STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Program Integrity Impact on Health Equity

Bureau of Program Integrity & Compliance

December 1, 2022

Objective

- Program Integrity (PI) mission and purpose
- Why do we have PI?
- How is PI organized and how does the program work?
- With whom do we collaborate?
- Definition of Fraud, Waste & Abuse
- Types of Medicaid fraud
- PI's Role in the fight against Medicaid
    - Medical assistance fraud lifecycle
    - Medicaid eligibility fraud lifecycle
- Fraud trends & vulnerabilities
    - National perspective
    - Iowa perspective
    - How does Iowa's fraud conviction compare with other states in our region?
- Improper payment error rates
    - What is it?
    - How is it measured?
    - How does Iowa rate?
    - What are key areas impacting improper payments error rates?
- Working collectively in support of health equity

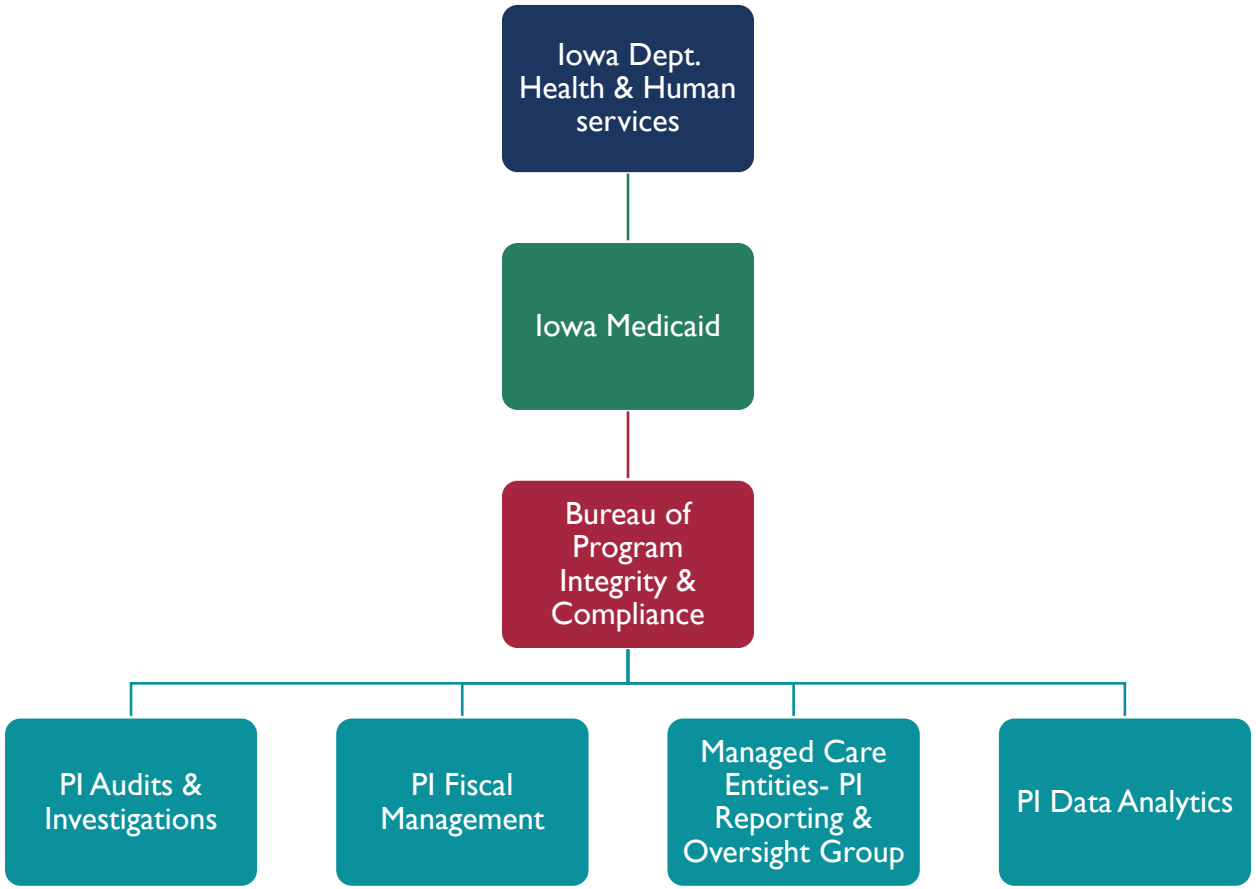
Program Integrity Mission

- Provide systems of sustainable and equitable oversight that targets accountability and compliance, focusing on prevention of fraud, waste and abuse of Medicaid programs.

Why do we have program integrity?

- Ensure member's access to care
  - Right time
  - Right Place
  - Choice of network providers
- Ensure compliance with federal requirements governing Medicaid programs.
- Ensure financial accountability
- Ensure public dollars are spent for services and supports
- Oversight of managed care plans program integrity programs.

How is the Bureau of Program Integrity & Compliance organized?



How does the program work?

- Federal audits/investigations
  - Liaison between local/state and federal law enforcement
  - Provide state policy, rules & regulations support during case investigations
  - Coordinate federal/state compliance audit activities
- Program integrity related audits
  - Performs medical necessity and post-payment reviews
  - Identify improper payments and issue notice of recoveries
  - Perform surveillance activities
  - Perform program compliance reviews
  - Perform managed care oversight
- Other Program Integrity Efforts
  - Provide oversight of provider enrollment/screening process
  - Issues payment suspension and sanctions

Examples of program integrity responsibilities

- Contract compliance oversight
- Conduct compliance audits
  - Fee-for-Service
  - Medicaid managed programs oversight
- Provider enrollment and screening oversight
- Program integrity policy support
- Enforcement
  - Provide education and training
  - Exclusions and sanctions
  - Overpayment recoveries
- Investigate fraud allegations

With whom do we collaborate?

- Iowa Medicaid collaborates with internal and external stakeholders to support our work, to confer and solicit feedback on various program integrity related activities.

Intra-agency Collaboration

Inter-agency Collaboration

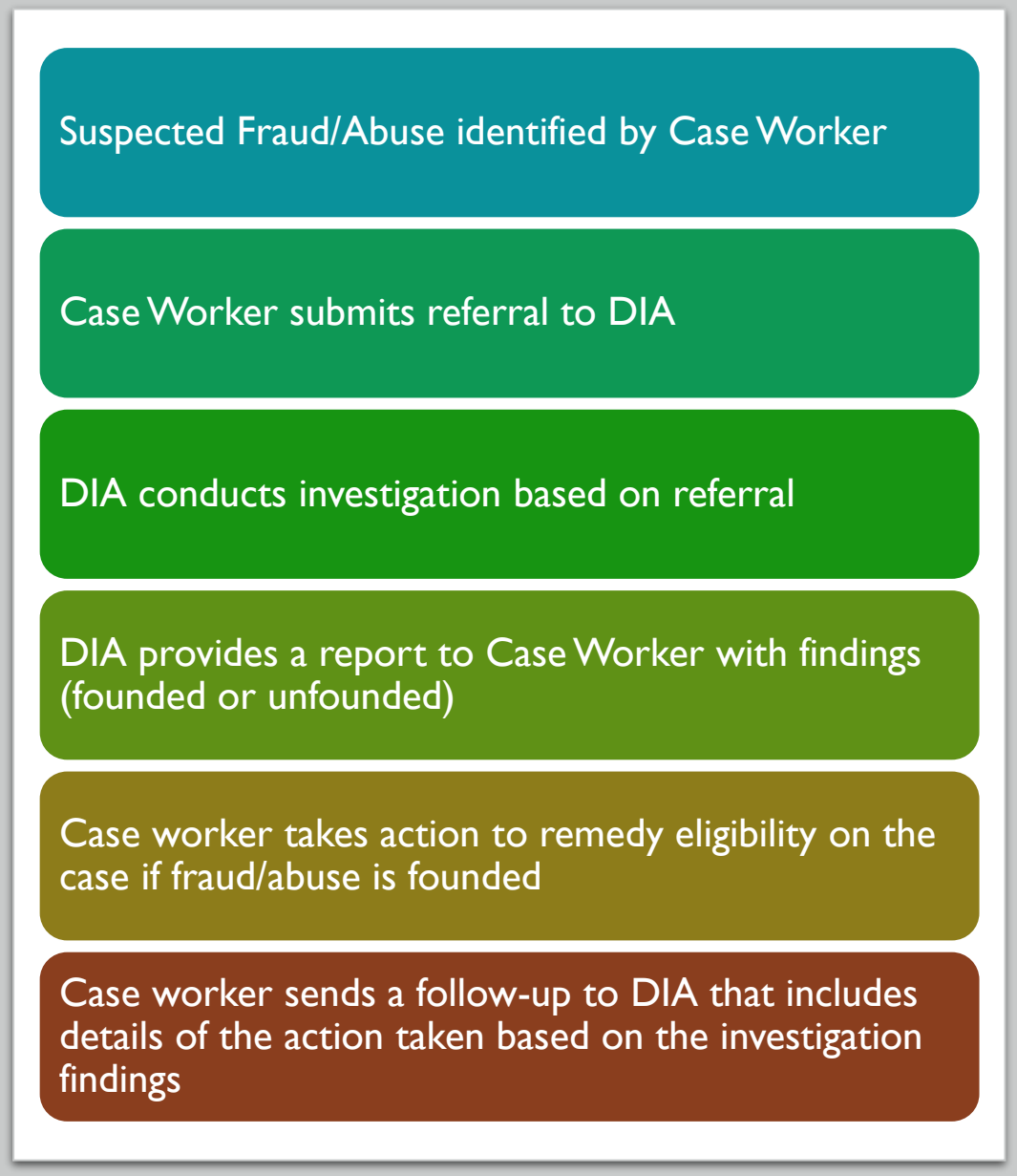
Definition of Fraud, Waste and Abuse

- 42 CFR 433.304 “Fraud”
  - An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
- 42 CFR 455.2 “Abuse”
  - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.
- Waste
  - Waste is defined as overutilization of resources, causing inaccurate payments and unintentional duplication of payments for services.

Types of Medicaid Fraud

- Medical Assistance
  - Intentional claims for services not provided.
  - Providing unnecessary services.
  - Providers ordering unnecessary labs or tests.
  - Durable medical equipment companies submitting claims for services neither ordered nor delivered.
- Medicaid Eligibility
  - Intentional misrepresentation of assets and income to obtain Medicaid benefits he/she is not eligible to receive.
  - Knowingly participate in a kick-back scheme with a provider to obtain Medicaid benefits for the purpose of allowing a provider to bill Medicaid for unnecessary services for a share of the financial gains.

Medicaid Eligibility Fraud Lifecycle



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Medicaid Eligibility Fraud Referrals

TOTAL COST AVOIDANCE

As a result of the bureau's investigative work, the State recognized **$2,791,069** in total cost avoidance for SFY 21. A breakdown of cost avoidance by program is illustrated in Figure 3.

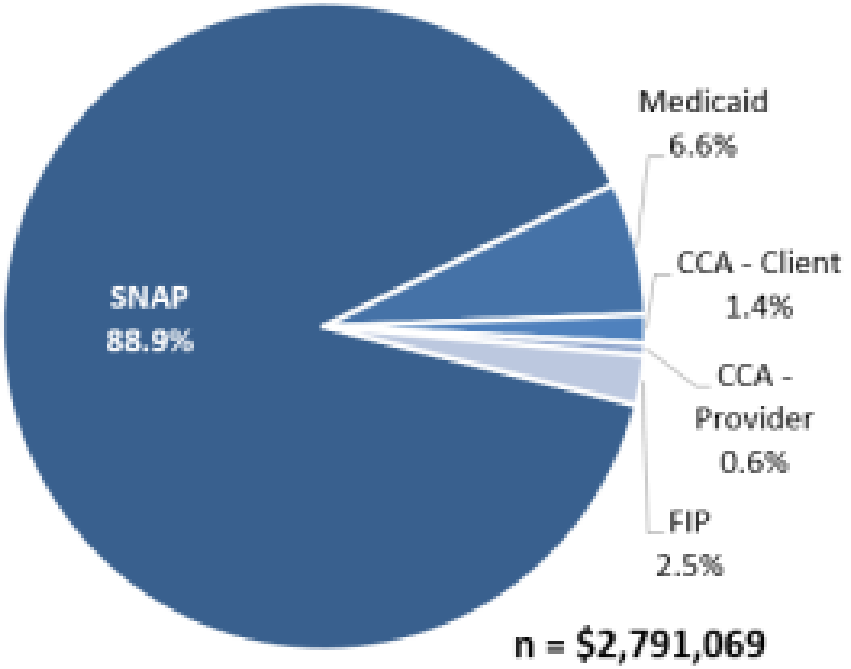
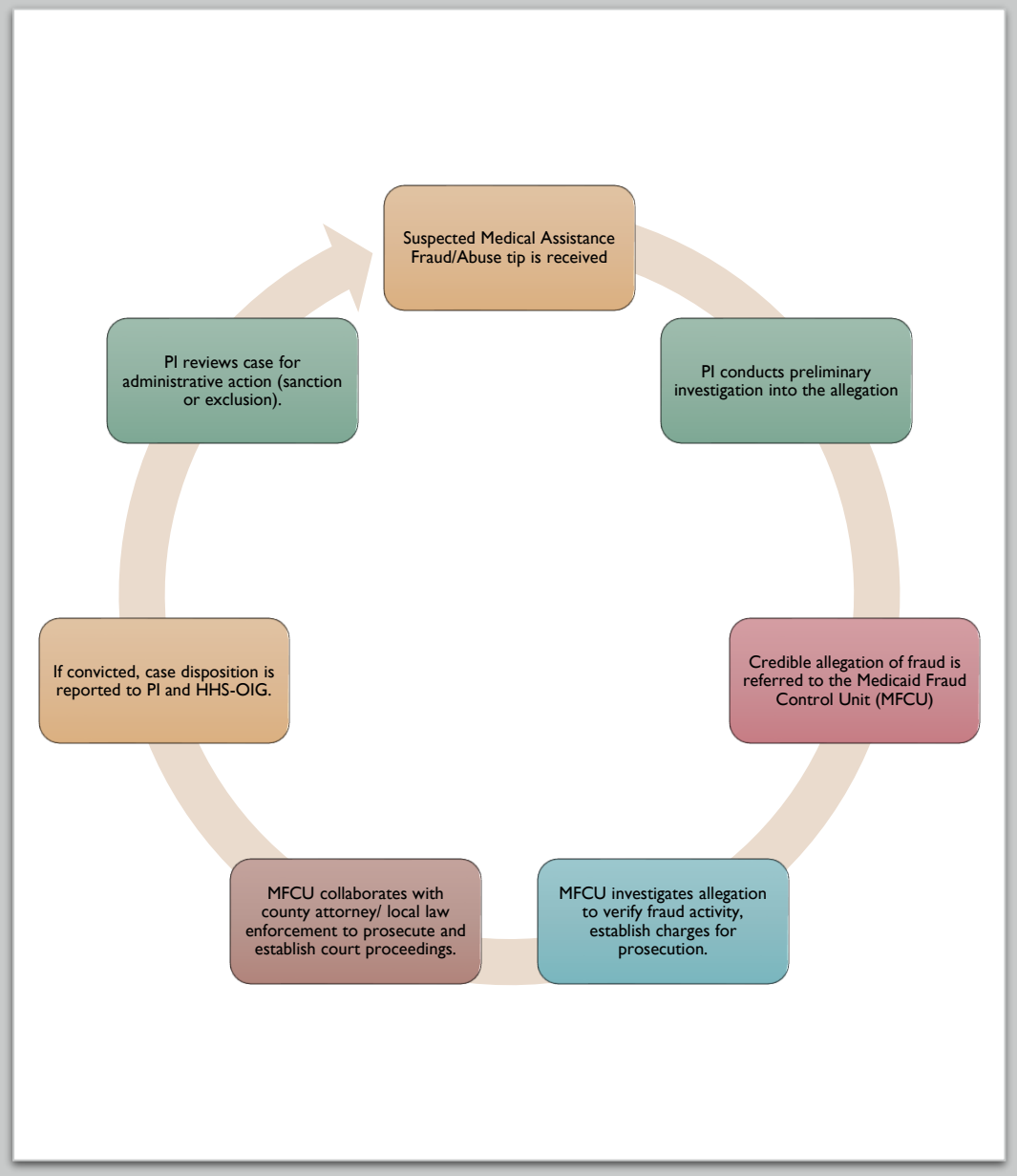


Figure 3. Cost Avoidance by Program, SFY 21

Medical Assistance Fraud Lifecycle



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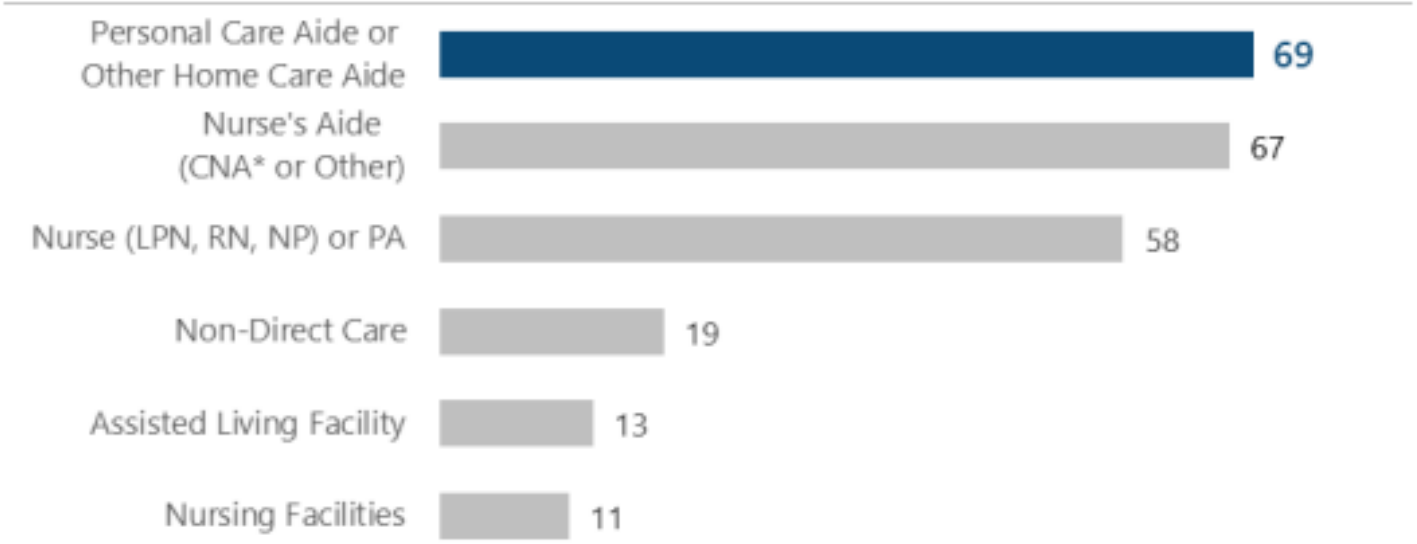
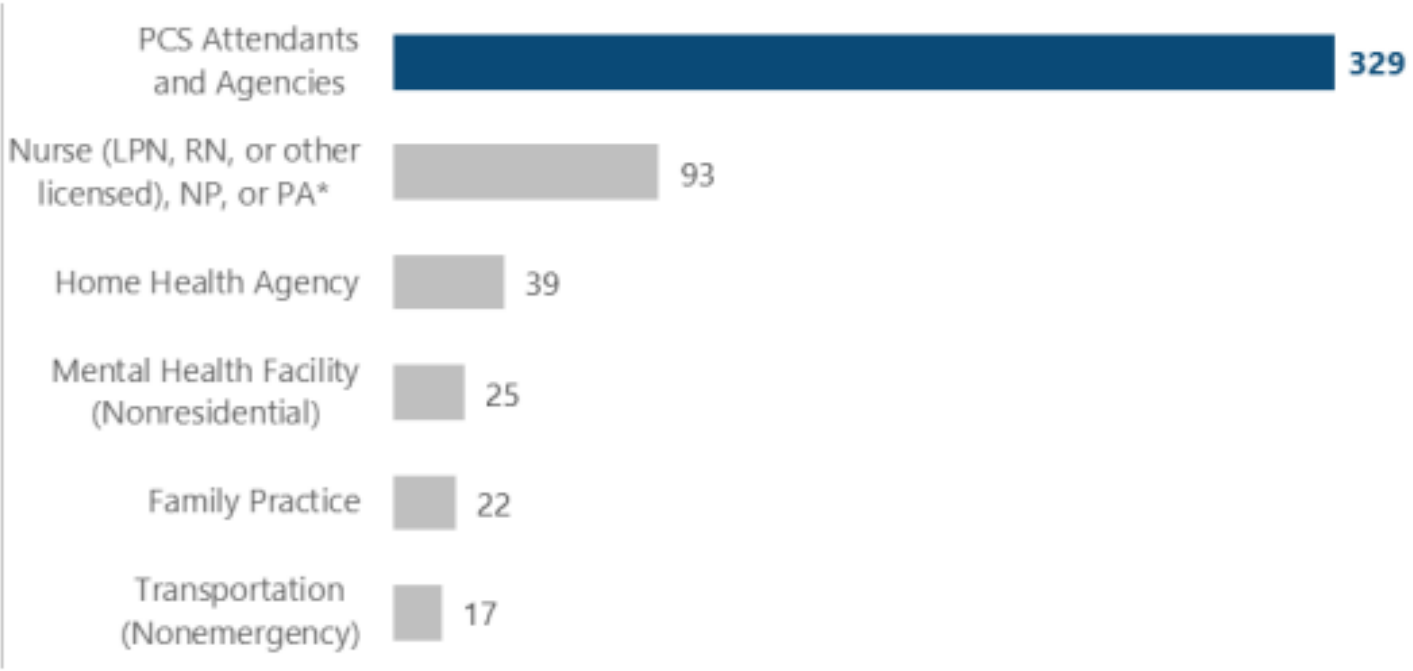
Convictions of Abuse or Neglect by Provider Types



*CNA=Certified Nurse Assistant.
Source: OIG analysis of FY 2021 Annual Statistical Reports.

Control Units Fiscal Year 2021 Annual Report

Convictions of Fraud by Provider Types

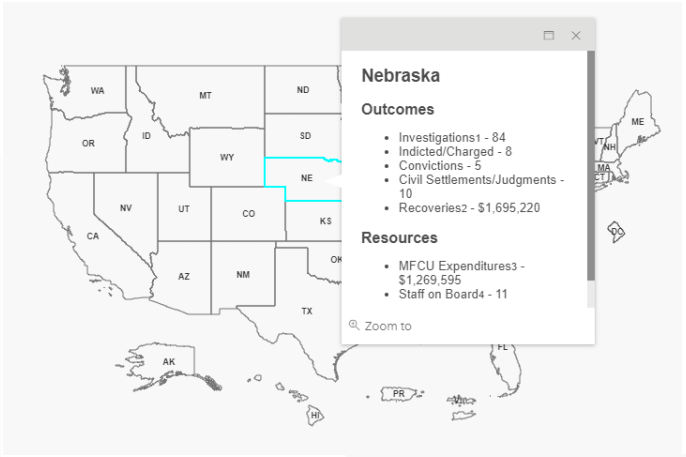


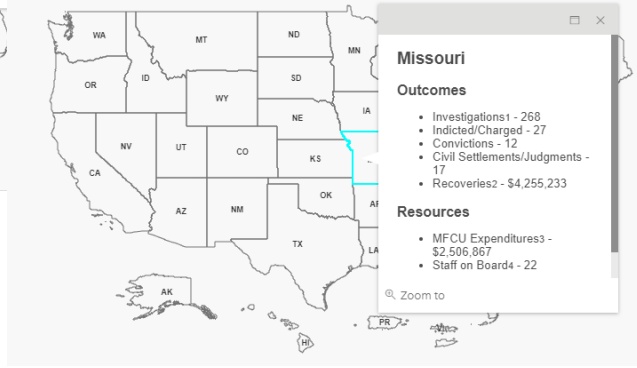
*LPN=Licensed Practical Nurse, RN=Registered Nurse, NP=Nurse Practitioner, and PA=Physician Assistant.
Source: OIG analysis of FY 2021 Annual Statistical Reports.

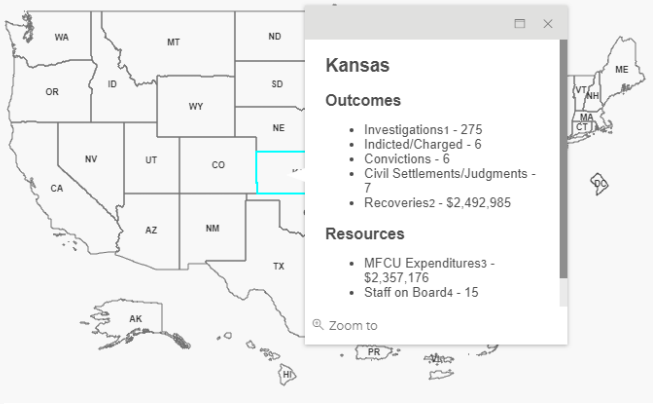
Medicaid Fraud Control Units

Statistical Data for Fiscal Year 2021

Return to Medicaid Fraud Control Units







https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/maps/interactive-map2021.asp

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Program Integrity Vulnerabilities- National Trends

- Initial and ongoing Medicaid eligibility determination
- Telemedicine as a mode of healthcare service delivery system
- Mental health and substance use disorders services
- Behavioral health services
- Misuse of opioids- Drug diversion
- Covid-19 related schemes
- Pharmacy drug rebates
- Durable Medical Equipment
- Home and Community Based-Personal Care Services

Program Integrity Vulnerabilities- Iowa Trends

- Behavioral health services-Excess time billing
- Controlled substances without prior visits or ordering provider reported
- Telemedicine services
- Overuse of modifier 59
- Excessive diagnostics
- E/M upcoding
- Age-inappropriate procedures
- PT/OT/Speech Therapy
- Medical equipment & supplies

How are Medicaid improper payments measured?

- The PERM program measures improper payments in Medicaid and CHIP and produces improper payment rates for each program.
- The improper payment rates are based on reviews of the Fee-For-Service, managed care, and eligibility components of Medicaid and CHIP. This is a measurement of payments made that did not meet statutory, regulatory, or administrative requirements.
- PERM reviews are done by contractors selected by CMS. State staff answer questions and provide support as needed to the contractors in the review process.
- Upon completion of the PERM cycle, the contractor provides CMS with review findings, providing guidance on origin of errors and summarizing state findings.

- The state is responsible for submitting a corrective action plan to address the errors identified by the contractor.

What is the purpose of a Medicaid Eligibility Quality Control (MEQC) program?

- Under the MEQC program, states design and conduct projects to evaluate the processes that determine an individual's eligibility for Medicaid and CHIP. The projects are to identify vulnerable or error-prone areas.
- The parameters of what must be excluded from the sample and the number of reviews needing completed are set by CMS each new MEQC cycle.
- States conduct MEQC reviews during the "off-years" that occur between their triennial PERM review year.

- The MEQC program does not generate an error rate but when an MEQC project concludes, the state must submit to CMS both a case-level report on the results of their project and payment reviews, as well as a corrective action plan to address the errors and deficiencies identified.

Key factors contributing to improper payments of Iowa Medicaid programs

- No documentations to support claimed services.
- Insufficient documentation to support claimed services.
- No documentation to support required verification of an individual's eligibility, such as income, specifically for Medicaid, CHIP, and the Federally-facilitated Exchange.
- Provider failed to respond to auditor's request for medical records.
- Untimely response to medical records request.
- Contact information not current.
- Provider enrollment and screening requirement not met.

Tips for successful PERM experience

ENSURE YOUR CONTACT INFORMATION IS CURRENT WITH IOWA MEDICAID

CONFIRM YOU ARE SENDING THE CORRECT MEDICAL RECORDS

Program Integrity's role in promoting health equity

- Ensure access to quality of care by qualified providers.
- Provider enrollment and screening is compliant with program requirement.
- Provide education and outreach in order to process improve and assist providers with program compliance.
- Promote provider self –audit and process improvement activities
- Perform data analytics to assess risks and vulnerabilities
- Promote reporting of fraud, waste and abuse activities

Who do we contact?

- How to report fraud, waste & abuse
  - fwareports@dhs.state.ia.us
  - 877-446-3787 (toll-free)
- How to contact Program Integrity Unit
  - imepi@dhs.state.ia.us

Questions