kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

July 2012

Program Integrity in Medicaid: A Primer

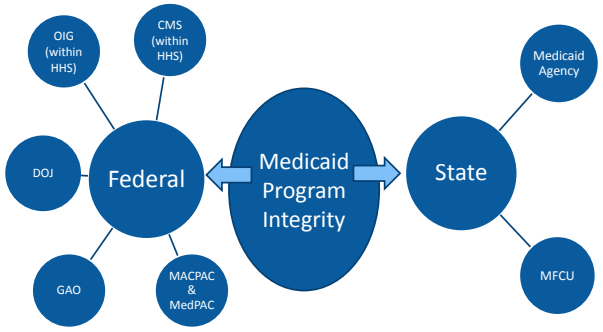
Medicaid is the public insurance program that provides health coverage and long-term care services and support for low-income individuals and families. The program covers more than 60 million Americans and accounts for about 1 in 6 dollars spent on health care. Medicaid is jointly financed by the federal government and the states, and states administer the program within broad federal rules. Medicaid's important role in providing coverage and its share in state and federal budgets, make it critical to prevent waste, fraud, and abuse and ensure appropriate use of taxpayer dollars. Multiple agencies at the state and federal levels are involved in program integrity efforts and many initiatives are yielding positive results. New investments in the Affordable Care Act built on earlier investments through the Deficit Reduction Act to bolster the capacity of government to promote Medicaid program integrity. Program integrity has been a focus of a number of recent Congressional hearings and briefings.[1] This brief explores 4 key questions:

What is Program Integrity in Medicaid? Program integrity refers to the proper management of Medicaid to ensure quality and efficient care and appropriate use of funds with minimal waste. Program integrity initiatives work to prevent and detect waste, fraud, and abuse, to increase program transparency and accountability, and to recover improperly used funds. Waste, fraud, and abuse risks are concentrated in providers, managed care plans, and drug manufacturers, and not beneficiaries. Program integrity efforts consist of a combination of administrative functions (like setting program rules and enrolling providers and plans), oversight (through audits, data reviews, and survey and certification) and through law enforcement activities.

What Entities are Involved in Program Integrity Efforts? Ensuring program integrity in Medicaid is the responsibility of both the federal government and the states. States manage the day-to-day operations of Medicaid and are on the front-lines of ensuring Medicaid program integrity, primarily through the state Medicaid agency and the Medicaid Fraud Control Units (MFCUs). The federal government oversees and helps finance state program integrity efforts and also has additional responsibilities to combat fraud and abuse through federal agencies within the Department of Health & Human Services (HHS), the Department of Justice, and through Congress (ES Figure 1).

ES Figure 1

Agencies Involved in Medicaid Program Integrity



NOTES: CMS = Centers for Medicare & Medicaid Services, OIG = Office of Inspector General, DOJ = Department of Justice, GAO = Government Accountability Office, MACPAC = Medicaid and CHIP Payment Advisory Commission, MedPAC = Medicare Payment Advisory Commission. CMS and OIG are federal agencies within the Department of Health & Human Services, while GAO, MACPAC, and MedPAC are Congressional agencies.

What Key Medicaid Program Integrity Initiatives are Underway? There are currently a variety of federal program integrity initiatives that focus on efforts to coordinate activities across Medicare and Medicaid, to collaborate within and across states, to conduct reviews and audits of suspicious activities, and to pursue law enforcement actions. In addition to federal efforts, states are also implementing program integrity initiatives. The federal government shares state best practices.

What are Central Issues for Program Integrity in Medicaid? While many efforts to combat fraud and abuse are yielding positive results, a range of challenges and opportunities to improve upon current efforts exist. Focus areas include efforts to improve coordination across payers and states, enhance the use of data, and to employ data analytic strategies to bolster prevention and early detection efforts. It is important for program integrity efforts to find a balance between program oversight and provider participation. Understanding the return on investment for various initiatives will help allocate limited public resources. Finally, program integrity initiatives must continue to develop to meet new threats as the Medicaid program continues to evolve and expand.

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Introduction

Medicaid, the public insurance program that provides health coverage and long-term care services and supports for individuals and families, covered more than 60 million low-income Americans in 2011. Jointly financed by the federal government and the states, Medicaid is run by the states within broad federal guidelines. After meeting federal requirements, states are able to determine key elements of their Medicaid programs, including who is eligible, what benefits are offered, and how much providers are paid.[2] The result has been wide variation in Medicaid programs across the country. Despite this variation, Medicaid plays an important role in the financing of health care services throughout all states. Each year, Medicaid funds 40 percent of all long-term care services, 40 percent of all births, and 17 percent of all health care services in the U.S.[3] In 2010, federal and state Medicaid spending totaled an estimated $389 billion, of which about 64 percent paid for acute care services and 32 percent paid for long-term care services.[4]

Given the magnitude of the Medicaid program and the important roles it plays in the health care system, ensuring appropriate use of taxpayer dollars is critical. Program integrity, which refers to the proper management and function of the Medicaid program, including the prevention of waste, fraud, and abuse, is the responsibility of both the federal government and the states. There are currently multiple agencies at both the federal and state levels that are working to ensure Medicaid program integrity. New investments in the Affordable Care Act (ACA) build on earlier investments through the Deficit Reduction Act (DRA) to bolster the capacity of the government to promote program integrity. While many efforts have been successful, challenges and opportunities for program improvements exist today and will continue to exist in the future. The Medicaid expansion under the ACA will mean more Medicaid enrollees, additional providers, and increased use of managed care organizations. The larger program scope increases the challenges to maintaining and enhancing program integrity.

Background

Since the enactment of Medicaid in 1965, the statute has evolved to promote program integrity.[5] The Deficit Reduction Act of 2005 (DRA) included new initiatives and funding to focus on four key program integrity priority areas: prevention, detection, transparency and accountability, and recovery.[6] The bill contained several Medicaid provisions designed to improve the ability of both the states and federal government to address program integrity issues. Three important provisions in the DRA are the creation of the Medicaid Integrity Program (MIP), the expansion of the Medicare-Medicaid Data Matching Project (Medi-Medi), and the establishment of monetary incentives to states to create State False Claims Acts (FCA).[7]

The Affordable Care Act of 2010 (ACA) marked another major investment in program integrity efforts in Medicare and Medicaid, providing an additional $350 million in resources over 10 years.[8] The ACA provides new resources for provider screening and data-matching efforts, establishes new authorities to federal and state agencies and contractors to take action against suspected program abusers, and creates new program coordination and state-to-state collaboration opportunities.[9] The ACA also increases the emphasis on collaboration efforts across payers and states to make sure that efforts are not duplicated and that a provider found to be fraudulent in one state does not attempt to practice in another state or in another public program.[10,11]

To implement Medicaid program integrity efforts, states and the federal government rely on various sources of data, including eligibility data, claims data, administrative data, other payer data, provider enrollment data, and provider operating data.[12] New program integrity initiatives rely heavily on health information technology. For example, predictive analytics use models to examine claims to detect inappropriate or suspicious billing patterns.

One recent article identified six categories of waste (care that did not add value) as overtreatment, failures of care coordination, failures in execution of care processes, administrative complexity, pricing failures, and fraud and abuse; and it indicated that lowest available estimate associated with these categories exceeds 20 percent of health care expenditures.[13] Changes in health care delivery across payers would be required to address many of these categories such as overtreatment and care coordination. The total amount of fraud that exists in Medicaid is unknown, but despite investments and initiatives to combat fraud and abuse, it is impossible to eliminate. Recent Congressional hearings have highlighted federal and state activities to promote program integrity, and cases that document instances of waste, fraud, and abuse.[14] The Obama administration has continued to invest resources in program integrity efforts, and, the FY 2013 budget proposal included additional funding for the Health Care Fraud and Abuse Control (HCFAC) program for total HCFAC spending of $21 billion over the 2013-2022 period. The Administration accounts for $11.3 billion in savings tied to HCFAC investments. In addition, the budget includes 12 (9 Medicaid and 3 joint Medicare and Medicaid) program integrity legislative proposals expected to yield $3.6 billion in savings for Medicare, Medicaid, and CHIP over the ten year period.[15] In February, HHS and DOJ issued a report showing that fraud prevention and enforcement efforts resulted in $4.1 billion in recoveries across federal health care programs, including Medicaid.[16] Other reported program improvements were increases in the usage of data screening and analysis tools, the closing of loopholes, and legislative and administrative actions to make funds available for better use.[17]

What is Program Integrity in Medicaid?

Program integrity refers to the proper management and function of the Medicaid program to ensure quality and efficient care is being provided while funds – taxpayer dollars – are used appropriately with minimal waste. Program integrity efforts encompass a variety of administrative, oversight, and law enforcement strategies. In the past, program integrity efforts have focused primarily on the recovery of misspent funds; but more recent initiatives have attempted to move beyond "pay and chase" models and focus more heavily on prevention and early detection of fraud and abuse and other improper payments. However, it is often difficult to quantify estimates of savings associated with prevention activities. A comprehensive strategy outlined by the Medicaid Integrity Group (MIG) at CMS involves detecting suspicious claims, revoking bad actors, focusing on risky areas, preventing fraudulent providers from enrolling or re-enrolling, and sharing information across states, payers, and law enforcement entities (Figure 1).

Figure 1

Comprehensive Strategy to Addressing Program Integrity

SOURCE: Angela Brice-Smith, Director of the Medicaid Integrity Group at the CMS Center for Program Integrity presentation at the MACPAC Commission Meeting, November 17, 2011.

The Government Accountability Office (GAO) reports improper payments across all government programs including Medicaid. These improper payment measures are often cited when discussing program integrity. However, it is important to understand the definition of improper payment. According to the GAO's 2011 report, "It is important to recognize that improper payment estimates reported by federal agencies…are not intended to be an estimate of fraud in federal agencies' programs and activities."[18] Improper payments may result from a variety of circumstances including errors (services provided without sufficient documentation), waste (services that may not be medically necessary), abuse, and fraud. These reports help to understand problems, challenges, and progress in addressing improper payments. Errors and waste may result in unnecessary expenditures, but are not criminal activities like fraud and abuse (see box at right for a definition of terms).

Definition of Terms

Improper Payment: Any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other requirements. It includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received, and any payment that does not account for credit for applicable discounts. Office of Management and Budget (OMB) guidance instructs agencies to report as improper payments any payments for which insufficient or no documentation was found.

Error: The inadvertent product of mistakes and confusion.

Waste: Inappropriate utilization of services and misuse of resources.

Abuse: Action that is inconsistent with acceptable business and medical practices.

Fraud: The intentional act of deception or misrepresentation.

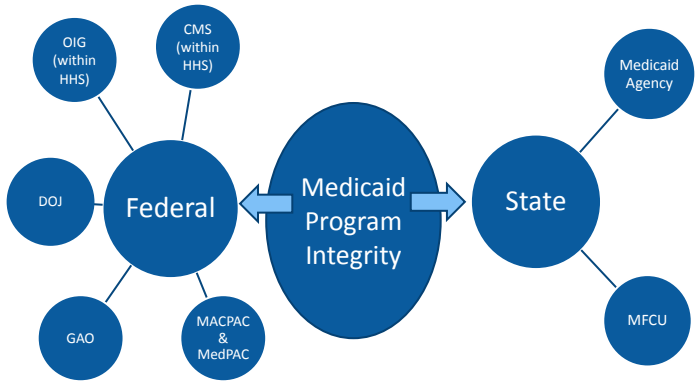
Medicaid program integrity includes financial and quality of care risks. Drug manufacturers, hospitals and physicians, and drug and durable medical equipment (DME) suppliers can pose high financial program integrity risks to Medicaid. Some waste, fraud or abuse practices may include unethical drug marketing, false or duplicative billing for services, and artificially inflated prices. Long-term care and managed care providers, as well as hospitals and physicians, can pose high quality of care risks by underproviding or overproviding care, allowing unqualified personnel to provide care or perform tests, and patient abuse and neglect.[19] Therefore, strong eligibility and enrollment guidelines for providers and behavior monitoring systems are important parts of a comprehensive strategy to prevent threats to Medicaid program integrity.

What Entities are Involved in Medicaid Program Integrity?

Multiple entities are involved in program integrity (Figure 2).[20] States are responsible for the daily management of Medicaid (conducting enrollment and eligibility verification; licensing and enrolling providers; setting rates and paying providers; monitoring quality of care and provider claims ("data-mining"); conducting audits; detecting improper payments and recovering overpayments; and investigating and prosecuting provider fraud and patient abuse or neglect).[21] The federal government monitors and enforces state compliance with federal rules; reviews state agency performance; audits, evaluates, and investigates individuals or organizations suspected of fraud; imposes sanctions; and provides training and guidance to the states.[22]

Figure 2

Agencies Involved in Medicaid Program Integrity



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Federal Entities:

Centers for Medicare and Medicaid Services (CMS) – Works to deter, detect, and combat fraud and abuse and take action against those that commit or participate in fraudulent activities. These activities are primarily implemented through the Center for Program Integrity (CPI), which was created to coordinate all program integrity efforts across CMS and other state and federal partners. The Medicaid Integrity Program (MIP) is administered by the CPI with responsibility to: hire contractors to review Medicaid provider activities, audit claims, identify overpayments, educate providers about Medicaid program integrity issues, and to provide support and assistance to states in their efforts to combat provider fraud and abuse.[23] CMS issues deferrals and disallowances to states that provide inadequate documentation or justification for Medicaid claims.[24]

Department of Justice (DOJ) – Monitors and enforces federal fraud and abuse laws and prosecutes law violators. Several offices within DOJ are involved in Medicaid program integrity activities, including the Office of the U.S. Attorneys, the Criminal Division, and the Federal Bureau of Investigations (FBI).[25,26]

Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) – Conducts audits, investigations, and evaluations of HHS programs, including Medicaid. It oversees state Medicaid Fraud Control Units (MFCUs), provides resources and education to the health care industry and the public to combat fraud and abuse.[27,28]

Government Accountability Office (GAO) – Is a Congressional agency that investigates the federal spending of tax dollars and individual fraud allegations. GAO can audit agency operations and assess whether programs and policies are meeting objectives.[29] Other Congressional agencies involved in program integrity activities include the Congressional Oversight Committee, the Medicare Payment Advisory Commission (MedPAC), and the Medicaid and CHIP Payment and Access Commission (MACPAC).

State Entities:

State Medicaid Agency – Develops policies and handles the day-to-day operation of Medicaid. In some states, program integrity responsibilities are distributed across agencies, including the Office of the Attorney General and the Office of the State Auditor.[30] Most program integrity efforts implemented by the states are matched at the standard 50 percent administrative match rate, but some efforts receive higher match rates, including the Medicaid Management Information Systems and survey and certification.

Medicaid Fraud Control Unit (MFCU) – Is an entity of state government that investigates program administration and health care providers, prosecutes (or refers) those defrauding the program, and collects overpayments. They also review cases of abuse and neglect and the misuse of patient personal funds in long-term care facilities.[31] MFCU costs are matched at a 75 percent rate.

What are the Key Medicaid Program Integrity Initiatives are Underway?

There are currently multiple ongoing initiatives that focus both on different areas of the Medicaid program and on different aspects of program integrity. Some efforts are targeted specifically to Medicaid, but other efforts were initially designed to address program integrity in Medicare have been extended to incorporate Medicaid. A current focus of federal program integrity efforts is on increasing coordination and collaboration efforts across payers and states to reduce duplication and more efficiently utilize limited resources. There has also been an increased emphasis on identifying and sharing effective state-based programs and practices among states through publications, such as CMS's Best Practice Annual Summary report (selected examples in box on page 8).

Efforts to Coordinate Across Medicare and Medicaid:

National Fraud Prevention Program (NFP) – The two main activities of the NFP are provider screening and claims processing, using shared data across Medicare and Medicaid. The NFP use of predictive analytics help to take quick action to prevent improper payments. Provider screening helps to identify bad actors and prevent enrollment in Medicare and Medicaid and to take quick action to remove providers from public programs.

Termination of Provider Participation– The ACA requires states to terminate provider participation in Medicaid if the provider was terminated under Medicare or another state program, such as the Children's Health Insurance Program (CHIP). CMS has established a secure web-based portal for states to share information with one another about providers or entities that have been terminated because of fraud, integrity, or quality. The goal of this program is to bolster program integrity efforts by sharing information across programs and states. States are expected to report all terminations.[32,33] HHS is planning to bolster provider enrollment and screening procedures, establish new requirements to withhold payment to providers and suppliers who are suspected of fraud and abuse, and coordinate provider termination information and procedures across Medicare, Medicaid, and CHIP.[34,35]

Medicare-Medicaid Data Matching Project (Medi-Medi) – The DRA called for the national expansion of the Medi-Medi pilot program, which provides resources to enable states to match and compare data and billing patterns of providers that participate in both Medicare and Medicaid. Connecting provider behaviors across the two programs can reveal wasteful, fraudulent, or abusive behaviors that are not apparent when solely looking at either Medicare or Medicaid individually.[36] Currently, 14 states participate in the program.

Fraud Prevention System for Medicare - In June 2011, CMS implemented the Fraud Prevention System for Medicare which uses state-of-the-art predictive modeling technology to identify suspicious behavior and billing irregularities.[37] The goal is to extend this program to Medicaid in the near future.[38]

Other upcoming programs include the creation of new coordination strategies between Medicaid and Medicare to track data and activities of dual eligible beneficiaries and their providers.[39]

Efforts to Collaborate with States:

The Medicaid Integrity Institute (MII) – This is the first comprehensive program integrity training academy and is housed at the DOJ's National Advocacy Center in Columbia, South Carolina. The MII holds a variety of classes for state stakeholders to assist them in their program integrity activities, such as details on program integrity investigations, information on CPT coding, legal processes, and data analysis. In addition to training key state workers and officials about program integrity, the institute offers an opportunity for the federal government and the states to learn what is happening in other states around the country. Thus far, over 3,000 individuals have been trained at the institute[40,41]

Medicaid Integrity Group (MIG) Efforts to Target High-Fraud Areas – Through the MIG, there have been joint federal-state efforts to support special projects in high-fraud areas. MIG has worked with California, New Jersey, and Florida to target home health and DME providers resulting in 400 actions taken against providers including fines, suspensions, licensing referrals, fraud referrals, and education letters.[42]

Audit and Oversight Efforts:

Medicaid Integrity Contractors (MICs). CMS contracts with Review MICs, Audit MICs, and Education MICs. Review MICs analyze state Medicaid claims data and identify potential overpayments, audit MICs conduct audits of providers to identify Medicaid overpayments using MSIS data; and Education MICs educate providers and beneficiaries about program integrity issues.[43] Between 2009 and November 1, 2011, Audit MICs initiated 1,663 audits in 44 states to identify $15.2 million in overpayments.[44] Despite the high level of overpayments identified, the OIG, GAO, and states have identified problems with review and audit MICs, including problems with reliance on Medicaid Statistical Information System (MSIS) data for program integrity analysis, use of state resources, overlap with the RAC audits, and a low return on investment.[45,46] In 2010, states invalidated over one-third of sampled potential overpayments identified by Review MICs because of inaccurate or missing data.[47] In FY 2011, CMS moved to work more collaboratively with states on audits.[48]

Recovery Audit Contractors (RACs) – Review claims after payment to identify under and overpayments and recoup overpayments. Originally designed for the Medicare program, they were expanded to Medicaid under ACA. States are required to pay the RACs a contingency fee for identification of overpayments. Under the law, states are required to contract with RACs and, as of April 2012, 26 states have been awarded RAC contracts.[49,50]

Payment Error Rate Measurement Program (PERM) – Managed by CMS' Office of Financial Management and designed to comply with the Improper Payments Information Act of 2002, PERM reviews state payment and eligibility records to calculate payment error rates using a random sample of claims and eligibility determinations. The most common PERM errors are due to missing documentation. In FY 2011, the national error rate was 8.1 percent (for fee-for-service payments it was 2.7%, managed care payments it was 0.3%, and eligibility rates it was 6.1%). Seventeen states are reviewed each year and each state must develop a corrective action plan to reduce improper payments based on the PERM findings. Each state is also required to return the federal share of overpayments.[51] Concerns have been raised about the PERM program. Reporting requirements are an administrative burden for states and providers, and the corresponding results have been misleading. The payment error rate reported is the absolute value of both overpayments and underpayments, and often the errors reflect problems in coding and reporting or missing documentation, as opposed to intentional fraudulent activity.[52,53]

Medicaid Eligibility Quality Control Program (MEQC) – Established under CHIPRA (the CHIP Reauthorization Act), MEQC requires states to perform post-eligibility checks to assess whether or not a proper determination was made, and then report to CMS an estimate of improper payments. States can choose to sample the Medicaid population or focus on a specific group.[54]

Law Enforcement Efforts:

Federal False Claims Act (FCA) – Under the FCA, individuals or entities that knowingly submit false claims for payment of government funds can be held liable for three times the government's damages plus civil penalties of $5,000 to $11,000 per false claim. The FCA also contains whistleblower (qui tam) provisions that allow citizens with evidence of fraudulent activity to sue on behalf of the government to recover the stolen funds. These cases are reviewed by the DOJ and the whistleblower may be awarded a portion of the state recovery.[55] States elect whether to establish a FCA and the DRA incentivized them to do so by reducing the amount states must repay the federal government by 10% from the Medicaid match rate for claims recovered in states with FCAs that meet federal standards. Thirty-two states and DC have enacted False Claims Acts.[56] Entities that receive more than $5 million in Medicaid payments are also required to provide Federal False Claims Act education for employees.[57]

Health Care Fraud and Abuse Control Program (HCFAC) – Was established through the Health Insurance Portability Act of 1996 (HIPAA) under the joint direction of the DOJ and HHS to coordinate federal, state, and local law enforcement activities related to health care fraud and abuse across all health plan types (public and private). The goals of HCFAC are to also conduct investigations, audits, inspections and evaluations relating to the delivery and payment of health care services, facilitate enforcement of remedies, provide guidance to the health care industry regarding fraudulent practices, and establish a national data bank to receive and report adverse actions against health care providers and suppliers.[58]

Health Care Fraud Prevention and Enforcement Action Team (HEAT) – A joint effort between HHS and DOJ, HEAT was created in 2009 to coordinate activities across government agencies. Comprised of top-level law enforcement agents, auditors, and evaluators, HEAT engages in actions to prevent fraud, enforce current anti-fraud laws, and increase efficiency in prosecuting complex fraud cases. It also works to increase coordination, intelligence sharing, and training among law enforcement officials.[59,60,61]

Additional Proposals for Medicaid Program Integrity Included in the President's FY 2013 Budget:

The President's Budget proposal included a number of new program integrity initiatives. For example, one proposal would allow CMS to use RAC recovery funds to implement corrective actions (under current law funds are restricted to administration). Another proposal would expand the current authority to exclude individuals and entities from federal health programs if affiliated with a sanctioned entity. Proposals specific to Medicaid include a proposal to require states to track high prescribers and utilizers of prescription drugs in Medicaid and a proposal that would strengthen Medicaid third-party liability. The budget also proposes to consolidate the PERM and MEQC programs.

Key State Initiatives

While federal efforts can help better help coordinate program integrity efforts across states and payers, there are a number of state initiatives that have been identified by CMS as best practices in their 2011 Best Practice Annual Summary report.[62] Some key examples from that report and elsewhere are listed below.

Provider Enrollment: Kentucky uses a centralized provider enrollment process that requires that all providers be enrolled by state staff on the Kentucky Department of Medicaid Services website that links to the Kentucky Sanction Provider list, available for public viewing. Providers also undergo a thorough enrollment or re-enrollment review that checks the List of Excluded Individuals and Entities (LEIE) and Excluded Parties List System (EPLS) databases, and the state's Medical Licensing Board.[63]

Provider Review: Program integrity staff in Louisiana collaborated with a staff from a sister agency, mental health rehabilitation (MHR), to conduct a review of 100% of all HMR providers. Together the staff monitored and audited 131 providers, which resulted in cost avoidance, overpayment recoveries, and referrals to the state's MFCUs.[64]

Data Analysis: Tennessee has developed a three-step process to validate and verify managed care encounter data. First, the data is processed through a software program that automatically rejects bad data and sends it back to the managed care organization. Second, the data is processed through the fee-for-service claims engine, and third, the state uses a contractual withhold each month that requires an entity to have a certain percentage of clean claims.[65]

Program Safeguard Activities: Alabama checks its state list of excluded providers with the Department of Industrial relations to see if any excluded individuals are working for Medicaid providers or plans. This way it can make sure that these individuals do not attempt to defraud the program again but through a different role or capacity. The state's exclusion list has combined both the Medicare Exclusion Database (MED) and Alabama-initiated exclusions.[66]

Communication across Programs: Arizona sponsors a semi-annual Compliance Officer Network Group meeting for program integrity staff, the Attorney General's Office, CMS Regional Office staff, and MCO Compliance Officers to provide them with updates and training on program integrity activities. This is also an opportunity for individuals to meet one another and network which, the state reports, has increased their wiliness to work together.[67]

Data Analysis and Systems: Washington installed a new Fraud and Abuse Detection System that has enhanced algorithms, focuses on managed care, and uses a new MMIS with advanced edit/audit capabilities.[68]

Prescription Drug Monitoring Program: New Jersey launched the New Jersey Prescription Monitoring Program (NJPMP) through the state's Division of Consumer Affairs to help control prescription drug abuse (http://www.njconsumeraffairs.gov/pmp/).

What are Central Issues to Program Integrity in Medicaid?

As the Medicaid program evolves and expands, so do program integrity efforts. There is a current focus on coordinating efforts across payers and across states; improving access to and use of data analytics to enhance efforts; measuring the effectiveness of various efforts; balancing the goals of preventing, detecting, and eliminating waste, fraud, and abuse with the challenges these efforts impose on providers that participate in the program; and adapting to new care delivery models like managed care that bring a new set of program integrity challenges. It is essential but difficult to balance competing priorities and reach high program integrity standards with limited resources.

Collaboration and Coordination. Working to collaborate and coordinate initiatives across states, across agencies, between the states and the federal government and across payers is already a key focus and mission of the CPI; however, there is near universal consensus that there is room improvement. GAO stated that one of the key challenges CMS faces in implementing Medicaid program integrity is ensuring effective coordination to avoid duplicating state program integrity efforts, particularly in the area of auditing claims.[69] These concerns are echoed by the National Association of Medicaid Directors (NAMD). NAMD calls for more clarification of the roles of states and the federal government and points to the RAC and MIC audit programs as areas of duplication.[70] GAO, NAMD, and others call for continued improvements to developing databases and in access to data (such as the Integrated Data Repository (IDR), a database of Medicare and Medicaid claims data, and the One Program Integrity (One PI) designed to provide access to the IDR)) to help coordinate program integrity efforts across payers. NAMD also calls for improvements in collaboration between states and the HHS OIG to help identify priority targets for investigations. A letter from Members of the Senate Finance Committee called for input from members across the health care community (providers, payers, health plans, contractors, non-profit entities, consumers, data analytics entities, and other professionals to identify solutions regarding efforts to combat fraud and abuse in Medicare and Medicaid). The Committee sought input until June 29, 2012 and committee staff is now reviewing submissions to compile a summary later this year.[71] On July 26, 2012, the Obama administration announced the creation of a new public-private partnership to coordinate program integrity efforts across federal agencies, state officials, several health insurance organizations, and anti-fraud action groups. This partnership aims to build upon current screening and prevention efforts across entities and states.[72]

Measurement. Multiple groups, including MACPAC, NAMD, GAO, and the OIG, call for better methods for quantifying the effectiveness of program integrity activities. Understanding the return on investment (ROI) of various initiatives will help to allocate scarce federal and state resources, focus on the most effective programs, and potentially eliminate duplicative or ineffective programs. A recent OIG report pointed to problems with the MIC audits, showing that there was a negative ROI, partially because the audits use MSIS data that does not have sufficient information for program integrity initiatives and the data is lagged.[73] A June 2012 report by GAO also cited potential shortcomings with MSIS data when it found that 60 percent of MSIS audits assigned to contractors through February 2012 were either discontinued, had low or no findings, or were put on hold.[74] Increasing the use of state-based Medicaid Management Information System (MMIS) data for audits has been suggested as a method for analyzing more complete and up-to-date information. Recoveries from improper payments are easier to quantify than efforts that strive to prevent improper payments. As prevention efforts increase, recoveries may decline.

Limited Resources. MACPAC specifically recommended that program integrity efforts make efficient use of federal resources and not place an undue burden on states or providers. Understanding the ROI on certain investments could help allocate scarce resources. From the federal perspective, investment in new program integrity initiatives often requires new resources, even if savings are expected. The Congressional Budget Office (CBO) generally does not score mandatory savings tied to additional spending for program integrity initiatives (i.e. CBO may include a memo line citing "non-scoreable effects" as it did in the ACA legislation).[75] From the state perspective, NAMD has recommended that resources be redirected from reviews of Medicaid integrity programs to consulting teams that could work with states to identify specific challenges and assist more directly with program integrity efforts. NAMD has also recommended that the federal government leverage investments in technology and data analytics tools to make those more available for states. Other state officials also point to the need for additional resources for state program integrity efforts, noting that the DRA and the ACA largely increased federal funding for program integrity.

States also argue that most program integrity efforts are only matched with the 50 percent federal match rate (although MFCUs are matched at a 75 percent match rate) and an enhanced match rate could help states implement additional initiatives.

Managed Care Expansion. Under the current program, states continue to expand managed care programs. This trend is likely to accelerate looking to 2014 with the expansion in Medicaid under ACA. GAO has reported recently that CMS oversight of managed care rate-setting has been inconsistent and oversight of supplemental payments needs improvement.[76] As more complex populations are moved into managed care arrangements it will also be important to develop initiatives to evaluate utilization and if beneficiaries are receiving the correct amount of care.

Looking Ahead

Under the current system, states and the federal government share in the financing of Medicaid and in the administration of the program. Both states and the federal government have an important interest in ensuring program integrity. The DRA in 2005 and then the ACA provided new tools and investments to implement program integrity efforts in Medicaid. Although a number of federal and state initiatives are showing positive results in combatting fraud and abuse and in improving program integrity in Medicaid, there is room for improvement and many challenges remain.[77]

Looking ahead to 2014, the ACA will expand Medicaid to new beneficiaries, providers, and managed care plans. The increase in scope will present new program integrity challenges, including balancing the needs to increase the number of participating providers and plans, while also ensuring that these providers are "good actors" and will not engage in waste, fraud, or abuse. The large increase in enrollment in managed care plans will exacerbate the current challenges in monitoring program integrity outside the fee-for-service delivery system. Another area to monitor will be related to ensuring program integrity in the newly established demonstration programs for dual eligible beneficiaries (those eligible for Medicare and Medicaid). The duals are a high-need and high-cost population, so while efforts to better integrate care hold promise for better patient outcomes, opportunities to integrate financing could place large sums of money for vulnerable populations in public programs into the hands of providers and plans. Therefore, a high level of scrutiny around the development of these demonstrations is critical.

More immediately, Medicaid will remain in the middle of budget debates as states continue to face fiscal challenges and there is continued focus on reducing the federal deficit. One proposal at the federal level is to convert Medicaid into a block grant and give states additional flexibility to administer their programs. While some argue that reduced federal funding will encourage more efficiency and less fraud, others argue that more flexibility will mean less federal oversight and more potential (not less) for waste, fraud, and abuse. This tension between flexibility and oversight will be central to federal deficit reduction debates. While there are no estimates that suggest eliminating waste, fraud, and abuse will solve all health care cost problems, scarce resources make it imperative to ensure that tax payer dollars are spent appropriately through Medicare and Medicaid.

[1] Recent Congressional hearings include: House Energy & Commerce Committee hearing, "Waste, Fraud, and Abuse: A Continuing Threat to Medicare and Medicaid", March 2, 2011; House Committee on Oversight & Government Reform hearing, "Examining Abuses of Medicaid Eligibility Rules", September 21, 2011; House Committee on Oversight & Government Reform hearing, "A Medicaid Fraud Victim Speaks out: What's Going Wrong and Why?" December 7, 2011; Senate Committee on Finance hearing, "Prescription Drug Abuse: How are Medicare and Medicaid Adapting to the Challenge, March 22, 2012; Senate Committee on the Judiciary hearing, "Protecting Medicare and Medicaid: Efforts to Prevent, Investigate and Prosecute Health Care Fraud", March 26, 2012; Senate Committee on Homeland Security & Government Affairs hearing, "Assessing Efforts to Combat Waste and Fraud in Federal Programs", March 28, 2012; Senate Committee on Finance hearing, "Anatomy of a Fraud Bust: From Investigation to Conviction", April 24, 2012; House Committee on Oversight & Government Reform hearing,

"Assessing Medicare and Medicaid Program Integrity", June 7, 2012; and Senate Committee on Homeland Security & Governmental Affairs hearing, "Saving Taxpayer Dollars by Curbing Waste and Fraud in Medicaid", June 14, 2012.

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This publication (#8337) is available on the Kaiser Family Foundation's website at www.kff.org.

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