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MIP on the radar
the new drive to end Medicaid fraud

Two years ago, CMS launched a new effort to detect and prevent Medicaid program fraud and abuse.

AT A GLANCE

To ensure their billing integrity, providers should:

- Review every aspect of their billing integrity compliance program
- Review the existing quality and methods of their statistical sampling
- Examine an agency's or prosecutor's findings of loss to ensure accurate loss calculation

A significant date in the government's quest to stop Medicaid fraud may well have been July 18, 2005, when *The New York Times* published the first installment in a series highlighting egregious examples of Medicaid providers who purportedly abused the system. But the series not only illustrated examples of fraud and abuse—it also laid much of the blame on state and federal authorities whose chief responsibility was to safeguard the program and strongly suggested that regulators were asleep at the switch. The prevailing sense among lawmakers seemed to be that when it came to prosecuting Medicaid fraud and abuse, inertia had set in among those who were supposed to manage the first line of defense.

Since 2005, many federal and state laws, programs, mandates, and budget increases have been passed directed toward eliminating opportunities for Medicaid fraud, waste, and abuse.

Creation of the MIP

In particular, section 6034 of the federal Deficit Reduction Act of 2005 (DRA) created the Medicaid Integrity Program (MIP), to be implemented by the Centers for Medicare and Medicaid Services (CMS). The MIP's sole purpose is to identify, recover, and prevent overpayments resulting from fraud, waste, and abuse in Medicaid. This ambitious and carefully designed strategy will go into full force late this year or in early 2009.

To carry out the program, CMS is contracting with private entities known as Medicaid integrity contractors (MICs). This initiative is divided into two principal assignments: Medicaid review of provider contractors (by reviewer MICs), and Medicaid integrity audit of task order contractors (by audit MICs). Reviewer MICs will develop a data mining tool to review provider billing databases by introducing fraud and abuse typologies into the mining process.

Once the data mining tool has been developed, the audit MICs will audit targeted providers based on paid claims. During that phase, any findings will be referred to applicable federal and state agencies for prosecution.

The MIP will also support the efforts of state Medicaid agencies through a combination of oversight and technical assistance. Although CMS has a wealth of experience in the financial management of the Medicaid program, the auditing of providers has primarily been the responsibility of the states. The MIP is designed to better coordinate investigations and audits among CMS, the Department of Health and Human Services Office of Inspector General, the states, and other interested agencies to increase the number and effectiveness of fraud, waste, and abuse investigations and improve recoveries.

The DRA defines three main objectives of the MIP:

- A comprehensive review, through the billing database, of Medicaid providers that furnish items or services, with an eye to fraudulent, wasteful, or abusive billing activities
- A comprehensive audit of claims for payment for items or services furnished, as identified by reviewer MICs
- The identification and collection of overpayments made to providers identified through the initiative

As ambitious as the MIP appears, it is just the beginning of the new battle against Medicaid fraud. Many states have reorganized their Medicaid fraud- and abuse-fighting efforts, with new legislation and with the creation of well-staffed Medicaid fraud inspector general's offices to raise the level of enforcement activity and monetary recoveries.

Importance of Statistical Sampling

The MIP represents an effort to increase recoveries consistently from year to year. One of the main features of the program is better coordination among federal and state initiatives, as well as initiatives among the states, through the use of the data mining tool and information sharing.

The data mining tool is expected to be able to introduce fraud and abuse typologies in an ongoing basis, operated by the reviewer MIC, and then to target providers for further audits and referrals for investigations because of the shared characteristics of the typologies.

A criticism lodged against some state enforcement actions is that they often devote a disproportionate number of resources to relatively small, fee-for-service providers—cases that do not yield substantial restitution amounts. Although the MIP will not ignore smaller providers, there likely will be greater enforcement efforts focused on larger providers. In fact, the DRA mandates that any provider receiving $5 million or more of Medicaid funding per year must have an effective compliance program in place. This is not to suggest that no enforcement action will be taken against a provider that receives less that $5 million; however, it may indicate that providers that would naturally bill in excess of $5 million annually, and historically have been high-yield targets by investigators for fraud and abuse (such as durable medical equipment suppliers, hospitals, nursing homes, and pharmaceuticals), are more likely to be targets for the MIP.

> The MIP initiative will likely increase the number of investigations and even criminal prosecutions of healthcare providers, both large and small.

Because Medicaid remains largely a fee-for-service program, the challenge in auditing paid claims for any healthcare investigator is to extrapolate the audit findings of fraudulent or erroneous billings from statistical samples into a larger dollar figure to make the investigative effort worthwhile. Many fee-for-service procedures pay relatively small amounts of money, and to identify even 100 erroneous claims may not add up to much but will consume a high percentage of investigative resources. It is essential that the sample of claims chosen for review by government investigators,

either through chart audits or directly from the billing database, be statistically valid to accurately extrapolate damages over the entire universe of claims. The projection is derived from the findings in the sample; if the sample is not precise, the projection can be inaccurate by a wide margin, and the amount estimated that is due the government can be overstated substantially.

The data mining tool promises to be the most sophisticated and effective weapon in the battle against Medicaid fraud, waste, and abuse. Significantly, a requirement for the reviewer MIC is the use of a qualified statistician—crucial to assist in developing the data mining tool to ensure that the mining technique is grounded in sound statistical principles, both for targeting providers and for selecting sampling criteria.

Depending on the task at hand, there are multiple methods grounded in mathematical principles that will determine the method of selection to derive an unbiased representative sample. Also, regardless of whether litigation is civil or criminal, the government must still prove its findings to a certain standard of proof. The danger of faulty or unscientific sampling may not become apparent until the moment that a finder of fact is required to review the evidence, and by then it may be too late for the government to fix the problem. Once litigation has begun, judges have little patience to wait for the government to go back to the drawing board.

The deficiencies in sampling methodology can manifest themselves in a number of ways. For example, perhaps the sample was chosen using commercial software that did not sufficiently account for bias, was not stratified, or failed to account for variables that need to be introduced into the sampling method. This is particularly true for estimates derived from a universe of healthcare billings, because the data contain variables peculiar to provider type, procedures billed, and other criteria that should be factored into the technique used. In addition, computer

programs cannot be cross-examined; merely presenting the results of what the software sampled without testimony from a qualified statistician whose expertise enabled the software to derive the sample may constitute inadmissible hearsay. At the very least, the method to derive the sample, and thus the extrapolation, would be subject to attack at trial or hearing.

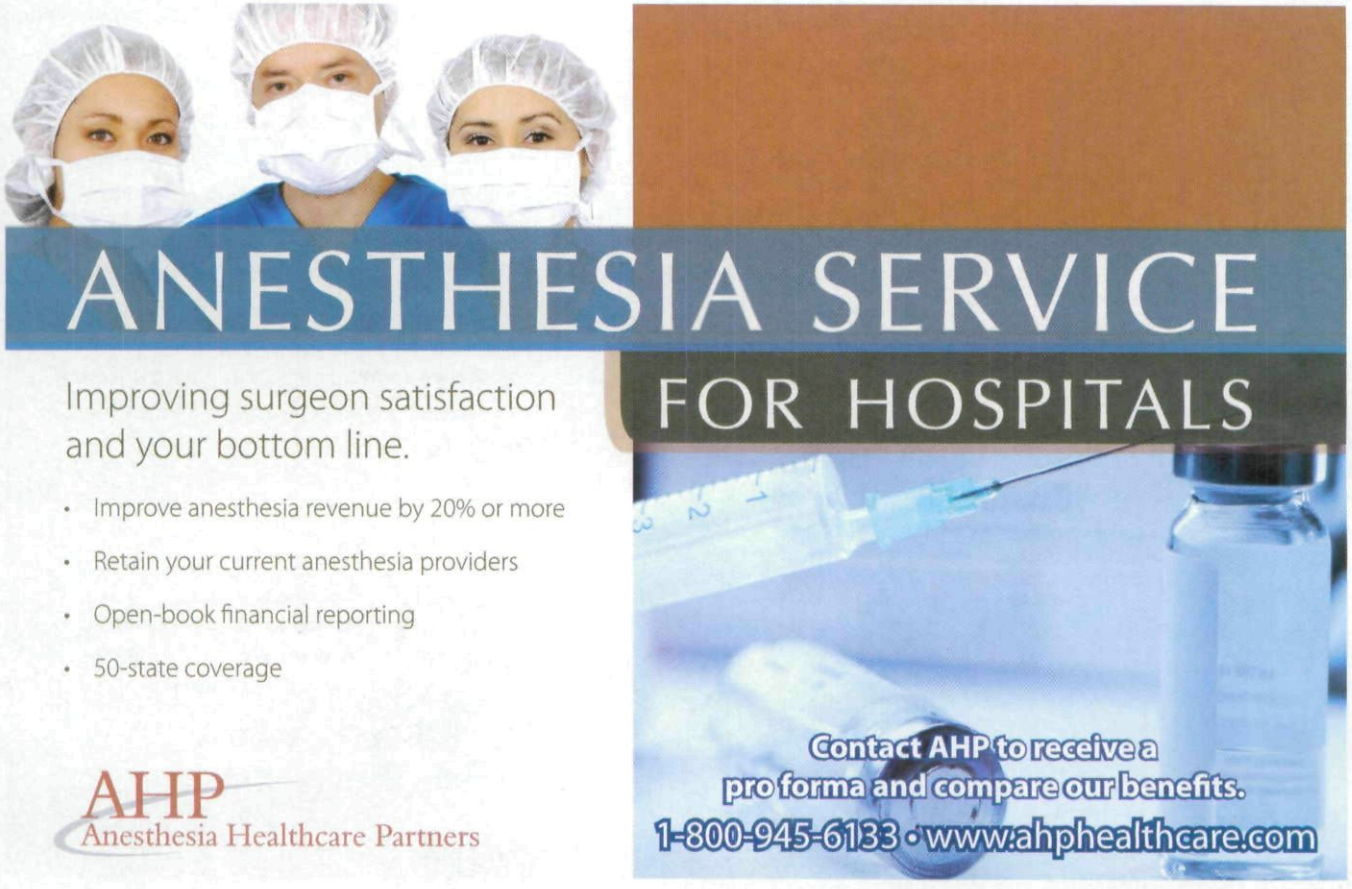
Importance of Process Review

The strategy to implement the MIP is ambitious in scope and, according to CMS, represents the most serious national undertaking to date to bring Medicaid fraud under control.

Consequently, providers should carefully review every aspect of their billing integrity compliance program. An organization's first reaction may be to review and possibly enhance existing written policies and procedures. However, simply relying on the presence of policies and procedures is not enough; implementing practical methods and well-designed procedures to identify and correct billing errors, fraud, and abuse is equally important.

Regardless of provider type, one measure that should be taken to better ensure billing integrity is to increase the frequency of internal statistical sampling. Changes that affect billing integrity can occur gradually and are not readily visible. Increasing the frequency of sampling is a hedge against these changes because it will improve the chances that vulnerabilities will be identified much sooner.

In addition to increasing the frequency of sampling, providers should also review their existing sampling techniques as well as the quality of those techniques, because they may not be either statistically valid or as stringent as CMS's preferred methods, which are grounded in accepted statistical principles, such as stratifying the universe of claims for greater precision in sampling. Properly performed sampling will provide the



MORE ABOUT THE MIP

The Medicaid Integrity Program (MIP) was established by Section 6034 of the Deficit Reduction Act (DRA) to provide resources to fight Medicaid fraud, waste, and abuse. Its major operational roles will be to review provider activities, audit claims, identify overpayments, conduct provider education, and provide effective support and assistance to states in their efforts to combat provider fraud and abuse. CMS has developed, and will regularly update, a five-year comprehensive Medicaid integrity plan to guide MIP development and operations.

The MIP was created with funds that will rise from $5 million in 2007 to $75 million by FY09 and each year thereafter. Congress specifically required the use of contractors to review the actions of those seeking payment from Medicaid, conduct audits, identify overpayments, and educate providers and others on program integrity and quality of care. Congress also mandated that the agency devote at least 100 full-time staff to the project, which will also be in collaboration with state Medicaid officials.

However, the MIP is actually one of three provisions enacted by the DRA to target Medicaid fraud and abuse.

The DRA also includes two False Claims Act-related provisions to promote fraud "whistleblower" activities in Medicaid. Section 6031 of the DRA creates financial incentives for state fraud and abuse laws. If a state enacts a False Claims Act that is closely modeled on the federal version of the law, CMS will increase the state's share of any amounts recovered under such a law by 10 percent. The OIG has released guidelines for state legislatures to enact state False Claims Acts.

Section 6032 of the DRA requires any entity that receives or makes payments under the state Medicaid program of at least $5 million annually, to provide False Claims Act education to their employees.

best offense against fraud and abuse within the facility and the best defense during an audit, potentially saving the organization millions of dollars in fines and restitution.

Significance of Loss Calculation

The MIP initiative will likely increase the number of investigations and even criminal prosecutions of healthcare providers, both large and small. An important area on which providers should focus is careful review of an agency's or prosecutor's findings of loss. The loss calculation is critical because the calculation made by the government will drive criminal sentencing and restitution. Because a considerable amount of a provider's money is often returned to Medicaid in the form of restitution after an investigation, the calculation of loss is very significant.

Because government agencies and prosecutors arrive at multimillion-dollar findings by reviewing a limited number of claims that often involve small dollar amounts per claim, the methodology used to claim huge losses from a sample of a few thousand dollars' worth of erroneous billings should be viewed with some degree of skepticism. Some agencies' statistical sampling and projection methods are more accurate and thorough than others. Deriving millions of dollars of findings from a sample is neither unfair nor wrong, and statistical sampling has been widely accepted for many years as long as the method is statistically valid. Should an investigatory agency or prosecutor's office arrive at findings based on reviewing samples of claims, a provider may very well find it worthwhile to undertake an in-depth review of both the sampling method and the projection of damages. It could potentially save the provider millions in restitution. ●

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