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The New Medicaid Integrity Program: Issues and Challenges in Ensuring Program Integrity in Medicaid

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THE HENRY J. KAISER FAMILY FOUNDATION

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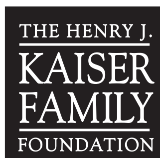

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Executive Summary

In 2006, Congress created the Medicaid Integrity Program, a new federal effort within the Centers for Medicare and Medicaid Services (CMS) to ensure program integrity in the Medicaid program, which covers health and long-term care services to more than 50 million low-income children, parents, seniors and people with disabilities. The creation of this program offers an opportunity for the federal government to increase its commitment to promoting the efficiency, effectiveness, and integrity of Medicaid, which purchases about one-fifth of all health care services in the United States and is one of the largest programs in the budget of both the federal government and the states. However, there are few comprehensive analyses of the overall program integrity challenges that Medicaid faces. This paper is intended to provide such an analysis, and relies on reviews of the existing literature and perspectives provided by a group of experts in program integrity in Medicaid.

The paper finds:

The new Medicaid Integrity Program brings substantial new resources to bear on the issue of program integrity in Medicaid, including federal funding that will ultimately reach $75 million a year, 100 additional staff at CMS dedicated to ensuring Medicaid program integrity, and new program integrity contractors who will perform many of the program's core functions. The Medicaid Integrity Program is modeled on the *Medicare* Integrity Program, which was created in 1996 but is much larger. The Medicaid Integrity Program was created in the Deficit Reduction Act of 2005 (DRA) as part of a set of Medicaid program integrity reforms.

Program integrity is central to program management and ensuring a program's effectiveness and efficiency. Program integrity is a critical component of program management and should help ensure public confidence that a government program is serving its target population effectively and fulfilling the purpose for which the program was created and is maximizing the return on taxpayers' investment in the program, with minimal waste. Program integrity should also help achieve key program goals. In Medicaid, program integrity requires setting policy and managing the Medicaid program so that health and long-term care services are provided to beneficiaries as effectively and efficiently as possible. It should ensure that quality health care to low-income people or state and federal tax dollars are not being put at risk through violations of the rules or abuses of the system. More specifically, program integrity should ensure appropriate amounts are being paid to legitimate providers for appropriate and reasonable services provided to eligible beneficiaries. Achieving these goals is a complex undertaking that involves all aspects of program management, from policy development to staffing to day to day operations.

Program integrity has traditionally been defined much more narrowly. A narrow focus that exclusively defines program integrity as issues related to "fraud and abuse" 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 addressing cases of fraud and abuse, even if the monetary effects of these efforts are harder to quantify.

A holistic approach also helps legislators, program managers, and the public identify and evaluate tradeoffs between goals for the program that are important but at times compete with each other. For example, policy goals of preventing errors, waste or fraud may at times conflict with goals to improve quality and accessibility of services, or ensuring that eligible people enroll in the program. Having a holistic view of program integrity can promote operational success, ensuring that policies in different program areas are coordinated and work well together. Evaluating tradeoffs and coordinating different policies and management areas is especially important in a program that is as large and complex as Medicaid.

Program integrity is extremely difficult to measure. Supporting this holistic definition of program integrity would require robust analytic measurements across a range of program areas. Currently, a much more limited set of program integrity measures is reported. Existing program integrity metrics generally measure: recoveries of amounts in cases of fraud and abuse that are brought against organizations or individuals; payment errors; and costs that are avoided by implementing new policies and procedures. Each of these measures, while meaningful, has limitations and drawbacks as a measure of program integrity. Individually, none of these measure program integrity, even as that term is narrowly defined. Developing additional measures of program integrity would better help those who run the program at the federal and state levels set priorities, identify high-risk areas, and allocate limited resources.

For example, error rates have the potential to be a significant program integrity and management tool by focusing attention on preventing mistakes and targeting program integrity efforts to high-risk areas. CMS is currently implementing a payment error rate measurement system (PERM) for Medicaid and SCHIP. The implementation of this system, which is designed to meet the requirements of federal law governing measurement of improper payments in major federal programs, has raised significant concerns about burden and accuracy from states. From a programmatic perspective, PERM could put state policies designed to simplify eligibility at risk if measurements do not accurately reflect state policies and mistakenly classify accurate eligibility determinations as errors.

The program integrity challenges facing Medicaid mirror those facing the health insurance system nationwide. As one of the nation's leading health insurers, Medicaid faces the same set of challenges to its integrity that other insurers do. The broadest challenge facing insurers is balancing the need to effectively address "fraud and abuse" with the need for covered individuals to get the services they need without needless delay

and ensuring that providers can participate in a transparent, efficient system in which they can provide high-quality care. Additional challenges involve Medicaid's and other insurers' role as third-party payers that pay others (such as managed care organizations) to provide services, as opposed to providing them directly. Having the actual provision of services removed from program administrators can make it difficult to prevent program integrity violations and promote quality. Another central challenge for administrators is to recognize that those who are intent on committing fraud change tactics at least as rapidly as insurers' efforts to thwart them do.

In addition, Medicaid faces a set of challenges that set it apart from other insurers: it finances half of the nation's long-term care, has a population that is more transient than the covered populations of other insurers, especially *Medicare*, and has payment rates that are lower than those of *Medicare* and private insurers, creating consistent concerns that program integrity efforts will discourage provider participation in the program. These concerns may be especially strong in light of some recent evidence that provider participation in the program seems to be diminishing. Finally, because Medicaid serves an extremely vulnerable low-income population, new policies and procedures that may impede eligible people from enrolling or obtaining services once they have enrolled can cause serious consequences.

Responsibility for ensuring Medicaid program integrity is shared between the federal government and the states. Medicaid's federal/state partnership, in which states operate the program within broad federal guidelines, makes ensuring program integrity a considerably more complex undertaking than it is for other insurers. States determine key elements of their programs within federal guidelines, deciding who is eligible, what benefits are offered, and how much providers are paid, so the Medicaid program can vary dramatically state to state. States also perform the day to day management of their programs, meaning that most operational program integrity responsibilities reside with the states. Recent budget proposals to reduce federal support for administrative activities would make it harder for states to invest in new or improved approaches to ensuring program integrity. It will be extremely difficult for the new federal Medicaid integrity program to guarantee compliance with the rules of 56 different states and territories. Moreover, it will be a challenge for the federal government to make sure that increased efforts work to complement the program integrity efforts that states already have underway. Extensive collaboration between the federal government and the states would promote the successful implementation of the Medicaid Integrity Program.

Quality of care is a significant program integrity issue. Ensuring that the health and long-term care services that Medicaid finances are provided in accordance with generally accepted medical practice can also be considered a program integrity issue. Although measuring and improving quality require broad approaches, a component of program integrity can help monitor care and ensure that beneficiaries are not receiving substandard care, or care that can be harmful to their health. In Medicaid, program integrity violations that have compromised quality of care have, for example, occurred with regard to providers who provide unnecessary or risky services, drug manufacturers who market drugs "off label" for unapproved use, and managed care and institutional care providers

who are paid for providing a set of services to beneficiaries but fail to do so. Because the area in Medicaid in which the closest examination of quality of care issues has been conducted is long-term care, this paper devotes attention to quality in this context, but quality of care issues arise in many other areas as well.

Targeting high-risk areas would help employ limited resources most effectively. Employing a holistic definition of program integrity would require that the program examine some of the broad challenges it faces. Even under a narrow definition of program integrity, limited resources will have to be matched to significant challenges. Resources are limited, and setting priorities will be critical. Targeting resources to where the risks are the highest would help maximize efficient use of funds and staff. Risks can be measured both in terms of financial risks and risks to the quality of care provided to beneficiaries. A review of the program integrity literature indicates that high-risk areas are (**Figure 1**):

Figure 1

Key risks in Medicaid Program Integrity

Provider Type	Risky Practice	Fiscal Risks	Quality of Care Risks
Drug Manufacturer (primarily)	Abuses related to Medicaid's purchasing of prescription drugs	$$$$$	**
Hospitals, physicians, DME suppliers, clinical labs, pharmacies, home health, transportation	▪ Billing Fraud ▪ Providing Services that are not medically necessary or that compromise quality of care	$$$$	****
Managed Care	▪ Underproviding services ▪ Inappropriate beneficiary marketing and enrollment practices	$$$	***
Long-term Care	▪ Patient abuse and neglect ▪ Services not provided as specified ▪ Falsified cost reports	$	*****

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Purchasing Prescription Drugs. Some drug manufacturers have fraudulently gamed the rebate structure Medicaid uses to purchase prescription drugs. Practices have included marketing the spread, concealing best price and relabeling drugs to evade inclusion of some sales in the calculation of the Medicaid drug rebate. A separate set of cases has involved manufacturers illegally marketing prescription drugs for uses that have not been approved by the Food and Drug Administration. There have also been issues raised with regard to some pharmacies' repackaging prescription drugs. Drug diversion schemes have involved organizations, some pharmacies, and people who resell prescription drugs. Some of the recent cases involving drug manufacturers have been extremely large, and it has been estimated that total recoveries from Medicaid-related settlements and judgments

involving drug manufacturers totaled more than $3.8 billion between 2000 and 2006, suggesting that the financial risks in this area are large.

Provider Billing Issues. Some providers have used the billing process to bill for services that were not provided, bill multiple times for services that were provided, falsify signatures and certifications, and "upcode" to obtain higher reimbursement than what would be paid for services that were provided. Some providers have also provided services that are not needed by patients. The frequency of cases involving these practices and the size of some of the settlements and judgments of these cases imply that the financial risks to the program in this area are significant.

Issues Related to Managed Care. The program integrity risks that arise from managed care are different in nature from those that exist in traditional fee-for-service arrangements. Capitated payments provide an incentive to underprovide care, whereas in fee-for-service payment arrangements incentives exist to overbill. Fraudulent practices engaged in by some managed care organizations include underproviding services, irregularities in marketing to and enrolling beneficiaries, and providing fraudulent information during the contracting process. At times some MCOs have been perpetrators of fraudulent or abusive schemes, while at others they have been victims of such schemes, because they, like other insurers, can be subject to fraudulent practices by the providers with whom they contract.

Quality issues in long-term care. Ensuring quality of care is an important program integrity issue throughout the Medicaid program. Over time, there has been an especially close examination of quality of care issues in long-term care. Medicaid is the nation's largest purchaser of nursing home care, and there have been significant concerns raised by some analysts, particularly the Government Accountability Office, about quality of care and patient safety in some nursing homes. Serious deficiencies in some nursing home care, including instances where nursing homes caused harm or placed residents in danger, as well as cases of patient abuse, have been documented. There has been a concerted, multi-year federal effort focused on nursing home quality. These efforts appear to have helped reduce the rate at which these reported instances occur, but some significant problems persist. Risks to patient well-being can also arise in home and community based long-term care settings.

Other Program Integrity Issues. From the review of the program integrity literature, the risks arising from fraud by beneficiaries appear to be very low, and where such risks do exist, the program's financial liability and threats to quality of care are slight. Recent Medicaid policy developments, including some changes in the DRA could pose new program integrity challenges. For example, the move toward consumer spending accounts (such as "self-directed" home and community based care and Health Opportunity Accounts) as well as new state options to vary cost-sharing and benefit packages across beneficiary groups and geographic areas in a state can also pose new challenges in monitoring program integrity. New citizenship documentation requirements could make it more difficult for eligible people to enroll in Medicaid, raising a different program integrity concern. Recent movements toward contracting out

some key state administrative functions can also raise program integrity concerns. Finally, New York State's most recent section 1115 Medicaid waiver restructuring the state's health system requires a state for the first time to increase its fraud and abuse recoveries. Encouraging states to do more to promote program integrity fits with Congress and CMS' increased emphasis in this area and sends a strong signal to providers that the state takes program integrity issues seriously. However, there are risks in using state recoveries including potentially fostering an overly aggressive approach to enforcement, making inappropriate determinations of what is fraudulent, or even discouraging prevention of fraud and abuse to facilitate meeting recovery targets.

Implications of the *Medicare* Integrity Program for Medicaid. The new Medicaid Integrity Program is modeled on the existing *Medicare* Integrity Program. Since the *Medicare* Integrity Program was created in 1996, some of its activities have generated a significant return on investment. In addition, since the 1996 inception of the Health Care Fraud and Abuse Control program, the enforcement and prosecution companion to the *Medicare* Integrity Program, recoveries from *Medicare* fraud and abuse cases have increased substantially. Few other measures of these program's successes and challenges are publicly available. One clear challenge to the early implementation of the *Medicare* Integrity Program was to carry out new program integrity efforts in such a way that rules were clear to and perceived as fair by providers. CMS recalibrated its efforts after significant concerns from the provider community were voiced, and Congress set some limits on how the integrity program could be carried out. CMS' efforts at working with the provider community appear to have paid off. Its collaborative work on program integrity with key provider groups has been credited with helping to reduce the *Medicare* payment error rate.

Although the *Medicare* Integrity Program may be a logical model for improving program integrity efforts in Medicaid, its applicability to Medicaid has some clear limitations. First among them is that *Medicare* is entirely federally run, but Medicaid is a state/federal partnership. The split of responsibilities between the federal government and the states – and the fact that states bear most of the responsibility for ensuring program integrity – will likely make it much more difficult to carry out the Medicaid integrity program than it was to increase program integrity efforts in *Medicare*. In addition, managed care has historically played a much larger role in serving Medicaid beneficiaries than it has in serving *Medicare* beneficiaries, and the kinds of program integrity cases faced in a managed care environment are different from those faced in a fee for service environment. Medicaid also serves a much broader population and plays a much larger role in paying for long-term care than *Medicare* does.

The Medicaid Integrity Program creates new opportunities to ensure sound and efficient management of the Medicaid program. Increasing program integrity efforts in Medicaid will likely require a careful and balanced approach, and ideally will be undertaken as a broad effort in which the overall effectiveness and efficiency of the program is maximized and progress is charted toward all of the program's many goals. Targeting efforts to focus on high-risk areas and minimizing efforts in low-risk areas could be critical. These efforts must be balanced with and integrated with program goals

of improving coverage, maintaining access to care, paying providers adequately, ensuring quality care, and enrolling eligible people. Given the variation across state Medicaid programs, collaboration between states and the federal government will be necessary to enhance program integrity efforts and to ensure that state and federal efforts complement, rather than conflict with, each other.

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