



Last updated 12/30/2024

# **Medicaid Program Integrity for Managed Care Entities (MCEs)**



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# How to Build a Program Integrity Team



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# **FISCAL AND OPERATIONS DIVISION**

## **Office of Program Integrity**

# PRESENTATION

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This training is intended to assist Oregon Managed Care Entities (MCE) to responsibly carry out their fraud, waste and abuse prevention, and compliance and oversight obligations under the applicable contract with OHA and federal and state Medicaid laws.

This presentation and the links imbedded in this document were prepared as educational resources; they are not intended to grant or create any rights, privileges, or benefits for you or your organization. No part of this training should be taken as the opinion of, or as legal advice from, any of the Office of Program Integrity (OPI), the Oregon Health Authority (OHA) or the State of Oregon.

Although every reasonable effort has been made to ensure the accuracy of the information within these training materials, the ultimate responsibility for complying with the federal and state fraud and abuse laws and Medicaid program requirements lies with the provider of services.

# What we will cover

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- Program integrity overview and goals
- Staffing your antifraud team
- Staffing for effectiveness: skills and training
- Staffing for effectiveness: avoiding compliance issues
- Operations to ensure success
- Building a fraud-aware culture

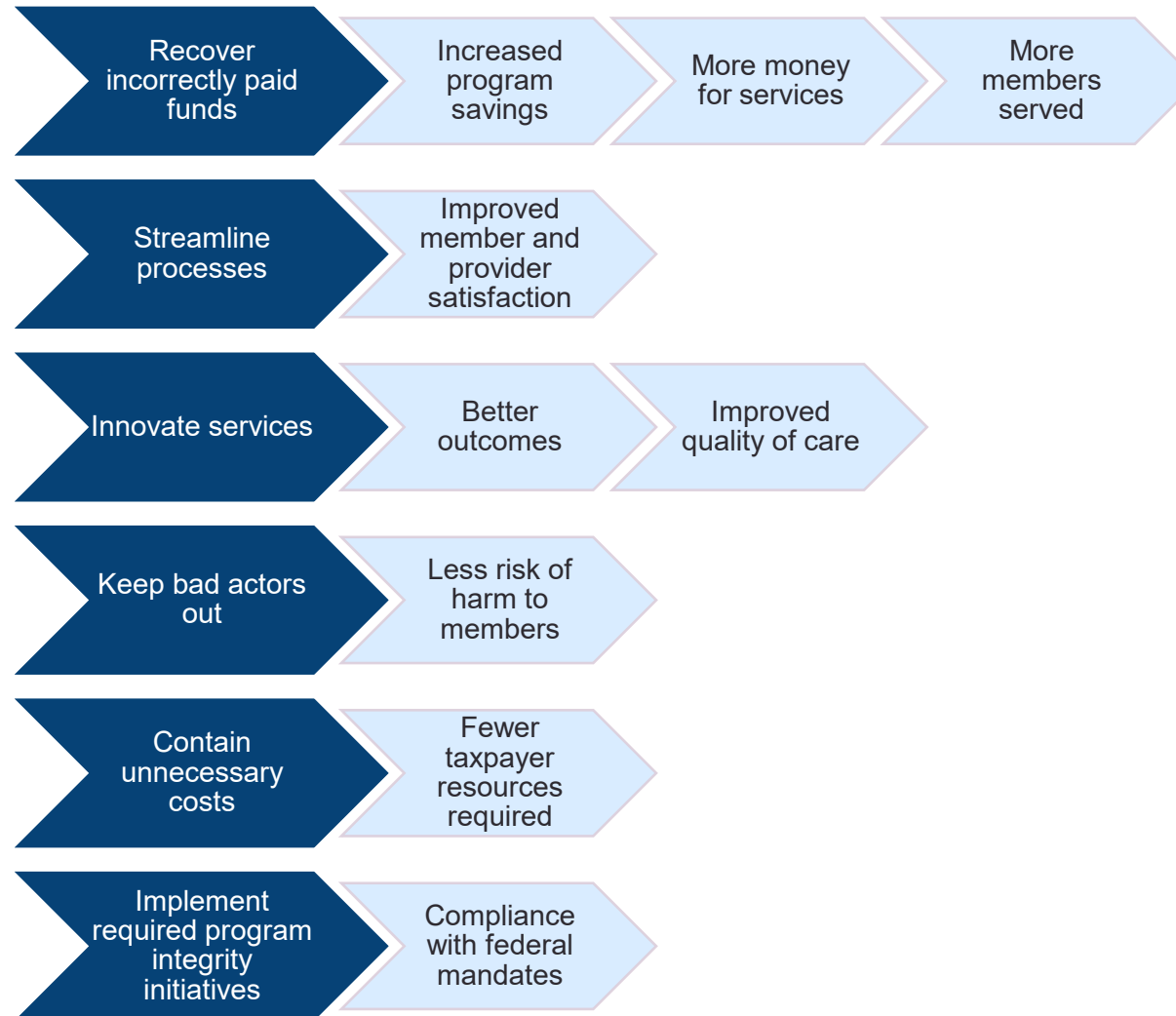
# Program integrity overview and goals

# Why program integrity?

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- Program integrity helps MCEs accomplish their missions.
- A highly effective compliance team and program integrity program can help you:
  - Avoid problems with improperly coded claims or incomplete medical records
  - Address small problems before they become big problems
  - Be better prepared for program integrity audits or investigations
  - Create a fraud-aware culture within your MCE.

# Program integrity actions and outcomes

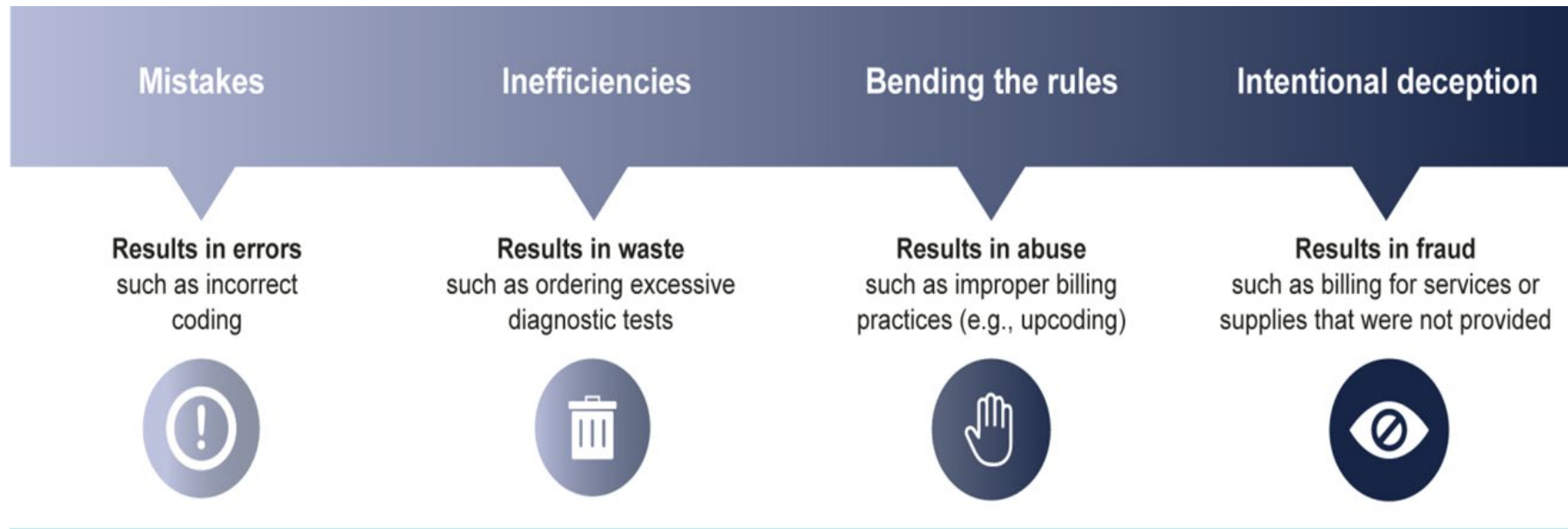




# What is program integrity?

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In Medicaid, “program integrity” means all level of violations, from unintentional mistakes and errors (human or system) all the way to intentional falsification and deception.



# **Antifraud team: Staffing throughout your organization**



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**What areas already support program  
integrity?**

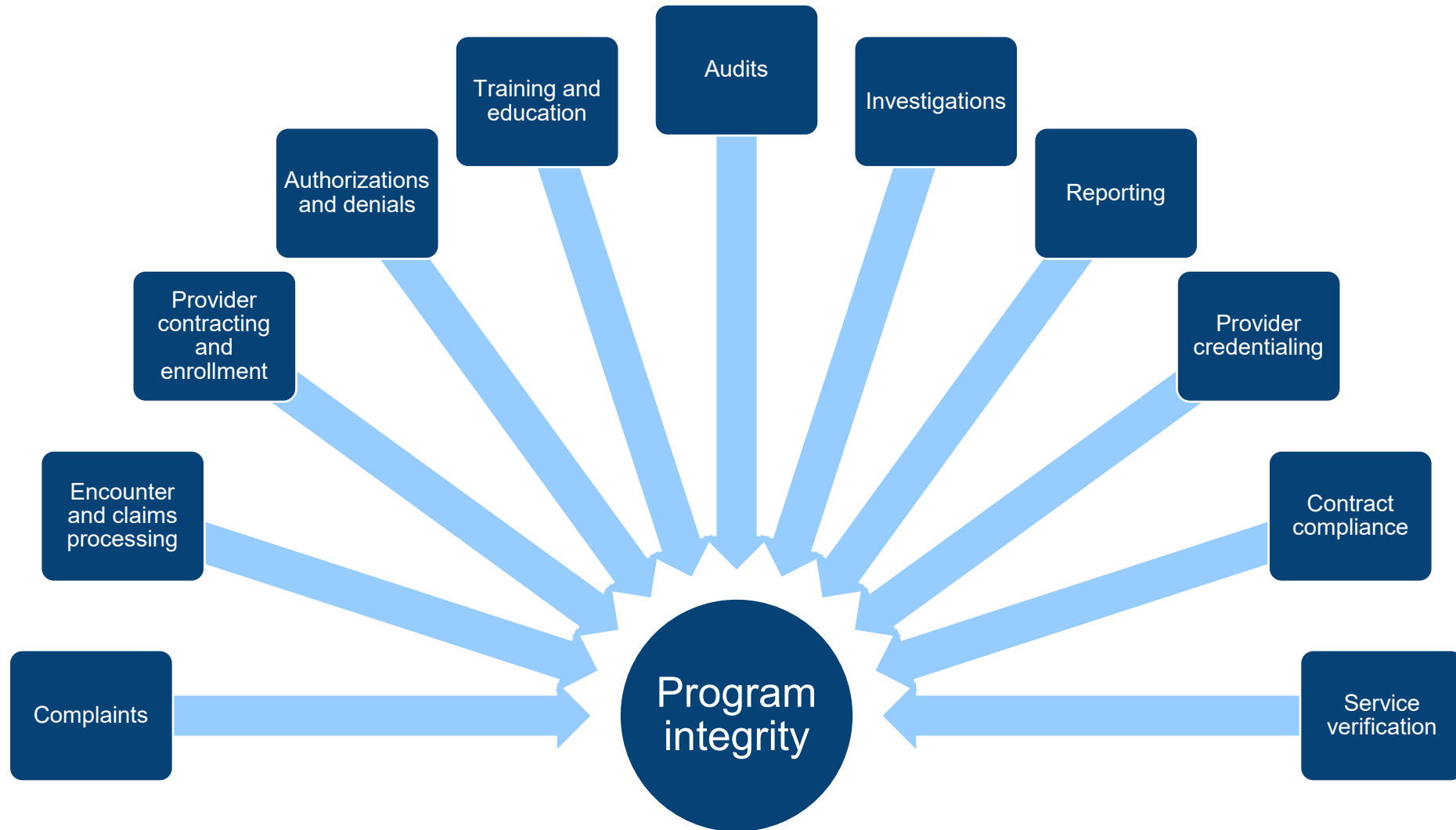
# Program integrity is organization-wide

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- A highly effective organization is prepared to:
  - Promptly respond to all types of Medicaid compliance, fraud, waste and abuse concerns across the program integrity spectrum
  - Correct any program integrity issues identified and
  - Prevent recurrence.
- The activities and tasks performed to ensure program integrity are wide-ranging.
- They encompass many business operations and different teams of employees within an organization.

# Areas that support program integrity

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# Program integrity goals

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- An effective Medicaid fraud and risk management approach has processes, controls and staff to support these three goals.
- The FWA prevention planning process is dynamic. You may need to adjust your plan throughout the year to:
  - Meet priorities and
  - Anticipate and respond to emerging issues with the resources available.

## 1. Prevent FWA and misconduct

- Pre-service safeguards

## 2. Detect FWA and misconduct

- Post-service, prepayment safeguards
- Post-payment safeguards

## 3. Respond

- When integrity breakdowns are identified:
  - Take corrective action
  - Recover misspent Medicaid dollars
  - Refer cases to federal and state agencies and law enforcement

# Pre-service safeguards

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- These activities occur before a service is ever provided or a good is delivered. They can prevent instances of fraud and misconduct from occurring.
- To staff these activities:
  - Consider opportunities to share employees across units/departments.
  - You may find that you already have staff with the expertise needed to support these activities.

## Provider Enrollment

- Prevent entry into the system of providers who do not qualify for participation in Medicaid.

## Member Eligibility

- Prevent entry into the system of members who do not qualify for participation in Medicaid.

## Provider/Beneficiary Education

- Ensure providers and members have clear understanding of the requirements for participation in Medicaid

## Prior Authorization

## Provider Contracts

# Post-service, prepayment safeguards

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- These activities detect instances of fraud and misconduct after a service or good is delivered, but before payment is issued.
- Consider opportunities to address any gaps in expertise within your MCE through:
  - Existing contracts,
  - New contracts, or
  - Partnerships with subcontractors or providers.

Manual  
Claims  
Review

Payment  
Suspension

Claims  
Edits/Audits



# Post-payment safeguards

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- These activities identify integrity breakdowns and respond by:
  - Taking corrective action,
  - Recovering misspent Medicaid dollars, and
  - Referring cases of FWA.
- Consider coordination across teams/units and with subcontractors to ensure you:
  - Do not duplicate work and
  - Efficiently use resources.

## Notification

- Explanation of Benefits
- Remittance Notices to Providers

## Data collection

- Fraud hotline
- Self-disclosure
- Data mining and fraud detection tools

## FWA response

- Fraud investigations and referrals
- Audits, investigations and reviews



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# Staffing for an effective anti-fraud team

# Team responsibilities

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- The ACFE 2018 Report to the Nations found that a dedicated fraud department, function, or team resulted in a 33 percent reduction in median losses from fraud schemes.
- The antifraud team plays a crucial role in executing your fraud risk management activities because of its expertise and ability to work across organizational silos.
- The antifraud team can help your organization achieve a fraud-aware culture.

# Team responsibilities

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Assessing fraud risks

Developing and  
implementing P&Ps

FWA Prevention Plan

- Coordinating risk management processes and mitigation activities

Education

- Raising fraud awareness
- Training other staff on your organizations antifraud policies and procedures.

# Roles

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- Building an effective team means not only assigning:
  - Overall responsibility for the compliance program to a Compliance Officer and
  - Responsibility for compliance tasks to employees
- An effective team must also:
  - Include qualified staff and
  - Train and educate staff frequently.

# Roles

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- You don't need a large antifraud team to make an impact. One or two devoted staff can be sufficient if they are motivated!
- If your organization has the resources to create a bigger team, include individuals with a mix of operations and fraud expertise based on the types of fraud your organization is most susceptible to.

# Roles

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## Compliance officer:

- Overall responsibility for the compliance program

## Program integrity (Anti-fraud) team:

- The qualifications and expertise of an effective team may include:
  - Certified Professional Coders (CPC)
  - Registered Nurse (RN), health clinicians
  - Certified Fraud Examiner (CFE), fraud experts
  - Program and Policy Expertise
  - Financial auditor, financial analysts
  - Research analyst, statistician, data scientists
  - Medical auditor, Medical Reviewer (MR)
  - Highly experienced management

# Skills and expertise

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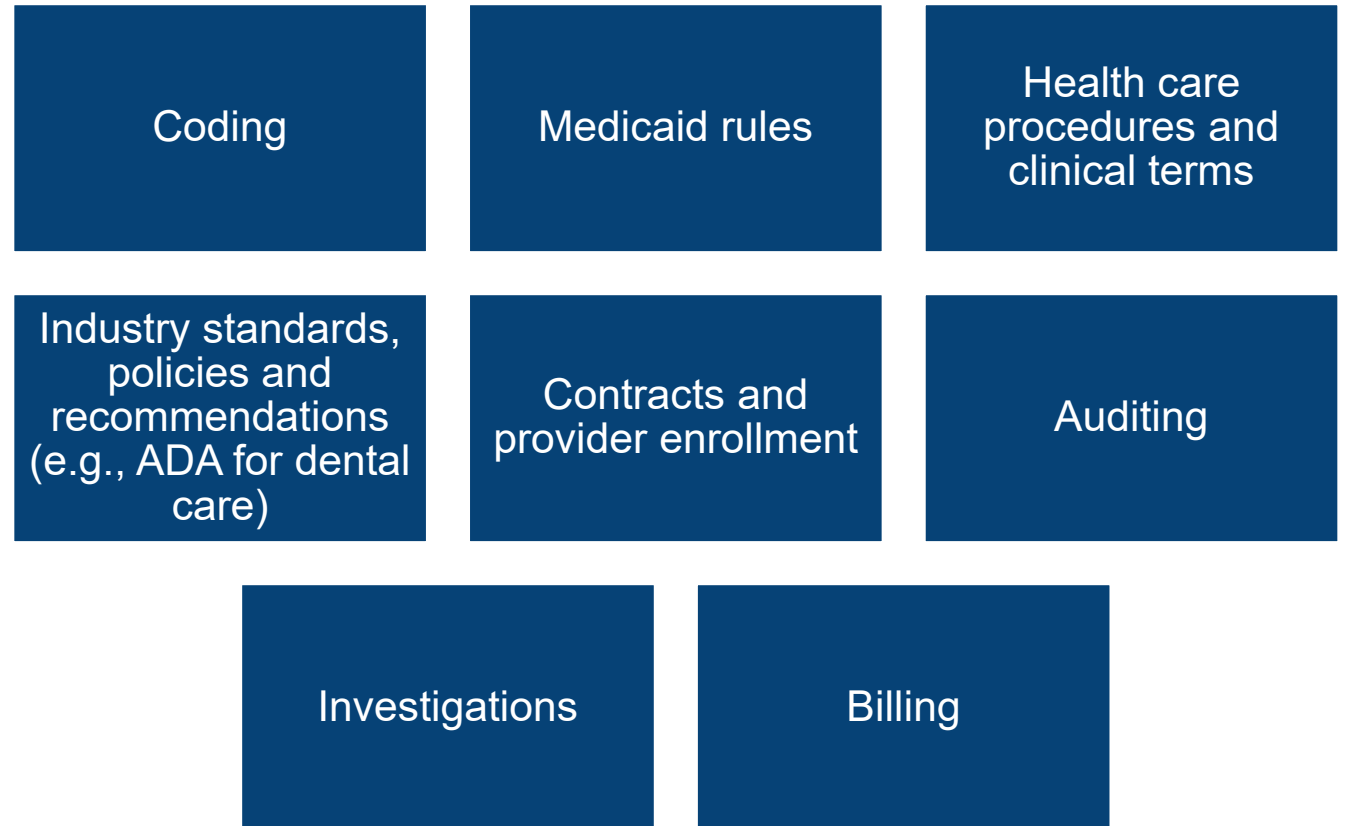
- Certification/credentials are strongly recommended but are not currently required by OHA for MCE compliance officers or the employees within your MCE's program integrity team
- There are many types of credentials/certifications that may be applicable to audits and investigations of healthcare fraud, abuse, and waste. OHA cannot endorse a specific credentialing body, but OHA OPI recommends that MCEs choose credentials/certifications that are appropriate for healthcare, such as:
  - [Certified Professional Medical Auditor \(CPMA\) credential](#)
  - [Certified Professional Coder \(CPC\)](#)
  - [Certified Coding Specialist \(CCS\)](#)
  - [Certified Fraud Examiner \(CFE\)](#)
  - [Certified Public Accountant \(CPA\)](#)
  - [Certified in Financial Forensics \(CFF\)](#)
- There are other organizations that have “auditors” such as bank auditors that would not be applicable to healthcare



# Skills and expertise

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- To prevent, detect and respond to FWA, your team needs skills and expertise in these areas.
- Your team will need staff qualified to meet all levels of violations - mistakes through intentional deception.
- Who in your MCE has these skills?



# Sharing expertise

The skills and expertise found in your organization's existing operations can improve the quality and effectiveness of your antifraud team



# Sharing expertise: Example 1

- Certified Professional Coders (CPC) may be found within your organization's encounter and claims processing operations.
- CPC skills and expertise can improve the quality and effectiveness of your antifraud team:
  - Audits
  - Investigations
  - Training/education
  - Authorization/denials



# Sharing expertise: Example 2

- Research Analyst/Statistician may be found within your organization's encounter and claims processing operations.
- Research analyst skills and expertise can improve the quality and effectiveness of your antifraud team:
  - Audits
  - Investigations
  - Reporting
  - Training/education
  - Service verification
  - Eligibility



# Sharing expertise: Example 3

- Registered Nurses (RN)/Clinicians may be found within your organization's claims authorization/denial operations.
- Clinical skills and expertise can improve the quality and effectiveness of your antifraud team:
  - Audits
  - Investigations
  - Training/education
  - Credentialing
  - Complaints
  - Eligibility
  - Service verification



# Sharing expertise: Examples

## Certified Professional Coders (CPC)

- Authorizations/denials
- Training/education
- Encounter/claims processing
- Audits
- Investigations

## Registered Nurse (RN)/Clinician

- Authorizations/denials
- Training/education
- Complaints
- Provider credentialing
- Service verification
- Member eligibility
- Audits
- Investigations

## Certified Fraud Examiner (CFE)

- Provider contracting/enrollment
- Training/education
- Reporting
- Provider credentialing
- Complaints
- Service verification
- Investigations

## Program and Policy Expert

- Provider contracting/enrollment
- Training/education
- Reporting
- Provider credentialing
- Contract compliance
- Member eligibility

## Research Analyst/Statistician

- Service verification
- Encounters/claims processing
- Member eligibility
- Audits
- Investigations

## Medical Auditor/Medical Reviewer (MR)

- Service verification
- Encounter/claims processing
- Training/education
- Audits
- Investigations

## Financial Auditor

- Audits
- Reporting
- Business operations
- Investigations

## Highly Experienced Management

- Compliance
- Claims/encounter processing
- Member eligibility
- Contracts
- Training/education
- Audits
- Investigations

# Roles

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- Your MCE must establish a reasonable and appropriate standard for these positions based on the activities each role performs
- MCEs must maintain records of employee qualifications, experience and education. This may include:

Policies and  
procedures

Hiring  
practices/minimum  
qualifications

Employment  
verification  
letters/offer letters

Position  
descriptions

Education and  
training records

Professional  
certifications

Contracts or  
agreements

Other documented  
work history

# Roles

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- MCEs often ask what is an “investigator” vs. an “auditor” role
- MCEs are responsible for determining these positions
- In general, these roles are:

## Investigator

- Performs the preliminary work that may lead to an audit such as:
  - Reviewing allegations
  - Identifying and gathering facts of the case/allegation and provider(s)
  - Reviewing data trends or reports
  - Identifying risk
  - Conducting employee, provider or client interviews
  - Determining potential overpayment(s)
  - Referring suspected providers to regulatory bodies (such as professional licensing boards) and to Oregon’s Medicaid Fraud Control Unit (MFCU) and OHA’s Office of Program Integrity (OPI) when provider fraud, abuse or waste is suspected

## Auditor

- Performs the audit:
  - Develops a audit plan and focus
  - Reviews encounter claims and billing codes, Medicaid rules, and the MCE’s own provider payment policies against the medical or financial documentation of a provider to determine whether those claims were paid appropriately
  - Identifies audit findings and the overpayment
  - Communicates audit findings to the provider and recovers any overpayments identified





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# **Training an effective anti-fraud team**

# Education and training

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- A highly effective program provides ongoing training to the antifraud team on:
  - The compliance program
  - Applicable statutes and regulations
  - Coding and billing
  - Documentation
  - Other risk areas

# Staff qualifications

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- Look for opportunities to:
  - Increase the qualifications of existing staff.
  - Train and educate staff frequently.
- Many certifications and training programs exist to enhance staff expertise and qualifications.

## Billing

- Medical Claims Expert
- Certified Professional Biller (CPB)

## Coding

- [Certified Dental Coder \(CDC\)](#)
- [Certified Professional Coder \(CPC\)](#)

## Medical Review Certification

- [Certified Professional Medical Auditor \(CPMA\) credential](#)

## Compliance

- [Certified Professional Compliance Officer \(CPCO\)](#)
- [Certified Fraud Investigator \(CFI\)](#)

And many more....

# Effective and efficient use of resources

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- Are there resources or expertise you need for your program that aren't available in-house?
  - Leverage existing contractors/agreements or
  - Seek new contractors to perform some of this work.
  - Select qualified individuals to join your organization/ team.
- Purchase data analytics antifraud solution.

# **Staffing for effectiveness: preventing compliance issues**



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**Think about the ways staffing can help  
your organization avoid compliance  
issues**

# Example 1

An OIG [report](#) on dental providers concluded that providers:

- Claimed unusually large number of services per day and high payments per child.
- They did not always verify or document medical necessity.
- One-third to two-thirds of the providers worked for a few specific management companies.

To prevent these types of findings, who should be on your team?

## Data experts

- Run reports and analyze large numbers of services

## Clinical experts

- For medical necessity reviews (dental/clinical/RN)

## Coding/claim experts

- Documentation (medical coders)

## Policy or contract experts

- Track providers and qualifications of those providers
- Coordinate communication/ processes across teams, contracts, network relationships

## Financial auditor

- Help disentangle the financial relationships between providers and management companies

## Investigators

- Gather facts and validate information before providers enter Medicaid and as providers participate over time.

# Example 2

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A [report](#) on pediatric dental claims in five states concluded that:

- 31 percent of services billed resulted in improper payments.
- 89 percent of improper payments were due to insufficient documentation.

To prevent these types of findings, who should be on your team?

## Clinical/Dental expert

- Knowledge of dental procedures and clinical terms
- Understand ADA and PDA policies and recommendations

## Certified Professional Coder

- Deep knowledge of dental codes
- Dental billing expertise

## Medical Auditor/Medical Reviewer

- Review dental documentation and dental charts.
- Familiar with Medicaid dental rules



# **Operations to ensure success of an antifraud team**

# Operations to ensure success

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- Has your organization implemented operations to:
  - Ensure success of the team and
  - Sustain that success over time?
- Here are some suggestions:

## Use FWA Deliverables

- Use FWA prevention plan for staffing/training efforts.
- Use Annual FWA Assessment to report how its going

## Employee Training

- Regularly review and update training programs.
  - Try different approaches.
  - Use “real-life” examples.
- Make training completion a job requirement.
- Test employees’ understanding of training topics.
- Maintain documentation to show which employees received training.
- Train the Board

## Team Training and Education

- Train yourself and your compliance staff.
- Stay up-to-date and get ideas:
  - Attend conferences and webinars
  - Subscribe to publications and OIG’s email list
  - Monitor OIG’s and CMS’ websites
  - Network with peers

# Operations to ensure success

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- Learn more by reading [OLG's guide to building an effective compliance program](#)
- Build and support a fraud-aware culture
  - Having employees and management in your MCE that understand compliance and fraud risks/concerns helps the antifraud team accomplish its goals.

# Building a fraud-aware culture

# Building a fraud-aware culture

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- Fraud-aware culture is key for program integrity.
- Such a culture can even act as a preventive measure for combating FWA at your organization.
- Organization responses occur within in different departments. To a achieve a fraud-aware culture throughout your MCE:
  - Building a strong structure is important.
  - Consider the skills and resources your organization needs to identify and respond to the full spectrum of program integrity issues, from mistakes through intentional deception.

# Supporting a fraud-aware culture

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- To support a fraud-aware (and antifraud) culture across your organization, your antifraud team can offer expertise, resources and support in many areas.
- Here are some examples.

## Education and training

- Create and maintain guidance, templates, and evaluation documentation
- Offer technical assistance
- Identify improvements needed and communicate the information back to MCEs departments

## FWA prevention and detection

- Prevent and detect unethical conduct
- Quickly and effectively identify and address suspected FWA concerns
- Create and maintain a case management program

## Contract support

- Become experts in the Medicaid contract(s)
- Evaluate and identify gaps in data gathered for contract deliverables
- Identify improvements needed to provider agreements and subcontract standard language to support MCE's anti-fraud efforts
- Processes to evaluate and correct contract non-compliance

## Encounters and claims

- Prevent overpayments before they occur
- Ensure MCE resources and money go to providers who deliver high-quality care

# Building a culture of integrity

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A culture of integrity can also support a fraud-aware culture.

Here are some characteristics of a culture of integrity.

## Organizational values:

- A set of clear values that, among other things, emphasizes the organization's commitment to legal and regulatory compliance, integrity, and business ethics.

## Tone at the top:

- Leadership across the organization encourage employees and business partners to behave legally and ethically, and in accordance with compliance and policy requirements.

## Consistency of messaging:

- Operational directives and business imperatives align with the messages from leadership related to ethics and compliance.

## Middle management carries the banner:

- Front-line and mid-level supervisors turn principles into practice.
- They often use the power of stories and symbols to promote ethical behaviors.

## Comfort speaking up:

- Employees across the organization are comfortable coming forward with legal, compliance, and ethics questions and concerns without fear of retaliation.
- When people believe that they will be heard, their level of trust in the organization increases. This in turn leads to higher-performing teams and increased employee engagement.

# Building a culture of integrity

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More characteristics  
of a culture of  
integrity

## Accountability:

- Senior leaders hold themselves and those reporting to them accountable for complying with the law and organizational policy.

## The hire-to-retain life cycle:

- The organization recruits and screens employees based on character, as well as competence.
- The on-boarding process steeps new employees in organizational values and mentoring also reflects those values.
- Employees are well-treated when they leave or retire, creating colleagues for life.

## Incentives and rewards:

- The organization rewards and promotes people based, in part, on their adherence to ethical values.
- It is not only clear that good behavior is rewarded, but that bad behavior (such as achieving results regardless of method) can have negative consequences.

## Procedural justice:

- Internal matters are adjudicated equitably at all levels of the organization.
- Employees may not always agree with decisions, but they will accept them if they believe a process has been fairly administered and they have been treated as such.



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