Overview of Medicaid Program Integrity
Iowa Medicaid Enterprise
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Principles

Medicaid program integrity is based on the following three key principles.

I. Medicaid payments must be:

- ✓ *For Medicaid eligible and enrolled individuals*
- ✓ *For State Plan covered, Medically Necessary, services, which:*
  - ❑ *Do not exceed State Plan limits regarding amount, scope and duration and which,*
  - ❑ *Have received prior authorization and/or are in accordance with an Individual Plan of Care (when required);*
- ✓ *Provided by a qualified, enrolled Medicaid provider;*
- ✓ *Properly billed;*
- ✓ *Paid at the correct rate*
- ✓ *Clinically documented in provider records*

The payment is proper (and, therefore, eligible for federal financial participation) only if all of the above conditions are met. If a payment has been made improperly (which may, of course, occur, in the absence of any intent whatsoever to mislead), the payee must return the entire amount and the State must return to the Federal government the entire amount of the federal financial participation in the payment which was made.

II. The Iowa Medicaid must operate in accordance with all applicable Federal and State statutes, rules, and guidance and an approved State Plan.

In the case of a conflict between State rules, policies and procedures, or the federally approved State Medicaid Plan, and federal requirements, federal requirements control. In the case of a conflict between State rules and policies and procedures and the federally approved State Medicaid Plan, the State Medicaid Plan controls.

III. All state Medicaid policies and procedures should be:

- *Developed in accordance with State statutes and regulations;*
- *Intended to support program performance which meets statutory, clinical and common sense operational and quality performance goals;*
- *Understood by members and providers; and*
- *Applied **consistently** statewide throughout the program.*

This includes the policy regarding exceptions to policy.

Tools and Strategies

Program integrity tools and strategies include:

- Rules
- Manuals

- Provider notices
- Provider Training
- Provider Services Call Center
- Utilization management programs and strategies (e.g. managed care, member lock-in, prior authorization)
- Claims processing systems and procedures
- Surveillance and utilization review systems
- Internal controls (including budget, purchasing, internal audits and financial reporting)
- DIA reviews
- Medicaid Fraud Unit
- External audits (State Auditor, CMS financial management reviews, OIG audits)

APPENDIX

Claims Processing System

The claims processing system (MMIS) reviews each bill or claim as it comes in to determine if the claim is payable. MMIS looks at each box on the claim form to ensure that the member was eligible at the time the service was provided, was medically necessary (through prior authorization, asking for submission of additional documentation, or by looking at the procedure code and quantity along with the diagnosis code), whether the provider is enrolled, checks the rate, and many other items. All of the parameters must be checked and OK for the claim to pay. If not, the claim will either suspend for additional review, or deny.

Additional Descriptions of Other Activities

- SURS – claims analyzed systematically and profiled to identify billing abnormalities. Providers are then selected and documentation reviewed in depth to verify that the documentation of the service exists, the service was medically necessary, and is in compliance with all state and federal rules.

- Internal DHS audits – Providers are randomly selected for audit. The audits review provider records to ensure there is documentation consistent with each claim billed and paid by Medicaid.

- DIA Audits – DHS has a contract with the Department of Inspections and Appeals to perform audits of facilities to ensure accurate expenditure claiming, and assure accuracy of client billing.

- Single State Audit – The Iowa State Auditor performs financial audits of randomly selected Medicaid providers, as well as the "Single State Audit", which is performed on behalf of CMS.

- CMS, OIG, and GAO – These three federal agencies also perform regular reviews and audits of Medicaid including review of comprehensive quarterly financial reports. In the past year OIG has also audited all Medicaid payments for prescription drugs and targeted case management services.

- PERM – This is a federal program aimed at reviewing states' accuracy in determining eligibility and payments. Iowa's review will begin in October 2007.

- Fraud and Abuse – If billing irregularities are identified in any of the above activities, or in any other way, the cases are referred to the DIA Medicaid Fraud and Abuse unit for investigation and potential referral to the County Attorney for prosecution.

- HCBS Waiver Quality Assurance - Quality assurance activities include Outcome Based (OB) provider reviews, consumer interviews, incident report management, and follow-up investigations on provider complaints and allegations of child and dependent adult abuse reports. The OB review process provides a critical analysis of the providers organizational, fiscal, and operational structure as well as the individualized services provided to consumers.

- Licensure and Accreditation - Individual providers' licensure and certifications is key to assuring the quality of services provided by health care providers. Licensure requires providers to meet educational standards, pass examinations proving knowledge and competence, and provide for complaint investigations, fines and sanctions for members who feel they did not receive quality care.

  In addition to the Licensed Practioners of the Healing Arts above, health care facilities are licensed and certified for Health and Safety by the Department of Inspections and Appeals. This process also has complaint and investigation to address quality of care and health and safety issues.

  Many providers must be accredited either by national organization or by DHS. The accreditation process for providers examines the policies and procedures and health care outcomes for providers.

- Other Quality Assurance activities - ICF/MR – IME medical services will conduct an annual quality review evaluating level of care needs, person-centered care planning, effective services delivered timely and discharge plans. These assurances will need to be at a satisfactory level as evidenced by:
  - Services individualized and reflect members' preferences
  - Services implemented as planned and produce desired results
  - Services achieve improved quality outcomes for members