- Dashboards should include all areas of significant expenditures including pharmacy, inpatient, and physicians
- Enhance collaboration between program integrity and data analytics contractor
- Build increased capacity for ad hoc analytics among PI staff
- Continue to develop and expand on-site audit capabilities
- Use the investigators on a “pool” basis
- Increase role of PI staff in reviewing clinical areas such as pharmacies and physician
- Emphasize cost avoidance benefits as TPL contractor shifts away from cost recovery

Measuring Results

- *Measured results have shown significant increase since SFY07, highlighted by a substantial increase in reported cost avoidance*
- *We recommend continuation of current measurement methods, but heightened validation that provider activity accounting for cost avoidance has ceased*

There Is an Increased Focus on PI Measurement of Financial Results

- As the profile of Medicaid PI has risen, there is an increased emphasis on reporting financial results as a measurement of program success
 - It is important that the measurement criteria remain stable so that financial performance can be tracked over time
- Comparing financial results across states is tremendously difficult because there is no uniformity in *how* savings are measured or *what* is measured
 - PI units sometimes count savings from TPL, COB, Estate Recovery and/or some elements of Drug Rebate recoveries
 - The scope of PI activity may or may not include high dollar services such as Mental Health and Long Term Care
 - Extent of MCO penetration can have a big impact on dollars available for review
 - There is tremendous variation in the methodology of how cost avoidance is calculated
 - Not all PI Units have administrative authority to assess interest and fines

MO HealthNet PI Measures Results in Terms of Cost Avoidance and Recoveries

- PI Cost Avoidance is tracked in three ways
 - Medical Reviews - The dollars from claims denied due to Medical Consultant Review and system edits for providers on review
 - Provider Case Cost Avoidance - An extrapolation of overpayments based upon a special project or provider review projected forward for one year
 - Participant Reviews - Claims not paid based upon lock-in or medical necessity review performed by a PI nurse
- PI Recoveries are measured in three ways
 - Direct recoveries by the PI Unit based upon provider reviews and special projects
 - Pharmacy Administrative Recoveries from the Top 50 Report
 - Voluntary returned payments
- Missouri should consider including TPL, COB and Estate Recovery with PI-reported results to get the most complete snapshot of all payment accuracy activities

MO Has Seen Overall Growth in Cost Avoidance and Recoveries Over the Past Several Years

- Total reported cost avoidance and recoveries have grown over the past several years from \$21.66 million in SFY07 to \$34.9 million in SFY09
 - SFY10 results through March are \$45.93 million
 - Growth has been solid in all measurement areas but has increased almost 3X for Provider Case Cost Avoidance (\$11.45 million in SFY07 to \$33.34 million YTD in SFY10)
 - PI Unit attributes increase to effective implementation of dashboards and successful completion of special projects
- Recoveries have fluctuated but increased overall and appear to be on target to increase in SFY10
 - Recoveries were \$6.6 million in SFY07 and are projected to reach \$9.3 million based on SFY10 YTD
- These increases occurred at the same time that staffing levels decreased (from SFY06 through SFY09 from 32 FTEs to 27 [current count is 30])

Provider Case Cost Avoidance Reporting Appears Appropriate, as Long as Behavior is Modified

- Provider Case Cost Avoidance methodology was put into place during SFY06
 - Current methodology has been consistently applied since, which is a good practice
- Cost avoidance estimation methodology is based on the assumption that once a provider is made aware of the aberrant behavior, that behavior should stop
 - Currently, however, the change in behavior is not verified
 - Paid claims data should be queried to make sure that behavior has actually ceased
- Avoidances are measured for one year and can continue beyond one year only if PI takes “an active and substantial role in maintaining the reduced expenditures through some type of administrative discipline which goes beyond the initial 12 month CA [cost avoidance] period”
 - e.g., provider is on pre-payment review

Cash Recoveries by Provider Type

SFY 09 Program Integrity Cash Recoveries				
Provider Type	SFY 09	SFY 08	SFY 07	SFY 06
Hospital	46.61%	21.98%	30.87%	25.73%
Nursing Home	9.46%	28.54%	22.11%	5.81%
Physician	8.42%	15.03%	18.45%	17.79%
Home and Community Based Services	11.84%	23.14%	12.39%	11.59%
Optical	0.18%	0.28%	0.60%	9.35%
Dental	1.11%	0.33%	2.91%	10.81%
Psychology	1.43%	4.01%	2.72%	6.33%
Pharmacy	12.42%	0.34%	2.45%	3.04%
Durable Medical Equipment	0.65%	1.59%	3.05%	1.81%
Laboratory/Radiology	0.74%	0.26%	0.78%	2.33%
NEMT/Ambulance	3.65%	0.06%	0.42%	0.49%
DMH Providers	0.94%	4.45%	3.24%	4.93%
Special Projects-Multiple Providers	2.56%	0.00%	0.00%	0.00%
	100.00%	100.00%	100.00%	100.00%

PI Measured Cost Avoidance by Provider Type

SFY 09 Program Integrity Cost Avoidance				
Provider Type	SFY 09	SFY 08	SFY 07	SFY 06
Hospital	3.65%	3.57%	2.29%	0.08%
Nursing Home	3.25%	0.82%	0.02%	0.00%
Physician	21.15%	22.65%	6.93%	0.93%
Home and Community Based Services	14.53%	5.06%	5.21%	1.33%
Optical	1.05%	0.00%	0.23%	0.19%
Dental	5.25%	0.88%	4.65%	3.34%
Psychology	5.81%	1.81%	2.37%	1.72%
Pharmacy	2.15%	61.67%	60.35%	56.64%
Durable Medical Equipment	2.85%	0.07%	0.20%	0.04%
Laboratory/Radiology	1.00%	0.05%	0.34%	0.42%
NEMT/Ambulance	0.59%	0.13%	0.02%	0.24%
DMH Providers	0.01%	0.28%	0.18%	0.00%
Special Projects-Multiple Providers	38.71%	3.01%	17.21%	35.07%
	100.00%	100.00%	100.00%	100.00%

Observations on Cash Recoveries and Cost Avoidance by Provider Type

- Each of PI's performance metrics has shown improvement each year since SFY07 (except for Voluntary Payments Returned)
 - Tracking PI is measuring better results with fewer staff
 - Measuring using six different metrics (three each for recovery and cost avoidance) is a good practice and allows PI to measure progress based upon particular initiatives
 - Number of cases (including special projects) completed has increased from 429 in SFY07 to 679 in SFY10 (to date)
 - Number of hours spent on special projects has increased dramatically from 3,672 in SFY07 to 11,973 in SFY10 (to date)
- No clear trends are observed from provider type breakdown, except with respect to pharmacy
 - Cost avoidance from special projects is not broken down by provider type
- Major decline in pharmacy attributed by PI staff to shift in responsibility from PI group to Pharmacy Services
 - In SFY 06 through SFY 08 pharmacy accounted for 56% - 62% of PI cost avoidances
 - This declined to 2.15% in SFY 09

Summary of Recommendations: *Measuring Results*

- Verify, through analytics and other methods, that provider activity accounting for Provider Case Review cost avoidance has actually stopped
 - Extrapolating for one year is a credible approach only if provider behavior has actually been modified
 - If provider activity has not stopped, proceed to recovery
- Continue to develop additional dashboards
 - Staff attributes increased savings to the dashboards
 - As described earlier, dashboards are also an important tool for improving front end edits and payment policy
- Evaluate impact of limiting focus on Pharmacy retrospective reviews based on the expected advantages of technological advances in pre-payment authorization

Coordination With MFCU

- *The relationship between Program Integrity and MFCU has, at times historically, been strained and inefficient, but new leadership in both areas have recently made significant steps toward improved collaboration.*
- *We recommend that positive steps toward a collaborative relationship continue, including training sessions and increased lateral flow of information.*
- *Improvements are in early stages and must be sustained.*

Historically, Relationship Was Strained, Limiting Effectiveness

- Regular meetings with MFCU were only conducted quarterly
- MFCU investigator did not know any PI staff beyond the few that attended the quarterly meetings
- Information transfer was limited, and often difficult

Significant Steps Have Been Taken to Improve Coordination

- Staff from both PI and MFCU report that the working relationship has improved significantly and that communication is much more frequent
- Quarterly meetings have been increased to bi-weekly to share information, concerns, etc.
- MFCU staff will be providing training for PI staff
- MFCU staff are returning referrals to PI for further work if MFCU decides not to proceed with fraud investigation
- MFCU will be working a broader range of fraud referral cases and service categories to assure that the sentinel effect is displayed and understood by all providers
 - In the past, cases with big dollars may have gotten more attention versus smaller dollar amount fraud/abuse cases
- Many of these interactions will be included in the new MOU that is being drafted to incorporate best practices

Continue to Reinforce the Need for Coordination and Cooperation with the MFCU

- Referrals on cases should go both directions
 - For example, if a referral to MFCU from an outside entity does not result in a case, it may still result in recoveries or policy changes through Program Integrity
 - Referral from MFCU should be tracked in the same way that referral to MFCU are
- Routine meetings should be held to discuss on-going cases and prospective cases as well
- Resources (human and technical) should be coordinated to obtain the most effective review of a case
- Memorandum of Understanding should be updated to reflect new process and best practices recommended by CMS
- Early efforts to improve collaboration must be sustained beyond this initial stage

Training Should be Reciprocal, with Each Agency Educating the Other

- PI would train on the FADS, SURS, and other detection and cost avoidance tools available
- The MFCU would train on documentation needed for referrals and data formats
- Training promotes understanding, teamwork, and shared success.

Streamline Information Sharing between PI and MFCU While Ensuring Accuracy and Completeness

- Ensure that responses to information requests are not unnecessarily delayed by tracking/approval processes within MO HealthNet
 - Such situations can create problems when two agencies are dealing with criminal and civil fraud investigations
 - Processes can delay action and permit fraud to occur for a longer period while information is passed from office to office
 - Process can also inhibit requests resulting in the investigating agency pursuing the action without contact and information sharing.
- Any contact with other Medicaid staff, such as suspending payments or taking administrative action against a provider, should originate from the PI Unit to other agency staff with agreement of the MFCU and PI staff

Summary of Recommendations: *Coordination with MFCU*

- Continue to Reinforce the need for coordination and cooperation with the MFCU
- Training should be reciprocal with each agency educating the other
- Ensure that responses to information requests are not unnecessarily delayed by tracking/approval processes within MO HealthNet

Creation of an OMIG

- *Some states have moved toward a consolidated Office of Medicaid Inspector General.*
- *There are pros and cons associated with establishing an OMIG.*
- *We recommend that Missouri not create an OMIG unless that action is the only mechanism that will raise the profile of Medicaid Program Integrity.*

Some States Have Moved Toward a Consolidated Office of Medicaid Inspector General (OMIG)

- Nine states -- Illinois, Texas, New York, New Jersey, Georgia, Kentucky, Utah, Florida and Michigan -- provide oversight of Medicaid investigation and recovery using an OMIG
- The programs included under the offices vary in each state
 - Some states include the Inspector General for all state programs, while others have a dedicated Medicaid Inspector General
- Organizational and reporting structures also differ across states
 - While distinctly separate from the Medicaid agency, most offices report to the department that houses the Medicaid agency
 - Utah, for example, has a different reporting structure: Utah's OIG reports to the State's Attorney General
- Counting of results also varies, making it difficult to compare states with an OMIG to those without (e.g., Texas reports recoveries related to all social services programs, not just Medicaid)

OMIG Has Advantages and Disadvantages

Pros

- Raises PI profile as a separate unique office with the goal of detection, investigation and recovery of money
- May reduce provider influence on decisions made on collections and investigations
- Perceived clout may create a stronger “sentinel effect” with providers (i.e., that OMIG cannot be influenced)
- May be able to take a stronger stance without need to balance policy perspective
- May be better able to obtain staff, systems, and other resources

Cons

- May reduce the PI role as a part of the “management” of the Medicaid enterprise
- OMIG staff may not communicate as closely on problems, policy changes, and system deficiencies, inhibiting front-end prevention
- Aggressive actions may counter Medicaid efforts to increase or protect access by discouraging provider participation
- Can set up an “Us vs. Them” mentality between the Medicaid staff and OMIG, creating opportunity for mistrust
- Provider irritation if the recovery projects are (or are viewed as) auditing for petty billing mistakes vs. fraud or abuse

We Believe Missouri's Decision to Establish an OMIG Should be Based on Ability to Raise the Profile of Medicaid Program Integrity

- Our most important recommendation is to raise the profile of Medicaid program integrity in Missouri
- Program integrity functions should be maintained within the MO HealthNet Division
 - Program integrity is an integral part of program administration and should be woven into the fabric of daily Medicaid operations
- However, if the profile can only realistically be raised through the creation of an OMIG, then this would be the preferred action
 - If an OMIG is created, a steering committee that includes Medicaid staff is strongly recommended
- Decision should not be based purely on a desire for “better numbers”
 - While OMIGs often report improved recoveries, differences in the way that they are counted make comparisons difficult

Summary of Recommendations: *Creation of an OMIG*

- There are advantages and disadvantages to the creation of an OMIG.
- Maintain program integrity operations in MO HealthNet unless establishing an OMIG is the only mechanism to raise the profile of these activities.

Incorporating Additional Best Practices into MO HealthNet Program Integrity

- *Additional best practices are focused primarily on enhanced collaboration and information sharing.*
- *The most effective program integrity units nationally combine first rate analytics and investigative skills with strong relationships with staff throughout the Medicaid program as well as law enforcement personnel and the provider community.*

Establish a Medicaid-Wide Steering Committee Including DSS, DHSS, and DMH

- Washington State for many years has utilized an Executive Steering Committee to oversee and coordinate Program Integrity activities across the entire human services enterprise
 - *Enforces the idea that fighting fraud, waste and abuse is an enterprise-wide responsibility, not just the responsibility of the PI group - Strong Executive Sponsorship is critical*
 - Brings together stakeholders from across the agency, including medical services, policy making and finance office, Mental Health Department, Aging and Disability Services
 - Agency CFO is the executive sponsor of the Steering Committee, although PI leadership has important role coordinating the meeting
 - Meets quarterly to discuss issues, coordinate plans, and discuss the status of current federal and payment integrity efforts
 - Discusses and prioritizes future areas of focus, drives decisions on matters such as technology investment
- Committee could be chaired by DSS senior leadership or, if created, a Medicaid Inspector General
- In the absence of a Steering Committee, standing meetings should be held with the other agencies

Coordination with Law Enforcement and MCO Program Integrity

- Relationship with MFCU is critical but coordination with other stakeholders is also critical - Don't work in a vacuum
- Some states have established multi-agency task forces that meet regularly (e.g., quarterly) meetings that bring together interested parties across the FWA spectrum to share information, leads, report on activities, etc.
- Attendees could include MFCU, U.S. Attorney' Office, FBI, Federal OIG, and Special Investigation Units from managed care organizations

Share Information/Knowledge with Other States and CMS

- It is critical to establish relationships with other States and CMS colleagues for the purpose of keeping abreast of emerging trends and best practices
- National Association of Medicaid Program Integrity (NAMPI), the Medicaid Integrity Institute and Program Integrity Directors' meetings are important forums for PI leadership and staff to learn what other colleagues are doing to combat fraud, waste and abuse
- Some states are also coordinating specific efforts and investigations with PI colleagues in other states, particularly around border providers

Provider Type Specific Working Groups

- Washington State has established provider-type specific working groups (“SME Groups”) to coordinate analytical and investigatory activities
 - Functions as a “steering committee” for a particular provider type
- Groups are program integrity-focused but contain staff from across the spectrum of the Medicaid enterprise (e.g., medical services, claims processing, policy, rate setting)
 - Effective strategies require multiple perspectives (minimizing false-positives)
 - Any group within the agency with knowledge or perspective important to program integrity is a critical attendee
- Groups meet on a regular schedule to bring forward new ideas for analytics and algorithms, review analytical results, discuss the status of open overpayment efforts, etc.

Establish a Detailed Work Plan Annually

- A common characteristic of high performing PI and MIG programs is that they establish periodic (usually annual) work plans
 - Defines goals (including financial) and priorities for the up-coming year
 - Outlines key initiatives and focus areas
 - Promotes buy-in by both staff and management
 - Coordinates and prioritizes use of technology and staff
- MO HealthNet PI has a financial goal, but not a true plan that goes beyond case counts and dollars

Enact a Missouri False Claims Act to Increase Recovery Potential

- False claims acts allow governments to hold providers liable for greater than the amount of the claim when a provider knowingly submits false claims for payment.
 - The Federal False Claims Act allows liability at three times damages, plus civil penalties of \$5,500 to \$11,000 per false claim
- *Qui Tam* or the “whistleblower provision” in the Federal False Claims Act allows citizens to sue on behalf of the government. Citizen whistleblowers may be awarded a portion of the funds recovered, typically between 15 and 25 percent
- While states may apply the Federal False Claims Act when prosecuting offenders, 23 states have enacted state false claims acts
 - States with state false claims acts share in settlements for cases prosecuted under the Federal False Claims Act; states without state false claims acts may only recover the money lost
 - States with false claims acts may qualify for enhanced FFP
 - Providers usually oppose enactment of a state false claims act

Considerations Regarding National Health Reform

- Federal Health Reform incorporates changes specific to Medicaid state program integrity
 - Requires states to comply with federally determined provider screening and termination requirements, including reporting of adverse provider actions to the Federal government
 - Expands the Medicare recovery audit contractor program (RAC) to Medicaid requiring states to contract with a RAC
 - By October 1, 2010 states must incorporate CCI methodologies into MMIS
- Medicaid expansion is likely to result in increases in Medicaid MCO enrollment nationally
 - MO HealthNet is taking appropriate steps to enhance MCO oversight
 - Medicaid expansion and implementation of an exchange will necessitate streamlining of eligibility activities
 - To ensure accuracy of determinations, Missouri may want to consider addition of increased timely, automated checks
 - State should monitor spikes in services for new enrollees to monitor potential provider fraud

Program Integrity Considerations for HIT Stimulus Payments

- States will be responsible for verifying that HIT stimulus funds under ARRA are being spent appropriately
- Questions that states must ask in developing audit plans include:
 - What should states audit 100% of the time before making payments?
 - What types of things could be audited based on sampling?
 - What types of proxy data measures would trigger a more extensive audit?
 - How can states minimize provider burden while maintaining a robust PI methodology?

Summary of Recommendations: *Incorporating Additional Best Practices*

- Establish Medicaid-wide steering committee including DSS, DHSS, and DMH
- Coordinate with law enforcement and MCO program integrity
- Share information/knowledge with other states and CMS
- Develop provider type specific working groups
- Establish a detailed work plan annually
- Enact a Missouri False Claims Act
- Prepare for enrollment increases due to national health reform
- Consider for HIT stimulus payments

Appendices

Appendix A: Noteworthy and Effective Program Integrity Practices

The following slides summarize CMS' MIG Review Teams' findings of noteworthy program integrity activities and activities that states reported to be effective

The full report, "Medicaid Integrity Program: Program Integrity Review Annual Summary," May 2009, can be found at:

<http://www3.cms.gov/FraudAbuseforProfs/Downloads/2009pireviewannualsummaryreport.pdf>

Appendix A: Noteworthy Practices Regarding Provider Enrollment and Disclosures

State	Noteworthy Practices Identified by MIG
Georgia	<ul style="list-style-type: none"> ▪ PI and Provider Enrollment units jointly conduct onsite reviews of skilled nursing facilities at which they screen all employees against both the Federal List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System ▪ Program integrity area also performs supplementary provider enrollment functions during fraud and abuse onsite reviews, which helps compensate for provider enrollment area staff limitations
North Carolina	<ul style="list-style-type: none"> ▪ Uses at-will provider contracts ▪ Has terminated provider contracts for failure to comply with State rules, clinical policy, regulations and guidance, failure to provide documentation of services rendered and billed, and questionable quality of care and billing practices
Oklahoma	<ul style="list-style-type: none"> ▪ Requires providers to re-enroll every three years ▪ During re-enrollment, providers must complete a new application; if they do not, their contracts lapse ▪ All contracts for a given provider type expire at the same time, regardless of when the contract began
Texas	<ul style="list-style-type: none"> ▪ Purchased an innovative software package that automates the verification of licenses of potential Medicaid providers and ensures that Medicaid does not allow payments to non-qualified providers ▪ Software allows the State to match a provider’s information against the State Master File, the LEIE, the Texas State Provider exclusion list, the Texas Medicaid Do Not Enroll List, and the Open Investigations list, so the user can easily determine if the provider is eligible to be enrolled
Wyoming	<ul style="list-style-type: none"> ▪ Instructs its fiscal agent to terminate all providers whose mailings have been returned to the contractor, eliminating the ability of those providers to bill Medicaid unless and until the fiscal agent gets the correct mailing address, enhancing the provider enrollment and system maintenance capabilities ▪ The process has resulted in a dramatic decrease in the number of providers with inaccurate addresses. ▪ The fiscal agent terminates providers who have not filed a claim within the past 365 days or providers who have not updated their license

Appendix A: Effective Practices Regarding Provider Enrollment

State	Effective Practices Identified by States
Illinois	<ul style="list-style-type: none"> ■ Maintains its own sanctions database ■ The system tracks providers who have been or are currently in the process of being sanctioned by the State, and also includes Department of Health & Human Services Office of Inspector General (HHS-OIG) exclusions and reinstatements ■ Database is updated monthly ■ Uses the system to screen providers during initial enrollment, within seven days after enrollment, and on a monthly basis
South Carolina	<ul style="list-style-type: none"> ■ Similar to Illinois, State also maintains a web-based exclusion database
North Carolina	<ul style="list-style-type: none"> ■ Uses its permissive exclusion authority to remove aberrant providers ■ The State identified and terminated two providers based on their billing practices and failure to provide records

Appendix A: Noteworthy Practices Regarding Cooperation and Collaboration

State	Noteworthy Practices Identified by MIG
North Carolina	<ul style="list-style-type: none"> ▪ Sends new policy issuances to the PI Section for comment before being released ▪ This practice affords the State a critical review of policies by the PI Section that may ultimately be interpreted and enforced by the PI Section
Oklahoma	<ul style="list-style-type: none"> ▪ Quality Assurance (QA) committee formulates organizational quality improvement policy and oversees the overall coordination and management of quality assurance activities, including those of the program integrity area ▪ Program integrity area utilizes the QA committee, which is composed of representatives from all components of the Medicaid agency, as a cross-check on its core activities. ▪ QA committee reviews surveillance and utilization review subsystem (SURS) findings and audits and recommends actions such as referrals, provider education, or termination to the State Medicaid Director for final decision. Referral actions against providers can be sent to the MFCU or the appropriate licensing board
Virginia	<ul style="list-style-type: none"> ▪ Has focused on program integrity as an agency-wide priority, reorganizing the Program Integrity Division and hiring a new management team ▪ The agency targeted durable medical equipment (DME), home health care and pharmacy services as priority areas ▪ State increased program integrity staffing, while contracting with nationally recognized companies to undertake specialized audits ▪ Other activities initiated to strengthen the Commonwealth's program integrity efforts include: enhancing tracking systems and processes; playing a larger role in Federal program integrity activities (such as participation in the Medicaid Fraud and Abuse Technical Advisory Group); and improving its relationship with its MFCU

Appendix A: Effective Practices Regarding Cooperation and Collaboration

State	Effective Practices Identified by States
North Carolina	<ul style="list-style-type: none"> ▪ Division of Medical Assistance has collaborated with the Division of Mental Health to conduct audits of behavioral health providers ▪ Review process enhanced by the Divisions' shared policy and integrity experience
North Dakota	<ul style="list-style-type: none"> ▪ State staff, both within the Fraud and Abuse Unit and in other parts of the State agency, communicate well with each other ▪ No artificial barriers between organizational units which limit the ability of the program integrity staff to gather information and work cohesively to resolve fraud and abuse issues
Utah	<ul style="list-style-type: none"> ▪ Bureau of Program Integrity (BPI) includes all internal components involved in program integrity in its meetings and communications ▪ Utah's contracted MCOs also take part in monthly BPI meetings

Appendix A: Noteworthy Practices Regarding Data Collection & Analysis

State	Noteworthy Practices Identified by MIG
Arkansas	<ul style="list-style-type: none"> ▪ Compensates for limited staff resources by using data-mining services and claims analysis provided by the State’s fiscal agent and its quality improvement organization (QIO) ▪ Fiscal agent’s data warehouse holds seven years of claims data and can be used to rank providers, generate other standard reports or develop customized reports ▪ QIO utilizes its own data-mining software in retrospective reviews of claims and services and has identified overpayment situations for the State ▪ Has undertaken a time-dependent analysis of mental health providers who are suspected of billing for simultaneously providing different kinds of services in different places ▪ Has also initiated similar analyses of overlapping provider billings in several home and community-based services waiver programs
Wyoming	<ul style="list-style-type: none"> ▪ Compensates for limited staff resources by using data-mining services and claims analysis provided by the State’s fiscal agent ▪ Contractor maintains a data warehouse and decision-support system that is used to rank providers, generate other standard reports, and develop customized reports ▪ Since 1997, the SURS within the MMIS has been supplemented with tools that provide a peer-to-peer analysis across a provider-specific claim type, advanced data analysis and filtering to analyze the universe of claims for abnormalities, and a query system

Appendix A: Effective Practices Regarding Data Collection & Analysis

State	Effective Practices Identified by the State
Illinois	<ul style="list-style-type: none"> ▪ Utilizes a centralized case tracking system that consolidates case management functions for all State OIG investigative, audit, and review activities ▪ System enables staff to utilize historical information to inform current fact-finding efforts, and interfaces with other State information systems as well as their medical data warehouse ▪ Documents are scanned or imported into the system to create electronic case files, and letters are automatically generated. Additionally, the system facilitates communication and joint decision making regarding provider sanctions as well as tracking of external agency actions
North Dakota	<ul style="list-style-type: none"> ▪ Has an experienced full-time investigative pharmacist who is both a subject matter expert on drug issues and committed to identifying and eliminating fraud and abuse across the program ▪ This pharmacist is involved in devising tracking mechanisms and setting up creative data collection methodologies
Oregon	<ul style="list-style-type: none"> ▪ SURS staff perform creative data analysis in identifying different types of fraud schemes, provider abuse, and overpayment situations, and staff generate backup confirmation for queries developed through the Office of Payment Accuracy and Recovery's data warehouse ▪ Data warehouse provides many components within the State much faster access to standard and customized reports and the ability to do innovative data-mining ▪ State believes that the quality of its encounter data allows the State to more clearly identify patterns of service delivery and provider practices than is normally the case ▪ This has facilitated fraud and abuse monitoring in the managed care sector; State will enhance its data collection and analysis tools further with the advent of a new MMIS

Appendix A: Effective Practices Regarding Data Collection & Analysis (Continued)

State	Effective Practices Identified by the State
South Carolina	<ul style="list-style-type: none"> ▪ SURS Unit works with two contractors to develop algorithms to assist in advanced fraud analytics ▪ State has a library that consists of approximately 350 algorithms; these algorithms are used to identify potential cases of providers who may fall outside of the normal range ▪ PI Unit and SURS Unit meet biweekly to discuss patterns and open cases for further investigation
South Dakota	<ul style="list-style-type: none"> ▪ SURS Unit reviews a randomly sampled paid claims report from MMIS on a weekly basis to ensure that the MMIS is paying according to existing rules and regulations and that providers are billing in accordance with program guidelines ▪ Reports have identified areas of questionable billing practices and payment issues resulting from MMIS enhancements and other changes that would otherwise not have been detected
Virginia	<ul style="list-style-type: none"> ▪ Indicated that its MMIS, which was implemented in 2003, is one of the most advanced claims processing systems in the nation ▪ Thousands of edits are built into the system to prevent inappropriate payment of claims

Appendix A: Noteworthy Practices Regarding Program Safeguard Activities

State	Noteworthy Practices Identified by MIG
Georgia	<ul style="list-style-type: none"> ▪ Initiated a project to validate the physical business address of all DME suppliers by performing a visual check; suppliers with questionable addresses are reviewed for possible fraudulent practices ▪ Another initiative involves an audit of the top five power wheelchair suppliers; Georgia determines if the supplier billed for a more expensive wheelchair than actually provided ▪ Survey is sent out to selected clients; as part of the survey, the clients review pictures of wheelchairs and scooters and identify the type of equipment they received by circling the appropriate picture ▪ Based on the discrepancies detected, the investigators conduct an onsite visit comparing the equipment with the DME supplier's billing
Illinois	<ul style="list-style-type: none"> ▪ Conducts site visits on all NEMT providers, during which the State verifies the address and inspects licenses. ▪ New transportation providers also subject to mandatory criminal background checks, and are placed on probation for 180 days, during which time Illinois' OIG monitors their claims ▪ All DME providers also receive onsite reviews, during which the State checks inventory to determine whether it is reasonably related to billings. Moreover, both NEMT and DME providers must re-enroll in the Medicaid program on a periodic basis
Michigan	<ul style="list-style-type: none"> ▪ Can impose a summary suspension (i.e., in high-dollar or otherwise egregious cases of fraud) that temporarily abrogates the existing Medicaid provider agreement and freezes all Medicaid payments until a provider has exhausted all administrative remedies or has been convicted in a court of law ▪ The passage of a State Whistleblower Law in 2005, which offers incentives to the public to report serious cases of fraud and abuse directly to the MFCU, has enhanced the State's ability to combat fraud, waste, and abuse
North Carolina	<ul style="list-style-type: none"> ▪ Follows up on every returned explanation of medical benefits (EOMB) by documenting each EOMB returned and telephoning the recipient ▪ Also recently added four questions to EOMBs which the State believes has increased the rate of return from 12% in 2005 to 50% currently

Appendix A: Effective Practices Regarding Program Safeguard Activities

State	Effective Practices Identified by States
Georgia	<ul style="list-style-type: none"> ■ Initiated a broker system for non-emergency medical transportation in 1997 which has been a cost-saving mechanism for the State ■ Currently the State has three transportation brokers covering five regions; the State teams up with the brokers to verify services with the providers ■ The State monitors transportation drivers to verify they are providing proper services and checks driver manifests, logs, and sign-offs by family members
Texas	<ul style="list-style-type: none"> ■ OIG developed a self-reporting protocol intended to encourage providers to voluntarily investigate and report inappropriate payments as well as possible fraud, waste and abuse in State-administered programs ■ After following the protocol, the provider makes an initial report to the OIG ■ This early disclosure of non-compliance to the OIG allows for a better result for the provider than if the OIG discovered and investigated the matter independently
Virginia	<ul style="list-style-type: none"> ■ Has contracted with independent audit contractors for pharmacy, DME, and long term care audits as well as other services ■ These contracts have helped triple audit recovery totals over a two year period

Appendix A: Noteworthy Practices Regarding Managed Care

State	Noteworthy Practices Identified by MIG
Illinois	<ul style="list-style-type: none"> ▪ Requires that all MCO providers be enrolled with the Medicaid program ▪ State is able to maintain centralized control over the screening and credentialing process, and better ensure the integrity of its programs
Michigan	<ul style="list-style-type: none"> ▪ Developed a desk audit tool, including a comprehensive fraud and abuse component, to assess overall MCO contract compliance ▪ Checklist permits State staff to assess ongoing MCO compliance and progress towards compliance or corrective action in virtually all program integrity areas
South Carolina	<ul style="list-style-type: none"> ▪ MCOs are contractually required to list the State's fraud and abuse hotline on all managed care marketing materials for members and providers ▪ MCOs report all instances of suspected fraud and abuse directly to the Program Integrity Unit for investigation ▪ The managed care policy and procedure guide is a well-organized, understandable, and comprehensive document that clearly delineates responsibilities between the MCOs and the State
Texas	<ul style="list-style-type: none"> ▪ Requires managed care providers to be enrolled with Medicaid as a precondition for health plan credentialing. ▪ Has strong set of managed care regulations for MCOs; State regulation explicitly requires that MCOs participating in the Medicaid program implement program integrity strategies, such as creating investigative units dedicated to detection and identification of fraud and abuse, developing annual fraud and abuse compliance plans, and conducting program integrity-related enrollee education ▪ OIG has dedicated program integrity staff who review MCO compliance plans and quarterly reports, and interact with compliance officers on a monthly basis

Appendix A: Effective Practices Regarding Managed Care

State	Effective Practices Identified by States
Georgia	<ul style="list-style-type: none"> ▪ MCOs are required by contract to submit monthly updates and quarterly reports on provider cases, which also note the overpayment amount ▪ The MCOs regularly submit information on problem providers to the PI Unit and receive direction from the PI Unit’s investigation director on how to proceed with investigations or other actions
Oregon	<ul style="list-style-type: none"> ▪ Has established an MCO Collaborative to improve communication across all components of the agency that oversee the managed care programs ▪ Key units within the agency meet on a monthly basis to discuss the full range of managed care oversight and compliance issues ▪ MCO Collaborative is an important step toward ensuring that the managed care programmatic areas of the agency do not overlook program integrity issues and requirements in the MCO contracting and monitoring process
Utah	<ul style="list-style-type: none"> ▪ Included program integrity and provider enrollment standards as components in the managed care compliance standards expected of Medicaid MCOs in the State ▪ Quality Assessment and Performance Improvement Plan compliance standards, which are monitored by the State’s External Quality Review Organization (EQRO), include both of these elements

Appendix A: Noteworthy and Effective Practices Regarding the Medicaid Fraud Control Unit

State	Noteworthy Practices Identified by MIG
Oregon	<ul style="list-style-type: none"> ▪ Solicited MFCU input on a planned new MMIS procurement, and the MFCU was responsible for the State changing language in provider enrollment packages to conform to Federal disclosure regulations
Virginia	<ul style="list-style-type: none"> ▪ Has enhanced communication between the State and the MFCU ▪ During regular quarterly meetings, the MFCU and State staff discuss open investigations and reconcile their case logs; MFCU also regularly sends the State a spreadsheet of all its open cases under investigation ▪ MFCU sends copies of its quarterly reports showing convictions and sentencing to the State
State	Effective Practices Identified by States
GA, IA, SD, TX, UT, ND	<ul style="list-style-type: none"> ▪ Georgia, Iowa, South Dakota, Texas, and Utah reported that they enjoyed an effective relationship between the State Medicaid Agency and the MFCU ▪ States noted a focus on mutual goals, respect for each other's roles, a comprehensive memorandum of understanding, frequent formal and informal communication, joint training of staff, and prompt attention to data requests from the MFCU as contributing to their success ▪ North Dakota, which has a waiver from operating a MFCU, reported a similarly effective relationship with the HHS-OIG

Appendix B: Acronyms Used in this Report

Appendix C: Acronyms Used in this Report

- ARRA - American Relief and Recovery Act of 2009
- BPI - Bureau of Program Integrity
- CCI - Correct Coding Initiative
- CFO - Chief Financial Officer
- CMS - Centers for Medicare & Medicaid Services
- CPT - Current Procedural Terminology
- DHSS - Department of Health and Senior Services
- DME - Durable Medical Equipment
- DMH - Department of Mental Health
- DSS - Department of Social Services
- DUR - Drug Utilization Review
- EOMB - Explanation of Medical Benefits Organization
- EQRO - External Quality Review Organization
- FADS - Fraud Abuse Detection System
- FFP - Federal financial participation
- FMAP - Federal Medical Assistance Percentage
- FQHC - Federally Qualified Health Center
- FTE - Full time equivalent
- FWA - Fraud Waste and Abuse
- GR - General Revenue (State funds)
- HCBS - home and community-based services
- HHS-OIG - Department of Health & Human Services Office of Inspector General
- LOC - level of care
- LTC - long term care
- MCO - managed care organizations
- MFCU - Medicaid fraud control unit
- MHD - MO HealthNet Division
- MIG - Medicaid Integrity Group
- MMIS - Medicaid Management Information Systems

Appendix C: Acronyms Used in this Report

- MR/DD - mental retardation/ developmental disabilities
- NAMPI - National Association of Medicaid Program Integrity
- NEMT - Non-Emergency Medical Transportation
- NF - nursing facility
- NPI - National Provider Identifier
- OIG - Office of Inspector General
- PC - personal care
- PCA - personal care assistance or personal care attendant
- PERM - Payment Error Rate Measurement
- PI - Program Integrity
- POS - Point of Sale
- PWD - people with disabilities
- QA - Quality Assurance
- QIO - Quality Improvement Organization
- RFP - Request for Proposal
- RAC - Recovery audit contractor
- ROI - Return on Investment
- SME - Subject Matter Expert
- SURS - Surveillance and Utilization Review Services
- TF - total funds (state and federal)
- TPL - Third Party Liability

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