

MITA outlines concepts for making healthcare programs more effective.

A Program Integrity initiative can make them a reality.



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MITA made real with Program Integrity.

The key value derived from Medicaid Information Technology Architecture (MITA) stems not from organizing business areas or describing various architectures, but from actually implementing defined healthcare processes which lead to lower costs and improve outcomes. This occurs when the industry works together to apply the principles of MITA to standardize data access and define common but flexible processes – thus delivering real monetary and health outcome results.

A great example is the attention that the Affordable Care Act (ACA) focuses on encouraging Program Integrity (PI) efforts to reduce fraud, waste and abuse in both Medicare and Medicaid. New legislation requires states to implement coordinated, multi-layered strategies to prevent and recover inappropriate payments. Successful PI efforts involve striking an important balance between protecting beneficiary access to necessary health care services while reducing the administrative burden on legitimate providers and ensuring that taxpayer dollars are not lost to fraud, waste, and abuse.

Processes Involved in Program Integrity

There are a number programs, processes and entities with responsibilities related to Program Integrity. Many of these programs have overlapping objectives. Some of the key processes are described below:

Medicaid Eligibility Quality Control (MEQC)

Federal regulations require states to conduct annual Medicaid eligibility quality control projects.

Medicaid Fraud Control Units (MFCU)

A MFCU is generally part of the Attorney General's office and conducts a statewide program for investigating and prosecuting healthcare providers that defraud Medicaid.

Medicaid Integrity Contractors (MIC)

The MIC is a regional contractor selected and funded by CMS that operates in three distinct components (data, audit and education). The data contractor searches the state Medicaid Statistical Information System (MSIS) fee-for-service data for aberrant providers, who are then audited by the audit contractor. The state recovers the overpayment and returns the federal portion.

Recovery Audit Contractors (RAC)

The RAC is a contingency fee-based contractor program mandated by the Affordable Care Act. While CMS provides states flexibility in contracting and operating their individual programs, the RAC audits the same claims from state data as MICs for overpayments and for mandated identification of underpayments.

Medicaid Integrity Group (MIG)

The MIG review determines if states are complying with the PI requirements in Title 42 CFR (Code of Federal Regulations). This includes having a plan for the identification, full investigation, reporting and referral of suspected fraud and abuse cases to appropriate agencies.

Medicare-Medicaid Data Match Program (Medi-Medi)

The Medi-Medi Program uses algorithms to combine Medicaid and Medicare data to identify improper billing and use patterns. Medi-Medi includes state, regional and national efforts and requires collaboration among state Medicaid agencies, CMS and state and federal law enforcement officials.

Payment Error Rate Measurement (PERM)

PERM reviews three areas: fee-for-service (FFS), managed care and program eligibility for both Medicaid and CHIP. The data is analyzed through sophisticated sampling and data stratification techniques. The results are used to produce national and state-specific program error rates. CMS has developed a national contracting strategy for measuring FFS and managed care programs while states are responsible for measuring program eligibility functions.

Medicaid Integrity Institute (MII)

The MII is the national Medicaid Program Integrity training center for states. Its comprehensive study program includes fraud investigation, data mining, analysis and case development.

Furthering fraud, waste and abuse detection with MITA.

The programs listed above represent some of the diverse approaches currently being used to curtail fraud, waste and abuse in federally funded healthcare. The following sections highlight additional actions that are being taken, and how MITA principles can help automate preventive measures.

Provider Enrollment Review

Many providers serve both Medicare and Medicaid populations, so it's likely that a provider improperly billing or committing fraud in Medicare is doing the same in Medicaid. The ACA now requires additional screening and verification measures for providers in each program. In 2011, CMS implemented the Automated Provider Screening System (APS). It screens Medicare enrollment applications using automated data checks of public and private databases. Providers failing these checks are disenrolled or prevented from enrolling as Medicare providers.

In Medicaid, state agencies must search a number of data sources – with varying degrees of manual and electronic accessibility – to determine if they should exclude a provider from the program. These include the following:

- Automated Provider Screening System,
- Office of Inspector General List of Excluded Individuals / Entities (LEIE)
- General Services Administration Excluded Parties List System (EPLS)
- Social Security Administration Death Master File
- HHS Healthcare Integrity & Protection Database

These repositories currently have gaps and overlaps in the data because each has a slightly different business purpose. Once a provider is added to an exclusion list, they may discontinue performing under that name and license and attempt to reenroll under a new business identity. Searching each of the exclusion repositories manually is both labor intensive and subject to error or delay.

To truly put MITA's principles into practice, a provider enrollment program would need to establish a secure Application Programming Interface (API) to provide electronic searches of these sources – preferably with a query to a single federal provider verification service. Automating these functions with standardized services supports the interoperable connectivity encouraged by the MITA maturity model and the Seven Standards and Conditions. This would reduce the human monitoring effort and improve the likelihood that providers who have committed fraud in one setting will be prevented from billing in others.

Conduent is working closely with a new workgroup within the MITA Technical Architect Committee (TAC) focused on Program Integrity. The goal of this workgroup is to promote awareness through education, establish opportunities for collaboration, compile industry input, and document best practices. The effort will culminate in a proof of concept demonstration project designed to showcase the use of MITA Technical Services to reduce human effort accessing these various provider exception data sources.

Data Analytics and Pattern Recognition

Effectively finding fraud, waste and abuse requires analyzing data through a number of filters. Different patterns emerge when reviewing claim data from distinct vantage points by consolidating data in ways that look within and across both program and service delivery methods.

Similar Provider Specialty

Predictive modeling and enhanced data analysis techniques have found patterns of billing fraud and abuse within and unique to behavioral health, schools, long-term care, home and community based services and other specialties. Finding patterns of billing improprieties can lead to additional edit and audit rules which can be shared across states.

Encounter vs. Fee for Service

There are both similarities and differences found in the billing patterns between fee-for-service claims and those processed by a Managed Care Organization (MCO) and submitted via encounter claims.

Reviewing this data separately and then together can reveal billing anomalies and potentially lead to identifying significantly inflated per member per month expenditures when compared to unmonitored encounter submissions.

Successful PI efforts involve striking the balance between protecting access to health care services while reducing the administrative burden on providers and ensuring that taxpayer dollars are not lost to fraud, waste, and abuse.



Medicare vs. Medicaid

Perhaps the most challenging type of fraud, waste or abuse to detect is that perpetuated across Medicare and Medicaid with dual eligibles, who have some of the highest healthcare expenditures. When either program is evaluated separately, problems may not be apparent; but when compared together, billing irregularities appear. Differences in data content, policies and timing make evaluating this data challenging – and intercepting fraud before payment very difficult.

There are challenges in collecting, combining and comparing data across service delivery methods – either FFS vs. MCO or Medicaid vs. Medicare. Differences in provider and beneficiary identifiers, differences in field definitions or value sets – as well as differences in policy – make integrated data analysis difficult. These differences may lead to false positives and require significant effort from both the agency and provider to verify or justify appropriate billing practices. Reconciling these differences takes time and resources. Where these processes cause excessive administrative burden on the provider, access to care by the members can be negatively affected.

MITA presents the opportunity to simplify the cross-program data comparisons by increasing the standardization of healthcare data. To a large degree, this is being enacted in the ACA by standardizing the operating rules and data content requirements of the HIPAA transactions and by simplifying and standardizing the beneficiary eligibility guidelines. Required use of the National Provider Indicator (NPI) and the eventual implementation of the Health Plan Identifier (HPID) allow for comparisons of providers and plans across programs. Standardization of the Essential Health Benefits provides more comparability and less uniqueness in the healthcare policies of different plans. While the ACA initiated these changes, MITA was an impetus of that standardization.

Sampling vs. Auditing

Another challenge in developing PI solutions involves the approach to data analysis. Programs typically sample data to identify patterns and outliers or conduct a full data review to initiate payment recovery in a pay-and-chase methodology, in which payments are audited for recovery purposes. Sampling is outstanding for identifying suspect or inappropriate billing patterns. After finding a particular pattern of fraud, waste or abuse, the most successful method of increasing the return on investment is to transition from pay-and-chase to a fraud prevention and cost avoidance strategy. This is accomplished by defining and implementing edits, audits and business rules based on the identified patterns of inappropriate billing.

Pay and chase tends to require more human effort and generally has a lower return on investment. However, it can be the most appropriate method to recover improper billing across service delivery methods (FFS vs. Managed Care) or programs (Medicaid vs. Medicare).

The various PI processes listed above tend to use one or the other of these methods. Recovery efforts supplement prevention, and include prosecuting fraud cases in court and pursuing overpayments to providers when they cannot be prevented. However, these overlapping data reviews tend to lead to “audit fatigue” and frustration on the part of many providers.

As a result, the National Association of Medicaid Directors sent a letter to CMS on Medicaid program integrity from the state perspective making the following four overarching recommendations: *

1. Clarify the role of federal and state governments with respect to program integrity responsibilities.
2. Improve collaboration and communication between states, CMS and other federal agencies engaged in health-related program integrity initiatives.
3. Invest in resources tailored to the needs of individual state Medicaid programs.
4. Evaluate "return on investment" of federal and state Medicaid program integrity activities.

Industry Participation in Furthering Program Integrity

The Private Sector Technology Group – Technical Architect Committee (PSTG-TAC, or TAC) is an organization of vendors, states, individuals and stakeholders that plays a key role in implementing the goals of enhanced Medicaid operations by providing a forum to understanding MITA concepts and requirements and sharing innovations and best practices for effective implementation.

TAC sees Medicaid Program Integrity as a real opportunity to further make MITA concepts a reality by working on those areas that benefit most from standardization and common technical services. For this reason, TAC has initiated a new subcommittee focused on Medicaid Program Integrity. The PI Subcommittee will increase and promote awareness and education and establish opportunities for collaboration, compilation of industry input, and documentation of best practices.

The Program Integrity Subcommittee has three objectives:

- Increase awareness of enterprise systems and concepts associated with Program Integrity, including generating a high-level technology blueprint for program integrity.
- Provide a forum for states and stakeholders to share and exchange requirements and challenges with each other and CMS.
- Organize and promote proofs of concepts and pilots that can be pathfinders for change.

The subcommittee's forum will encourage dialog among state healthcare PI stakeholders so they can develop a common lexicon for PI tools and architecture, catalog current and emerging PI tools and technologies and identify cross-industry coordination opportunities and best practices. The subcommittee will also facilitate a better understanding of legislative and regulatory PI requirements and provide education and general awareness opportunities for PI initiatives. TAC also hopes the subcommittee will foster opportunities for program and technical collaboration as well as a nationwide PI healthcare industry readiness program.

Conclusion

Putting MITA concepts into practice takes work – lots of work. But through automated access to key data repositories, standardization of data, sophisticated data management and insightful data analytics, it is possible to see a very real return on investment through the increased maturity of MITA processes such as Program Integrity. Conduent works in partnership with other industry leaders to identify and eliminate healthcare fraud, waste and abuse through PI efforts. Using powerful data analytics, flexible processing rules and intense utilization review activities, we help our clients react to the evolving PI landscape and make efficient use of limited resources – a very MITA-aligned objective.

*Allison, A., & Gordon, D.J. (2012, October). National Association of Medicaid Directors. Retrieved from medicaiddirectors.org; http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/namd_cms_pi_efforts_121005.pdf

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