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Key Issues and Opportunities: Implementing the New Medicaid Integrity Program

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A new federal law, the Deficit Reduction Act, creates a new Medicaid Integrity Program to increase the government's capacity to prevent, detect, and address fraud and abuse in the Medicaid program. The Medicaid Integrity program represents the most significant single dedicated investment the federal government has made in ensuring the integrity of the Medicaid program, and offers an opportunity to ensure the efficient administration of the program and promote sound stewardship of state and federal resources.

Under the provisions of the new law, the Centers for Medicare & Medicaid Services (CMS) must develop a comprehensive Medicaid program integrity plan before October 2006. Under the new Medicaid Integrity Program, which is modeled on a similar program created for Medicare in 1996, CMS can enter into program integrity contracts to review the activities of providers, perform audits, identify overpayments, and educate providers and beneficiaries. The law also requires CMS to hire 100 new employees to support states in their efforts to address provider fraud and abuse. The program provides new resources to CMS to carry out these responsibilities, as well as to the Department of Health and Human Services' (HHS) Office of Inspector General (OIG). (A description of the program integrity provisions of the Deficit Reduction Act (DRA) is included in the Appendix.)

HHS and the broader program integrity community now must determine how to carry out the program integrity provisions of the DRA to make sure these provisions meet their goals. The Kaiser Commission on Medicaid and the Uninsured is undertaking an analysis of issues in Medicaid program integrity, and in early May convened a meeting of experts to discuss issues and opportunities created by the new Medicaid integrity program. This paper discusses six key issues identified by the group of experts facing the federal government and states as development and implementation of the Medicaid Integrity Program begins. This paper does not reflect the views of any member of that group or the consensus of the group as a whole. A longer program integrity report will be released later this year.

The following were identified as key issues for consideration in developing and implementing the new Medicaid Program Integrity Program:

1) Using a broad-based approach can help to ensure program integrity. Simply stated, program integrity is setting policy and managing the Medicaid program to ensure that health and long-term care services are provided to beneficiaries as effectively and efficiently as possible. As such, a broad-based view of program integrity would help to ensure that:

- People who are eligible for Medicaid are aware of, and enrolling in, the program appropriately;
- Beneficiaries are receiving high quality care, and that health and long-term care services provided under Medicaid are appropriate and meet beneficiaries' needs;
- Providers are receiving appropriate payment for providing care to Medicaid beneficiaries;
- Providers who provide care to Medicaid beneficiaries meet basic participation standards established by the state;
- Providers and beneficiaries receive clear guidance describing program rules and requirements;
- Payments and services meet the requirements that are established in state and federal law;
- Quality health care or state and federal tax dollars are not being put at risk through violations of the rules or abuses of the system.

Meeting this definition of program integrity would mean that *all* the elements of setting policy and managing the Medicaid program are strong and functioning well. These elements include claims processing, coordination of benefits, provider enrollment, provider education and guidance systems, provider payment, quality assurance and clinical management, as well as identification and investigation of aberrant behavior and referral of suspected cases of fraud and abuse to appropriate enforcement and prosecution agencies.

Frequently, program integrity is defined much more narrowly, focusing on cases of fraud and abuse and criminal misconduct that result in large recoveries or settlements for the government. But focusing solely on enforcement of the rules and prosecution of cases in which program rules have been violated misses the much larger picture of managing a program to ensure that care is provided in an appropriate and efficient manner and in a way that prevents quality care and public funds from being placed at risk. In this larger picture, preventing violations of program integrity and avoiding inappropriate costs is at least as important as enforcement of cases of fraud and abuse, even if the monetary effects of these efforts are harder to quantify.

2) Close collaboration between the states and the federal government is key to the success of implementing the Medicaid Integrity Program. In implementing the Medicaid Integrity Program, a collaborative effort between the states and the federal government will help to ensure that the federal/state nature of Medicaid is accommodated and that duplication and confusion are minimized as the Medicaid Integrity Program begins. Collaboration will help address several challenges inherent in carrying out the Medicaid Integrity Program:

- **Ensuring program integrity is primarily a state responsibility.** States are responsible for carrying out their Medicaid programs within a broad set of federal guidelines. As such, states bear most of the responsibility for ensuring program integrity. States set policy (for example, deciding who is eligible, what benefits are offered, and how much providers are paid) and manage nearly all of the processes and systems that ensure program integrity (enrolling providers and beneficiaries, managing claims and other data systems, and identifying and investigating aberrant patterns of behavior.) In contrast, the federal government's role in ensuring program integrity has historically been one of interpreting federal rules for states and providing support and oversight of state program integrity activities.[i] The federal government, through the HHS Office of Inspector General and the Department of Justice, also has responsibility for investigating and enforcing federal fraud and abuse laws (Figures 1 and 2).

Figure 1

Federal Program Integrity Responsibilities

CMS responsibilities

- Interpreting federal requirements for states and providers
- Providing training and guidance to states
- Monitoring and enforcing state compliance with federal rules, including fraud and abuse rules
- Reviewing state agency performance through on site reviews
- Ensuring quality of institutional care through developing survey protocol and conducting "look behind" surveys
- The Medicare-Medicaid claims data matching program
- Providing financial support for state activities through matching funds

OIG responsibilities

- Monitoring and enforcing compliance with federal fraud and abuse laws that apply to providers
- Audits, evaluations, and investigations
- Sanctions (civil monetary penalties, exclusions)
- Negotiating and enforcing provider corporate integrity agreements agreed to during settlements of fraud and abuse cases
- Administering grants to, oversight of, and certification of MFCUs

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Figure 2

State Program Integrity Responsibilities

State Medicaid agency responsibilities:

- Beneficiary enrollment; income and eligibility verification
- Enrolling providers, setting rates and paying providers
- Monitoring quality of care
- Operating Medicaid Management Information Systems (MMIS), Surveillance and Utilization Review Subsystem (SURS), etc.
- Detecting improper payments and recovering overpayments
- Analyzing patterns in provider claims and payment ("data-mining")
- Preliminary investigation of fraud and abuse; referring fraud cases to the Medicaid fraud control unit (MFCU)

Responsibilities of other state agencies:

- Medicaid fraud control units investigate and prosecute provider fraud and patient abuse and neglect
- Nursing facility survey and certification
- States also license providers and conduct audits

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- **Different states will have different program integrity support needs.** Inasmuch as Congress intended the new Medicaid Integrity Program to support states' program integrity efforts, the program will have to offer flexibility to accommodate program integrity needs that differ substantially across states. Some states may find that the most useful tool they lack in improving program integrity is designing and procuring a new information technology system that helps them identify aberrant billing patterns; other states may need more investigative tools; still others will need or want to improve enforcement efforts. Some states may assign priority to educating providers or improving efforts to ensure that providers are properly credentialed. A one-size fits all approach to the Medicaid Integrity Program would not allow for flexibility in meeting states' different needs.

- **The *Medicare* Integrity Program model will have to be modified to be applied to Medicaid.** The model for the new Medicaid Integrity Program is the *Medicare* Integrity Program, which was created in 1996 to strengthen the federal government's ability to ensure program integrity in Medicare. But Medicare is run entirely by the federal government, with assistance from contractors that provide a limited degree of regional variation. The design of the Medicaid Integrity Program will have to fit the federal/state structure of Medicaid, and ensure that the resources it provides both support states in their efforts to ensure program integrity and accommodate the diversity of state program rules and requirements. The Medicaid Integrity Program will effectively have to ensure compliance with the policy, rules and procedures of the Medicaid programs that are operated by each of the 56 different states and territories. It will be extremely difficult for the federal government or its contractors to be knowledgeable about, review, and help enforce the rules of each of these 56 different programs. This will be a major implementation challenge for the Medicaid Integrity Program.

  Moreover, nearly all states have contracted out provision of health care services to a significant share of their Medicaid populations to managed care organizations. Just over sixty percent of the total Medicaid population was enrolled in managed care as of 2004, according to CMS.[ii] (The overwhelming majority of these enrollees are children and non-disabled adults, although some states are increasingly enrolling seniors and people with disabilities in managed care.) In managed care delivery systems, the state pays a capitated amount to a managed care entity which then employs or contracts with providers in a network. So, unlike a fee-for-service environment, the managed care entity rather than the state has a direct relationship with the providers. This creates overlapping program integrity responsibilities. The state bears responsibility for ensuring that MCO benefits are accessible and meet quality standards, and that coverage determinations are consistent with the state's requirements. Over time, managed care has posed challenges to states in terms of monitoring service use and quality of care provided to beneficiaries who are served through MCO arrangements.[iii] The MCO is responsible for ensuring the integrity of the care provided by providers with whom the MCO contracts. In contrast, managed care currently

serves only about 15 percent of Medicare enrollees.[iv] The *Medicare* Integrity Program has therefore focused only to a very limited degree on issues related to managed care organizations. New Medicaid program integrity efforts will need an increased emphasis and more sophisticated approaches in this area.

- **The Medicaid Integrity Program is separate from efforts to ensure the appropriateness of federal payments to states.** CMS has over the past several years increased the attention and resources the agency devotes to reviewing state financing arrangements to ensure that the federal government is making appropriate payments to states.[v] While these efforts have focused on ensuring the program's *fiscal* integrity, the new Medicaid Integrity Program has as its focus ensuring *program* integrity. Medicaid fiscal integrity efforts have at times created an adversarial relationship between the federal government and states as they struggle over which party bears financial responsibility for some transactions and services, and as the federal government ensures that the matching funds it provides are obtained transparently and spent appropriately by the states.[vi] A more collaborative relationship between the federal government and states can help to promote successful Medicaid program integrity efforts. This type of relationship would reflect shared responsibility for program integrity between the federal government and the states, with the states maintaining the lion's share of the day to day program integrity responsibilities. It would also reflect the states' and the federal government's shared interests in maintaining program standards, encouraging appropriate, high quality care, and minimizing financial risks to state and federal treasuries.

3) Cooperation among federal agencies and communication with stakeholders is also key to the success of the implementation of the Medicaid Integrity Program. In addition to having a close collaboration among the federal government and the states, it is important that close coordination occur among the different federal players with a role in assuring program integrity. The Centers for Medicare & Medicaid Services (CMS), HHS Office of Inspector General, and Department of Justice (DOJ) all share responsibility at the federal level for ensuring program integrity in health programs, as does the Government Accountability Office (GAO). Under the Medicaid program integrity provisions of the Deficit Reduction Act, consultations among these agencies are required, but consultations alone may be insufficient to ensure the success of the Medicaid Integrity Program. When CMS implemented the *Medicare* Integrity Program, OIG, GAO and DOJ partnered in CMS' implementation efforts, with the active engagement and support of high-level CMS leadership. Having these agencies work together also helped overcome some differences in approach and organizational culture between agencies that focus primarily on providing services and those that focus primarily on law enforcement.

Similar collaboration between program agencies and law enforcement agencies could be mirrored at the state level involving state Medicaid agencies, state Attorneys General Offices, state Medicaid fraud control units, and state Inspectors General, in those states that have them.

At both the state and federal levels, communication and consultation with contractors, provider and consumer groups early in the process of developing new program integrity efforts could help to ensure that they are aware of and have an opportunity to provide input about new policies and procedures. This would allow provider groups to identify concerns about the manner in which proposed program integrity procedures could affect their practices and their ability to provide high-quality care, and to suggest approaches that would minimize administrative burden.

4) One approach to increased Medicaid program integrity efforts would be to focus on areas where the risks are the highest. Although the creation of the new Medicaid Integrity Program is bringing a substantial new investment of federal funds to ensuring program integrity in Medicaid, these resources remain limited: even when funding grows to $75 million in fiscal year 2011, the annual new federal investment in the Medicaid Integrity Program will be roughly one-tenth of what the federal government currently invests annually in the *Medicare* Integrity Program.[vii] Resources at the state level are even more constrained. Administrative spending in states has historically been low, and over the past several years many states have been cutting back on spending on program management, reducing the size of their state workforces, or both.

As the Medicaid Integrity Program gets underway, one approach to implementation could be to focus on a few areas where the financial risks and/or risks to quality have been highest (Figure 3). This approach would give the federal government and the states the highest return on their investment. The program could, for example, focus on provider billing issues. Historically, a significant number of large Medicaid fraud and abuse cases have involved provider billing problems.[viii] In these cases providers bill the program for services that have not been provided, or "upcode" to claim reimbursement for services that are compensated at a higher rate than the services that were actually provided, or overstate the number of services that were provided. A similar and significant set of billing issues exists with respect to suppliers of medical equipment. Another potential focus could be on issues related to the Medicaid drug rebate. There have been a number of recent cases in which drug manufacturers have engaged in strategies involving the structure of the Medicaid drug rebate, in which the prices of drugs have been erroneously reported to and paid for by state Medicaid programs. [ix] Provider billing and the drug rebate are two areas in which the federal government and states could improve program integrity efforts and potentially yield the most significant fiscal gains to the program. Concentrating on these areas would be consistent with the emphasis that the Deficit Reduction Act placed on the need for the Medicaid Integrity Program to focus on controlling provider fraud and abuse.

Another priority for the Medicaid Integrity Program could be to address issues related to quality of care. The program could help states improve efforts to determine, measure and ensure quality of care to ensure program effectiveness and cost efficiency. While increased quality of care efforts could be enhanced program-wide, one potential area of focus could be to address longstanding concerns related to quality of care arising from cases of patient abuse and neglect in long term care settings.[x] While these cases have historically been in nursing homes, as long-term care is increasingly being provided in

the community, efforts at preventing patient abuse and neglect will need to focus on care that is provided in community and residential settings as well. In contrast to these program integrity challenges, which have been posed by providers and suppliers, instances in which the actions of beneficiaries have raised significant program integrity questions are rare; reports from the General Accounting Office and HHS Inspector General on Medicaid program integrity over the past several years identify very few issues with respect to beneficiary fraud. The risks to the program from beneficiary fraud are extremely small, particularly when they are viewed relative to the risks that have been posed by some providers.

Figure 3

Key Issues in Medicaid Fraud and Abuse

Activity	Provider Type	Practices	Dollars at Risk
Drug Rebate "Gaming"	Drug Manufacturer	• Concealing best price • Marketing the spread	$$$$$
Billing Fraud	Hospitals, physicians, DME suppliers, clinical labs, pharmacies, home health, transportation	• Billing for Services Not Provided • Upcoding • Overstating services provided (i.e., quantities of drugs provided)	$$$$
Drug Diversion	Physician, pharmacy	• Buying/selling diverted drugs • Unnecessarily prescribing drugs in exchange for kickbacks	$$
Quality of Care	Long-term Care	• Patient abuse and neglect • Services not provided as specified • Falsified cost reports	$
	Acute Care (Physicians, hospitals, dentists, other providers)	• Providing unnecessary services • Services provided by inappropriate or unlicensed provider	

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5) Defining adequate measurements of program integrity in Medicaid is a key challenge. As the Medicaid integrity program gets underway, one central challenge will be to define how to measure program integrity in Medicaid. What gets measured drives public perceptions of program integrity, expectations of the program, and behavior at the state and federal levels. CMS has been for some time developing an improper payment rate for Medicaid, which would be comparable to estimates of improper payment rates in traditional Medicare. This effort is a useful start, but additional measures could be added to get a more complete picture of overall program integrity. It might be useful for CMS to track how many states adopt certain key process measures related to basic program integrity functions like on-site inspections of providers, coordination of benefits, or criminal background checks of providers as an additional measure of states' progress toward improving program integrity. In addition, developing standardized methodologies to estimate the financial value of states' cost avoidance efforts would make state efforts in this area more easily quantifiable and comparable across states. Historically, much more attention has been devoted to recoveries from cases of fraud and abuse, likely because it has been easy to quantify and report. But the savings from increased cost avoidance activities could be substantial, and the disproportionate focus on recoveries

and settlements minimizes the impact and effectiveness of cost avoidance achieved by implementing appropriate processes that avoid inappropriate costs upfront.

6) Some recent Medicaid policy developments could pose new program integrity challenges. As mentioned above, Medicaid faces program integrity challenges as states have contracted with managed care organizations for the delivery of health care that is provided to the majority of Medicaid enrollees. In these delivery systems, the state has an indirect relationship with providers in a network. Some new policy changes that further remove the state from a direct contracting role could also pose program integrity challenges. For example, some changes in the Deficit Reduction Act allow states to implement increased self-direction of personal assistance services without needing a "cash and counseling" waiver. The DRA also allows states to create Health Opportunity Accounts (HOAs) to give individuals the ability to purchase services with a set allocation of funds. It will be much harder to track how individuals make these expenditures and ensure that funds are being spent appropriately, although the new cash and counseling options include safeguards and consumer protections. In addition, the DRA allows for variation in benefits and cost sharing rules across beneficiary groups and geographic areas of the state. This move away from a more uniform approach to the Medicaid program within a state will make it more difficult to monitor quality of care, provision of appropriate services, and program integrity.

Other states have been pursuing statewide demonstration waivers that allow them to receive federal matching funds without following all federal Medicaid rules. The waiver that is scheduled to be implemented in Florida in two counties starting in September moves away from a defined benefits approach to a defined contribution approach. Under the plan, the state would allot each beneficiary a risk-adjusted premium amount and then allow them to choose a health plan from a group of plans selected by the state. The health plans would have more flexibility to determine what benefits to provide.[xi] This waiver is another example of how states are moving away from directly contracting for patient services and toward increased variation across beneficiaries and areas of the state. Ensuring program integrity in this new arena will be very challenging.

Conclusion

As the development and implementation of the comprehensive Medicaid program integrity plan begins, the federal government and states have a new opportunity to ensure sound and efficient management of the Medicaid program. They will also be challenged to define program integrity, accommodate the shared state and federal nature of the program, and allocate limited resources to areas where the potential risks are highest. Some of these challenges will be enhanced in a Medicaid environment where program variation is increasing across and within states and states are moving further away from a role of directly contracting with providers for beneficiary care.

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Appendix
Medicaid Program Integrity Provisions in the Deficit Reduction Act

Medicaid Program Integrity Program ($255 Million 2006-2010 / $75 Million each subsequent FY)

- Modeled on the Medicare Program Integrity Program, the DRA gives CMS new authority to contract with eligible entities to conduct activities to address fraud and abuse including: 1) review actions of individual or entities that furnish item services under Medicaid to determine whether fraud waste or abuse has occurred, is likely to occur, or has the potential to occur; 2) audit claims for services, including cost reports, consulting contracts, and risk contracts; 3) identify overpayments, and 4) educate providers and beneficiaries about program integrity and quality of care
- Requires CMS to hire 100 full time employees "whose duties consist solely of protecting the integrity of the Medicaid program… by providing effective support and assistance to states to combat *provider* fraud and abuse"
- Requires CMS to develop a comprehensive plan in FY 2006 and then every five years to combat fraud, waste and abuse. The plan must be developed by the Secretary of HHS in consultation with other federal and state officials with responsibilities for controlling *provider* fraud and abuse.
- Appropriates an additional $25million in each year from 2006 through 2010 for the Office of the Inspector General in HHS for fraud and abuse control activities.
- Requires CMS to submit an annual report to Congress identifying the use of the Medicaid Program Integrity Funds.

Medi-Medi Data Matching Project ($180 Million 2006-2010 / $60 Million each subsequent FY)

- Call for a national expansion of the Medicare-Medicaid (Medi-Medi) data match program that currently operates in CA, FL, IL, OH, NC, WA, NJ, TX, PA and NY
- Coordinates Medicare and Medicaid program integrity efforts to protect both programs from fraud, waste and abuse by matching data and comparing billing patterns for providers that participate in both programs
- Funding levels: appropriations of $12 million in 2006, $24 million in 2007, $36 million in 2008, and $48 million in 2009 and $60 in 2010 and in each subsequent fiscal year

Other Program Integrity Provisions of the DRA

- Provides states incentives to establish State False Claims Acts (FCA). Reduces amount of federal repayments from amounts recovered by 10 percentage points from the Medicaid match rate for states with false claims acts that meet federal standards. Also requires entities receiving annual Medicaid payments in excess of $5 million to provide Federal False Claims Act education for employees
- Prohibits Medicaid payment for the ingredient cost of a drug for which the pharmacy has already received payment under Medicaid (other than a restocking fee)
- Strengthens requirements and procedures for Medicaid programs to seek payment from third parties and use Medicaid as the payer of last resort.

[i] Andy Schneider,et al., *The Medicaid Resource Book, Kaiser Commission on Medicaid and the Uninsured*, www.kff.org, July 2002, Chapter IV.
[ii] CMS, 2004 Medicaid Managed Care Enrollment Report. www.cms.hhs.gov/MedicaidDataSourcesGenInfo.
[iii] Andy Schneider,et al., *The Medicaid Resource Book, Kaiser Commission on Medicaid and the Uninsured*, www.kff.org, July 2002, p. 149 and Sara Rosenbaum,, et al., Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts, (3rd edition), Chapter 5.
[iv] Mathematica Policy Research, Inc., Tracking Medicare Health and Prescription Drug Plans, Monthly Report for April 2006, accessed at www.kff.org.
[v] General Accounting Office, *Medicaid Financial Management: Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts*, June 2006 and General Accounting Office, *Medicaid Fraud and Abuse: CMS's Commitment to Helping States Safeguard Program Dollars is Limited*, June 28, 2005.
[vi] Shelly Gehshan, et al., *Moving Beyond the Tug of War: Improving Fiscal Integrity in Medicaid*, forthcoming, National Academy of State Health Policy.
[vii] Funding levels to estimate this funding level taken from Deficit Reduction Act of 2005, P.L. 109-171, and Department of Health and Human Services *Fiscal Year 2007 Budget in Brief*, www.hhs.gov.
[viii] Inappropriate billing by providers serving program beneficiaries was one of the risks the General Accounting Office cited in designating Medicaid a "high-risk" federal program in 2005. See General Accounting Office, *High-Risk Series: An Update*, January 2005, www.gao.gov. For examples of the type and size of some of the provider fraud and abuse cases that have taken place in Medicaid and Medicare, see Department of Health and Human Services Office of Inspector General, *Semi Annual Report to Congress*, October 1, 2005-March 31, 2006, U.S. Department of Health and Human Services http://oig.hhs.gov/publications/semiannual.html (additional cases are described in previous versions of the semiannual report); *Department of Health and Human Services Office of Inspector General State Medicaid Fraud Control Units Annual Report*, Fiscal Year 2003, www.oig.hhs.gov (additional cases are described in earlier editions of the annual reports); Taxpayers Against Fraud, *Top False Claims Act Cases by Award Amount*, accessed at http://www.taf.org/top100fca.htm; Taxpayers Against Fraud, *False Claims Act Update and Alert*, http://66.98.181.12/newsletter/backissues.htm; Andy Schneider, *Reducing Medicaid Fraud: The Potential of the False Claims Act, Taxpayers Against Fraud,* June 2003, www.taf.org, pp. 29-31;
[ix] Andy Schneider, *The Role of the False Claims Act in Reducing Medicaid and Medicare Fraud by Drug Manufacturers: An Update*, Taxpayers Against Fraud, www.taf.org, November 2004.
[x] See, for example, General Accounting Office*, Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety*, December 2005, www.gao.gov and *Department of Health and Human Services Office of Inspector General State Medicaid Fraud Control Units Annual Report*, Fiscal Year 2003, www.oig.hhs.gov.
[xi] Joan Alker, *What Will Florida's Medicaid Reform Legislation Mean for Children?* Georgetown University Health Policy Institute Center for Children and Families, November 2005 (updated January 4, 2006), www.ccf.georgetown.edu.

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