Appendix A

SPIA Case Study Pilot Summary

March 2007

Section I: Scope of State Medicaid Program Integrity

In developing a framework for defining the scope of Medicaid Integrity, CMS (in consultation with its strategic contractor) created a Medicaid Integrity logic model to conceptualize the following components associated with States' efforts to assure the integrity of the Medicaid program:

- **Planning**: Activities undertaken to think strategically about Medicaid Integrity, including the size of the threat to the Medicaid program from fraud, waste, or abuse; identifying the program areas or provider types where the Medicaid program is most vulnerable to fraud, waste, or abuse; and deciding how to target program resources to these most vulnerable areas.
- **Prevention**: Activities used to minimize the risk of fraud, waste, or abuse entering the payment system and activities used to educate Medicaid program staff and providers.
- **Detection:** Activities aimed at recouping overpayments through (1) identifying overpayments and (2) referring fraud cases for investigation and prosecution.
- **Investigation and Recovery**: Activities that deal decisively with (1) recouping overpayment amounts administratively if the evidence is insufficient or inappropriate to support prosecution and (2) with identifying suspected cases of fraud.

The scope of Medicaid Integrity includes the following **core program outcomes** to ensure a return on investment:

- Effectively planning for, allocating, and managing resources to address threats and vulnerabilities to Medicaid Integrity.
- Preventing inappropriate individuals or entities furnishing items or services for payment under Medicaid from participating in the program.
- Preventing individuals or entities who are non-compliant with Medicaid payment policy or quality of care standards from continuing their program participation.
- Optimizing appropriate Medicaid payments and cost avoidance strategies.
- Maximizing Medicaid dollars recovered from identifying overpayments to participating individuals or entities furnishing items or services for payment under Medicaid.
- Taking administrative action and educating non-compliant providers who remain in the program to deter future non-compliance with Medicaid payment rules and regulations.

I.1 Defining the Scope of Medicaid Integrity

Based on analysis of the case study pilot data, the following activities conducted by States fall within the **core scope of Medicaid Integrity activities**:

Planning:

- Developing and regularly updating a documented strategic plan to address how the State maintains control mechanisms designed to minimize overpayments resulting from fraud, waste or abuse and incorporating feedback information from prevention, detection, and investigation/recovery activities;
- Informal discussions and ad hoc meetings with staff and other program integrity partners (e.g., Medicaid Fraud Control Units);
- Regular meetings and conference calls with staff and other program integrity partners; and
- Allocating staff and IT resources to address threats and vulnerabilities to Medicaid Integrity.

Prevention:

- Collecting and verifying information on potential and current providers during the provider enrollment process, including whether they meet State licensure requirements and are not otherwise prohibited from participating in federal health care programs.
- Conducting provider education and training programs about Medicaid payment rules and regulations to foster compliance and publicizing Federal, State, or local administrative and criminal disciplinary actions resulting in sanctions and/or monetary recoveries against non-compliant providers.
- Monitoring potential overpayments and care delivery by non-compliant and/or unqualified providers in fee-for-service and managed care delivery systems.

NOTE: Third party liability (TPL) and prior authorization are not included under the scope of Medicaid Integrity

- Coordinating benefits to avoid third party liability-related payments.[1]
- Conducting prior authorization reimbursement approval for selected acute care and long-term care services.[2]

[1] Most States did consider TPL as a Medicaid Integrity activity, but did not include it in their calculation of return-on-investment.
[2] Most States did consider prior authorization as a Medicaid Integrity activity, but did not include it in their calculation of return-on-investment.

Detection:

- Using data mining techniques to analyze fee-for-service claims and managed care encounter data to identify potential instances of inappropriate utilization of Medicaid services; conduct post-payment claims reviews of providers and others who deviate significantly from peer group norms or other aberrant patterns of claims submission; and match Medicare and Medicaid claims data.
- Using and maintaining a toll-free fraud hotline and/or other dedicated human intelligence platforms to receive tips about overpayments.
- Using information shared by other State or federal agencies to detect Medicaid fraud, waste, and abuse.
- Conducting provider-specific audits.
- Referring overpayment cases of suspected fraud to federal, State, and local law enforcement authorities for criminal investigation (e.g., the State Attorney General's Medicaid Fraud Control Unit).

Investigation and Recovery:

- Investigating overpayment cases for possible administrative action consistent with State law, rules, and regulations.
- Recovering identified overpayments from fraudulent and non-fraudulent providers.
- Imposing appropriate administrative sanctions on non-compliant providers.

I.2 Variation in State Medicaid Integrity Activities & Programs

Variation in State Medicaid Integrity programs presents challenges in functionally defining the scope of Medicaid Integrity on a national level. Analysis of the case study data suggests that State Medicaid Integrity programs are functionally organized into one of the following structural models:

- **Inspector General (IG) Model.** A centralized Office of Inspector General (or equivalent) within the State that is independent of the Medicaid program. It conducts and supervises all prevention, detection, audit, and investigation efforts for all Medicaid payers (e.g., Medicaid program, Office of Mental Health, Alcohol/Substance Abuse, and/or Long Term Care/Aging Services).
- **Distinct Program Integrity Model.** A distinct Program Integrity unit exits within the State Medicaid program. Medicaid Integrity activities such as prevention, detection, audit and investigation lie wholly within the State Medicaid Agency but are not necessarily centralized in a Medicaid "Program Integrity Unit."
- **Hybrid Model**. Medicaid Integrity activities are distributed across multiple bureaus, offices, or units throughout the State Medicaid Agency. There is no distinct Program Integrity unit. The State Medicaid Agency may conduct and supervise all prevention, detection, audit and investigation efforts for the Medicaid program, while the State's

Offices of Mental Health, Alcohol/Substance Abuse Services, and/or Long-Term Care/Aging may also have their own payment integrity activities that are not under the direct control of the State's Medicaid Director.

Section II: Proposed State Medicaid Integrity Profile Template

Criteria for Element Selection:

- Medicaid program descriptive information should give meaningful insight into the context of the scope of Medicaid Integrity activities.
- The element appears essential for measuring the performance of Medicaid Integrity activities.
- The element can be reported and measured validly and reliably by States

CMS understands that before collecting these data on a national basis, the definitions for the proposed elements need to be clearly defined to ensure that States have a solid understanding of what information to collect and provide to CMS.

Table 1. SPIA Case Study Pilot – Proposed Profile Elements

#	MEDICAID INTEGRITY PROPOSED PROFILE ELEMENTS	CORE MEDICAID INTEGRITY ACTIVITY/PROGRAM OUTCOME
SECTION I: MEDICAID PROGRAM DESCRIPTIVE INFORMATION		
1	Medicaid Enrollment - Fee-for-service recipients - Managed care enrollees - Total	Planning
2	Medicaid Expenditures - Fee-for-service program - Managed care program - Total	Planning
3	Medicaid Integrity budget (in dollars)	Planning
4	Estimated of expenditures for all Medicaid Integrity activities	Planning
5	Organizational structure for Medicaid Integrity activities within State - IG model - Distinct PI model - Hybrid model	Planning
SECTION II: MEDICAID INTEGRITY PLANNING		
6	Total number of FTEs by position type	Allocation of Staff Resources
7	Total number of FTEs by employment type (permanent, temporary, contractor)	Allocation of Staff Resources
8	Inventory of Medicaid Integrity information technology (IT) resources	Allocation of IT Resources
9 9a 9b	Does the SMA have a documented strategic plan addressing how the Agency maintains control mechanisms designed to minimize inappropriate payments resulting from fraud, waste, or abuse? (Y/N). If yes: - When was document last updated (for FFS vs. managed care programs) - How frequent are updates (for FFS vs managed care programs)	Strategic Planning
10	Inventory of risk assessment tools used to assess vulnerability to fraud, waste, and abuse	Strategic Planning
SECTION III: MEDICAID INTEGRITY PREVENTION		
A. PROVIDER ENROLLMENT		
11	Total numbers of providers, by provider type (?)	Provider Enrollment
12	Pre-enrollment screening conducted on providers (e.g., In-State licensing board, Out-of-State licensing board, HHS OIG's List of Excluded Individuals and Entities)	Preventing unqualified individuals or entities from entering the program
13	Pre-enrollment screening conducted on parties related to the provider who were identified in the enrollment application	Preventing unqualified individuals or entities from entering the program

#	MEDICAID INTEGRITY PROPOSED PROFILE ELEMENTS	CORE MEDICAID INTEGRITY ACTIVITY/PROGRAM OUTCOME
14	Re-enrollment cycle for providers, by provider type	Preventing non-compliant providers from continuing their participation in the program
15	Does the State have written policies giving direction to MCOs on the types and frequency of background screenings that should be conducted on staff or contracted providers? (Y/N)	Preventing unqualified individuals or entities from entering the program
16	Total number of annual applications, all providers	Provider Enrollment
17	Total number of annual approved applications, all providers	Provider Enrollment
18	Percentage of providers applied for enrollment, but were denied	Preventing unqualified providers from entering the program
19	Percentage of providers involuntarily dis-enrolled for reasons of billing or other misconduct	Preventing non-compliant providers from continuing their participation in the program
20	Does the State maintain a list of its own providers who have been involuntarily dis-enrolled? (Y/N)	Preventing non-compliant providers from continuing their participation in the program
21	Are there caps on provider enrollment? (Y/N)	Preventing unqualified individuals or entities from entering the program
B. THIRD PARTY LIABILITY		
22	Does the State consider TPL to be part of its Medicaid Integrity activities? (Y/N)	Scope
23	Does the State include TPL recoveries as part of its Medicaid Integrity return on investment? (Y/N)	Scope
C. PRIOR AUTHORIZATION		
24	Does the State consider prior authorization as part of its Medicaid Integrity activities?	Scope
25	Does the State include prior authorization cost avoidance as part of its Medicaid Integrity return-on-investment?	Scope
D. BUILDING AN ANTI-FRAUD, WASTE, AND ABUSE CULTURE		
26	Mechanisms used to communicate to & educate providers about Medicaid Integrity to minimize inappropriate payments	Provider education
27	Frequency of updates to messages in provider communication/education materials to maintain a deterrence effect	Provider education
28	Language included in MCO contracts related to Medicaid Integrity requirements	Preventing unqualified individuals or entities from entering the program
SECTION IV: MEDICAID INTEGRITY DETECTION		
29	Data mining techniques used to detect Medicaid fraud, waste, & abuse or inappropriate payments	Data Mining

#	MEDICAID INTEGRITY PROPOSED PROFILE ELEMENTS	CORE MEDICAID INTEGRITY ACTIVITY/PROGRAM OUTCOME
30	Overpayments (in dollars) identified through data mining activities	Data Mining
31	Does the State typically extrapolate overpayments? (Y/N)	Data Mining
32 32a 32b	Does the State have a well-publicized telephone hotline, email, and mailing address for the public to report suspected cases of Medicaid fraud, waste or abuse? (Y/N) If yes: - Total number of tips annually, if available - Percentage of tips that resulted in recovery or referral	Data Sharing
33 33a 33b	Does the State have written protocols guiding data-sharing between agencies? (Y/N) If yes: - What other State & Federal agencies share data for purposes of detecting Medicaid fraud, waste, or abuse - Describe data sharing with other State & federal agencies	Data Sharing
34	Number of provider audits conducted - Desk audits - Field audits - Self audits - Combination desk/field - Total	Provider Audits
35	Number of provider audits conducted by: - State staff - Contractors	Provider Audits
36	Overpayments identified through provider audits (in dollars) - Desk audits - Field audits - Self audits - Combination desk/field - Total	Provider Audits
37	Overpayments recovered through provider audits (in dollars) - Desk audits - Field audits - Self audits - Combination desk/field - Total	Provider Audits

#	MEDICAID INTEGRITY PROPOSED PROFILE ELEMENTS	CORE MEDICAID INTEGRITY ACTIVITY/PROGRAM OUTCOME
SECTION V: MEDICAID INTEGRITY INVESTIGATIONS AND RECOVERY		
38	Does the SMA have written policies regarding (Y/N for each): - To whom the fraud or suspicion of fraud should be reported in the first instance? - How the SMA should investigate fraud, waste, and abuse? - How to secure evidence in a legally admissible form? - When and how to contact the MFCU? - How and when to refer to the MFCU? - Evidence necessary and process needed to initiate recovery action? - Who else to contact for advice (e.g., insurers, regulatory bodies, legal advisors, Program Director, press office)? - How to disseminate lessons learned from the case?	Criminal actions
39	Does the State have formalized tracking systems to monitor the progress of Medicaid fraud, waste, & abuse investigations (Y/N)	Administrative actions
40	Does the State reconcile cases with the MFCU? (Y/N)	Criminal actions
41 41a 42b 43c	Does the State impose provider sanctions? (Y/N). If yes: - Number of providers SMA suspended payment - Number of providers SMA referred to licensing board - Number of providers SMA involuntarily dis-enrolled	Administrative actions