



Medicaid Integrity Program

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December 11, 2008

Goals for this Session

- Provide an overview of the national MIP provider audit program
- Learn about CMS guidance to States on screening for excluded providers
- Address any questions or concerns

Deficit Reduction Act of 2005

- Created Medicaid Integrity Program (MIP)
- Dramatically Increased Resources of CMS & HHS-OIG to Fight Medicaid Fraud
- Funding - \$560M over 5 Years
 - \$255m for Medicaid Integrity Program
 - \$180m for National Medi-Medi Expansion
 - \$125m for OIG for Medicaid Fraud
- Staffing - 100 FTEs for CMS

Medicaid Integrity Program

- Two key statutory requirements
- Create the first national Medicaid provider audit program
- Provide effective support & assistance to help States better combat provider fraud, waste and abuse

Contractor Responsibilities

- DRA required use of Medicaid Integrity Contractors (MICs)
- Four statutory functions
 - Review provider claims
 - Audit provider claims
 - Identify overpayments
 - Educate providers on payment integrity & quality of care

Audit Objectives

- To ensure that paid claims were:
 - for services provided and properly documented
 - for services billed properly using the appropriate procedure codes
 - for covered services
 - paid according to Federal and State policies, rules or regulations

Review of Provider MICs

- Analyze Medicaid claims data to identify high risk areas and potential vulnerabilities
- Provide leads/targets to the Audit MICs
- Use data-driven approach to ensure focused efforts on providers with truly aberrant billing practices

Audit of Provider MICs

- Conduct post-payment audits of Medicaid providers under Yellow Book standards
- Audits will identify overpayments, but Audit MICs will not be involved in collection of overpayments
- No contingency contracts
- Will use State adjudication process



Education MICs

- Highlight value of education in preventing fraud, waste and abuse in Medicaid program.
- Work closely with all of Medicaid's partners and stakeholders to provide education and training.
- Will develop training materials, awareness campaigns, and conduct provider training.

Who Are the Medicaid Integrity Contractors?

Audit MICs:

- Booz Allen Hamilton
- Fox & Associates
- IPRO
- Health Management Solutions
- Health Integrity, LLC

Review of Provider MICs:

- AdvanceMed
- ACS Healthcare
- Thomson Reuters
- Safeguard Solutions (SGS)
- IMS Govt Solutions

Education MICs – Information Experts & Strategic Health Solutions

MIC Procurement Status

- Region III/IV Review MIC task order award - Thomson Reuters - April
- Region III/IV Audit MIC task order award - Booz Allen Hamilton - April
- Region VI/VIII Audit MIC task order award – HMS – September
- Region VI Review MIC task order award – AdvanceMed - September
- Additional task orders for other CMS regions will be awarded in the future.

State's Role with MICs

- Inform MIG of providers that need to be reviewed
- Vet the monthly audit list to make sure MICs are not duplicating/interfering with State activities
- Review draft and final audit reports
- Recover overpayments from providers
- Adjudicate appeals

Common Audit Questions

- When will audits start in my state?
- What kinds of audits and types of providers will be reviewed?
- What are the requirements for the production of record and how many records will be involved?

Provider Exclusions – SMDL 08-003

- Issued on June 12, 2008
- Clarifies CMS policy
- Reminds States of their duty to report to HHS-OIG
- Tells States where and when to look for exclusions
- Reminds States of the consequences of paying excluded providers

Policy Clarification

Federal health care program funds cannot be used to pay for any items or services furnished, ordered, or prescribed by excluded individuals or entities until the provider has been reinstated by HHS-OIG.

Consequences of Paying Excluded Providers

- State payments to excluded persons or entities are not allowable for FFP.
- 42 CFR sections 455.104 and 455.105: States may not seek Federal match for payments to providers that have not supplied ownership and control and business transaction disclosures.
- 42 CFR section 455.106(c)(1): States may deny enrollment to a provider whose owner, agent, or managing employee has been convicted of a criminal offense relating to Medicare, Medicaid, or title XX.
- 42 CFR section 455.106(c)(2): States may deny enrollment or terminate a provider's enrollment if the provider did not fully disclose criminal conviction information.

General Rules on State Obligations

- States must determine whether current providers, provider applicants, all managed care entities and persons with an ownership or control interest in the provider or MCE are excluded from participation in Federal health care programs.
- States must prevent excluded providers from providing services under contract with MCEs and HCBS contractors.
- States must report to HHS-OIG certain disclosures.
- States must report to HHS-OIG adverse actions taken on a provider's participation in the Medicaid program.

Effect of Exclusion From Participation in Medicaid

- September 1999 OIG bulletin
- No excluded person can receive any compensation from federal health care programs
- In effect, this bars even janitors if their compensation is derived in any part from Medicaid
- <http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/effectuated.htm>

Where & When to Check for Exclusions

- Where States should check for exclusions:
 - HHS-OIG's List of Excluded Individuals/Entities (LEIE)
 - The Medicare Exclusion Database (the MED)
- When States should check for exclusions:
 - Upon application for enrollment or reenrollment in the program
 - Monthly



Questions?

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