Medicaid Integrity Group
Program Integrity Reviews

Division of Field Operations

Medicaid Integrity Group

Center for Program Integrity

NAMPI

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CMS Program Integrity Reviews

- Where we started
- What we've learned through Program Integrity (PI) reviews and SPIA, CMS 64 reporting
- Vulnerabilities vs. findings
  - Findings and vulnerabilities reflect systemic State agency organizational and infrastructure context not just PI unit
- Gaining higher profile e.g. GAO, Congress, State legislatures, and NAMD
- 2013 - 2014 period of evaluation, piloting and redesign for 2015 readiness for more empirical reviews and data collection
- Continuous improvement
- Primary goal is to assist States to improve and strengthen Medicaid program oversight in your respective States

What Is A Program Integrity Review?

- An assessment of **statutory** and **regulatory** compliance in a State's PI program
- Identifies both findings and vulnerabilities
  - **Finding**: Instance of non-compliance with a Federal regulation or law
  - **Vulnerability:** A lack of policy or procedure that leaves the State susceptible to fraud, waste, and abuse but is not a direct noncompliance with law or regulation
- Identifies and recognizes **effective and noteworthy practices** in State program integrity
- Vehicle to provide **support and assistance** to State oversight of program integrity efforts
- Offers a monitoring **framework** for State corrective action and CMS oversight

Value of PI Reviews

- Educates States and stakeholders about specific issues requiring attention and improvement
- Helps equip States with the tools to improve program integrity operations and performance
- Helps raise awareness of the importance of program integrity among States and various stakeholders
- Vehicle for providing technical assistance
- Helps inform CMS in developing future guidance to States
- Helps promote best practices
- Helps improve program integrity nationally

History of PI Reviews

- Prior to the creation of the Medicaid Integrity Group (MIG), Medicaid Alliance for Program Safeguards (MAPS) Reviews were conducted to identify "Enhancements, Best Practices, and Hindrances" within the State PI function areas of Provider Enrollment, SUR Subsystem and Investigation and Compliance.
- In 2007, the MIG began its first year of reviewing States' Medicaid Program Integrity procedures and processes; by the end of FY 13:
  - 110 Program Integrity Reviews will have been conducted in 52 States and Territories since inception.
  - Each State will have been reviewed twice under the original classic review framework.

Importance of PI Reviews

- GAO designates Medicaid as a high-risk program due to its size, growth, diversity of programs, and concerns about the adequacy of fiscal oversight and the ability to prevent inappropriate program spending.
- Nationwide Medicaid expenditures were $407 billion in 2011.
- By 2021, Medicaid enrollment is expected to reach 85 million beneficiaries which will account for 20% of national health expenditures.
- Provide an understanding of the Medicaid State PI framework and structure to be able to respond to inquiries.
- The reviews are designed to identify risks to the program and assist States in strengthening program integrity operations.
- Highlight the critical nature of State Medicaid program integrity oversight

What Are the Fundamentals of a PI Review?

Reviewing to see the efficacy of PI in a given State

- CMS reviews various aspects of PI including:
  - Are staff size and composition adequate for the size of the program?
  - Does the State Medicaid Agency demonstrate the capacity to handle fraud complaints?
  - Adequate safeguards in provider enrollment activities
  - Are there mechanisms to ensure that exclusions and terminations are processed?
  - Adequate Fraud and Abuse Detection
  - Are there Pre and Post Payment Activities and measures in place?
  - Adequate Inter/Intra Agency Relationships – Coordination with Sister Agencies and MFCU
  - Appropriate application of Payment Suspensions
  - Adequate oversight of Managed Care and other Special Programs that defend Medicaid dollars

Most Common Findings

Finding: Instance of non-compliance with a Federal regulation or law:

Lack of adequate provider enrollment and screening safeguards

- Failure to collect required ownership, control, and criminal conviction disclosures
- Failure to require the disclosure of business transaction information
- Failure to report adverse actions to the HHS Office of Inspector General (HHS-OIG)
- Failure to conduct database searches (i.e. LEIE) for federally excluded providers
- Incomplete implementation of key program integrity provisions of the Affordable Care Act.

Most Common Vulnerabilities

Vulnerability: A lack of policy or procedure that leaves the State susceptible to fraud, waste, and abuse but is not a direct noncompliance of law or regulation:

Lack of adequate provider enrollment and screening safeguards *in managed care*

- Inadequate protections in the provider enrollment process
- Lack of exclusion checking at the time of initial provider enrollment and thereafter
- Failure to verify with enrollees whether services billed by providers were received
- Failure to report to HHS-OIG adverse actions taken based on managed care provider applications

Resource Package to Address Frequent Findings

- CMS is putting together a package of tools to help States correct frequent findings and strengthen program vulnerabilities
- Expect to have something for FY 2014
- If States have ideas on what would be helpful, please let us know.

Effective and Noteworthy Practices

- PI Reviews also identify effective and noteworthy practices that are shared with other States
- Have identified effective and noteworthy practices in key areas such as:
  - Provider enrollment
  - Inter and intra agency coordination
  - Predictive modeling
  - Provider education

Corrective Action Plans (CAPs)

- States are to submit CAPs addressing each finding and vulnerability identified during the review within 30 days of release of the final report.
- CMS reviews the CAP submission, follows up on any concerns or issues, and notes the progress each State has made in correcting inadequacies and vulnerabilities during subsequent reviews
- Over past year CMS has been more active in monitoring CAPs
- CMS is developing technical assistance resources to help States address the most common findings and vulnerabilities and will be sharing these tools with States during FY 2014.

Changes In Store For FY 2014 and Beyond

- CMS committed to a 4 year review cycle from the current 3 year cycle
- To implement the changes, CMS will not conduct Comprehensive PI Reviews in FY 14
- CMS will use FY14 to reevaluate the comprehensive reviews, assess the results of the pilot reviews, and work on streamlining our processes in an effort to further improve technical assistance to States and reduce the burden on States
- CMS will conduct focused reviews on select PI areas (see next slide)in 2014
- CMS will, as part of the 2014 effort, integrate elements of SPIA into the PI Reviews
- Comprehensive PI Reviews will resume in FY 15

Focused PI Reviews

- During FY 14 CMS will conduct focused reviews which will look at a limited subset of PI areas
- Potential areas include:
  - Outstanding corrective action plans
  - Compliance with the program integrity provisions of the Affordable Care Act
  - Managed care oversight
  - High risk provider types
  - Services/payments that fall outside of the MMIS system
  - Medicaid Expansion risks, safeguards, and practices

Focused Reviews – Affordable Care Act

CMS may examine how effectively selected States have implemented certain PI provisions of the ACA such as:

- Provider enrollment and screening requirements
- Suspension of Medicaid payments pending investigation of credible allegations of fraud
- Termination of providers who have been terminated by Medicare or other State Medicaid or CHIP agencies.

Focused Reviews – Managed Care

- CMS will continue to focus on PI in managed care settings
- As of June 2011, 74% of the 57 million in Medicaid were enrolled in a managed care program
- Further many States are choosing to cover ACA expansion and dual-eligible beneficiaries through risk-based managed care arrangements.
- CMS will re-deploy existing resources to assist States in evaluating the program integrity capabilities and activities conducted by the managed care entities
- CMS will also review the effectiveness of States in their oversight of these entities

Focused Reviews

- Work in progress
- As the idea of focused reviews continues to be developed further, CMS will consult with the Medicaid Fraud and Abuse Technical Advisory Group
- If States have ideas for a focused review please send them to us
- Primary goal of any review is to help States improve and strengthen Medicaid program oversight and safeguards

NAMD Letter to Congress

June 29, 2012 letter from NAMD to Congress….

- The MIG should dedicate its resources to the formation and deployment of consulting teams to work with States to identify their challenges and assist States in implementing efficiencies in their PI programs.
- Federal Assistance could support various State activities including:
  - Support State initiatives to increase training, education, and implementation of tools to improve program integrity activities, and
  - Focus resources on vulnerabilities identified by the State including areas of newly integrated care models for various aspects of program integrity for managed care programs and home and community based services.

Questions?

Contact

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