Susan Montee, JD, CPA
Missouri State Auditor

SOCIAL SERVICES

MO HealthNet Division

Program Integrity Unit

June 2010

Report No. 2010-70

auditor.mo.gov

Office of the
Missouri State Auditor
Susan Montee, JD, CPA

June 2010

YELLOW SHEET

The following information and findings were included in our audit of the MO HealthNet Division, Program Integrity Unit.

The State Auditor is required by state law to conduct an audit of the Department of Social Services (DSS), MO HealthNet Division, Program Integrity Unit (PIU) "…to quantitatively determine the amount of money invested in the unit and the amount of money actually recovered by such office." The PIU annual report for the year ended June 30, 2008, did not include some information required by state law. The participant investigations completed by the MO HealthNet Investigations Unit and the age and type of provider/participant investigations were not reported. The number of provider investigations conducted by the Attorney General's Medicaid Fraud Control Unit (MFCU) based on DSS referrals, was not reported. Although the annual report included some overpayments, the overpayments identified by the PIU and Cost Recovery Unit were not included. The amount of fines and restitution ordered to be reimbursed, and other required information on provider investigations closed by the MFCU, were also not reported. Additionally, some monetary recoveries (collections) resulting from completed investigations, reviews, or audits were not reported.

Some supporting documentation was not retained and some information was not accurately entered in the overall cost avoidance spreadsheet used to prepare the annual report. Supervisory reviews of information included in the report are not adequate. In addition, the DSS has not established adequate procedures to ensure the correct amounts are brought forward from the supporting data to the annual report and some amounts were not accurately reported. The annual report identified overpayments, collections, and costs; however, these amounts were incomplete and/or misclassified, and the DSS did not disclose in the annual report that some amounts included in the cost avoidance total were estimates. In addition, adjustments to overpayment amounts identified and reported are not tracked and reported in the annual report.

The DSS does not deposit monies recovered by the MFCU in the proper funds as provided by state law. Restitution and investigation/prosecution costs recovered by the MFCU are transmitted to the DSS, Division of Finance and Administrative Services (DFAS) for deposit and recording in the state accounting system. The DFAS deposits these monies to the General Revenue Fund, or Title XIX-Federal and Other Fund, even though the MFCU instructs the DSS to deposit the monies in the MO HealthNet Fraud Reimbursement and Fraud Prosecution Revolving Funds.

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DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION
PROGRAM INTEGRITY UNIT

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STATE AUDITOR'S REPORT

SUSAN MONTEE, JD, CPA

Missouri State Auditor

Honorable Jeremiah W. (Jay) Nixon, Governor
and
Members of the General Assembly
and
Ronald J. Levy, Director
Department of Social Services
and
Dr. Ian McCaslin, Director
MO HealthNet Division
Jefferson City, Missouri

We have audited the Department of Social Services, MO HealthNet Division, Program Integrity Unit, as required by Section 191.909.2, RSMo. The scope of our audit included, but was not necessarily limited to, the year ended June 30, 2008. The objectives of our audit were to:

1. Determine the amount of money recovered by the unit.

2. Determine the amount of money invested in the unit.

3. Determine if the department has complied with certain legal provisions.

Our methodology included reviewing written policies and procedures, financial records, and other pertinent documents; interviewing various personnel of the department, as well as certain external parties; and testing selected transactions.

We obtained an understanding of internal controls that are significant within the context of the audit objectives and assessed whether such controls have been properly designed and placed in operation. However, providing an opinion on the effectiveness of internal controls was not an objective of our audit and accordingly, we do not express such an opinion.

We obtained an understanding of legal provisions that are significant within the context of the audit objectives, and we assessed the risk that illegal acts, including fraud, and violations of grant agreement or other legal provisions could occur. Based on that risk assessment, we designed and performed procedures to provide reasonable assurance of detecting instances of noncompliance significant to those provisions. However, providing an opinion on compliance

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with those provisions was not an objective of our audit and accordingly, we do not express such an opinion. Abuse, which refers to behavior that is deficient or improper when compared with behavior that a prudent person would consider reasonable and necessary given the facts and circumstances, does not necessarily involve noncompliance with legal provisions. Because the determination of abuse is subjective, our audit is not required to provide reasonable assurance of detecting abuse.

We conducted our audit in accordance with the standards applicable to performance audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform our audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides such a basis.

The accompanying History and Organization is presented for informational purposes. This information was obtained from the department's management and was not subjected to the procedures applied in our audit of the Program Integrity Unit.

The accompanying Management Advisory Report presents our findings arising from our audit of the Department of Social Services, MO HealthNet Division, Program Integrity Unit.

Susan Montee, JD, CPA
State Auditor

The following auditors participated in the preparation of this report:

Director of Audits:	John Luetkemeyer, CPA
Audit Manager:	Susan J. Beeler, CPA, CIA
In-Charge Auditor:	Terri Erwin, MBA
Audit Staff:	Emily Bias
	Kimberly Shepard

MANAGEMENT ADVISORY REPORT -
STATE AUDITOR'S FINDINGS

DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION
PROGRAM INTEGRITY UNIT
MANAGEMENT ADVISORY REPORT -
STATE AUDITOR'S FINDINGS

1. Annual Report

The Department of Social Services (DSS), MO HealthNet Division (MHD), Program Integrity Unit's (PIU) annual report did not include some information required by state law. We compared the information included in this report to the statutory requirements. In addition, we reviewed the supporting documentation to ensure the report information was complete and accurate.

Starting in 2008, pursuant to Section 191.909.2, RSMo, the DSS was required to report annually, by January 1 of each year, activities of the PIU. Our prior audit (Report No. 2009-26) covered the DSS annual report for the fiscal year ended June 30, 2007. Prior to the issuance of that audit, the DSS had already submitted the fiscal year 2008 annual report. In the prior report, the DSS responded the implementation of our recommendations would occur starting in the fiscal year 2009 annual report which was submitted in January 2010, after our current fieldwork.

Section 191.909.2, RSMo requires the DSS's annual report include the following activities:

"(1) The number of MO HealthNet provider and participant investigations and audits relating to allegations of violations under sections 191.900 to 191.910 completed within the reporting year, including the age and type of cases;

(2) The number of MO HealthNet long-term care facility reviews;

(3) The number of MO HealthNet provider and participant utilization reviews;

(4) The number of referrals sent by the department to the attorney general's office;

(5) The total amount of overpayments identified as the result of completed investigations, reviews, or audits;

(6) The amount of fines and restitutions ordered to be reimbursed, with a delineation between amounts the provider has been ordered to repay, including whether or not such repayment will be completed in a lump sum payment or installment payments, and any adjustments or deductions ordered to future provider payments;

(7) The total amount of monetary recovery as the result of completed investigation, reviews, or audits;

(8) The number of administrative sanctions against MO HealthNet providers, including the number of providers excluded from the program."

Additionally, the state auditor is required to conduct an audit of the PIU "… to quantitatively determine the amount of money invested in the unit and the amount of money actually recovered by such office."

The DSS interpretation of Section 191.909.2, RSMo, required all recovery activity of the MHD be reported, including PIU recoveries. In addition, although not required, the DSS also reported 1) cost avoidance amounts for various MHD units for the current year, 2) cost recovery and cost avoidance amounts for 4 previous years for the PIU and various other MHD units, and 3) recoveries of MHD monies by the DSS Division of Legal Services.

For the year ended June 30, 2008, the PIU reported recovering the following funds:

Collections	$	1,415,473	
Adjustments		1,106,468	(1)
Recoupments		1,819,687	(1)
Total	$	4,341,628	

(1) Adjustments and recoupments both adjust the amount of claims. Adjustments are individual claims that have been overpaid and need to be adjusted. Recoupments are accounts receivable adjustments that do not relate to a specific claim.

For the year ended June 30, 2008, the costs incurred to operate the PIU were:

Salaries and wages	$	916,871	
Fringe benefits		384,471	
Travel, in-state		550	
Supplies		2,616	
Professional services		1,166,357	
Maintenance and repair services		1,136,393	
Miscellaneous expenses		5,958	
Building lease payments		24,598	
Total	$	3,637,814	(1)

(1) Some office expenses (computer equipment, office equipment, and office supplies such as paper products) related to the MHD are not allocated to individual units within the division. Thus, there are additional expenditures related to the PIU not included above.

The following concerns were noted:

A. Some provider and participant investigations were not included in the report.

1) The report did not include some participant investigations completed during the reporting period. Although the report included the 326 investigations completed by the Welfare Investigations Unit (WIU), the investigations completed by the MO HealthNet Investigations Unit (MHIU) were not reported. In addition, the age and type of provider/participant investigations were not reported.

Both the MHIU and WIU are units within the DSS Division of Legal Services. The MHIU investigates fraud and abuse committed by recipients against MO HealthNet providers, such as use of multiple physicians and pharmacies, forged prescriptions, or the payment of covered medication with cash. The WIU investigates fraud and abuse committed by public assistance recipients based on eligibility issues, such as inaccurately reporting income or household composition.

The DSS should report the MHIU investigations and the age and type of all investigations.

2) The number of provider investigations, with the applicable age and type of case, conducted by the Attorney General's Medicaid Fraud Control Unit (MFCU) based on DSS referrals, is not reported.

The MFCU, not the DSS, is responsible for provider investigations related to fraud and abuse. However, the MFCU notifies the PIU of the outcome of all investigations completed on referrals from the DSS.

The DSS should consider reporting information regarding investigations completed by the MFCU on the DSS referrals.

B. Some overpayments, identified as a result of completed investigations, reviews, or audits, are not reported. Although the report includes overpayments identified by the WIU, the overpayments identified by the PIU and Cost Recovery Unit (CRU) are not reported. PIU records indicated overpayments identified totaled approximately $4.9 million for the year ended June 30, 2008.

The DSS should ensure all overpayments identified are reported.

C. The amount of fines and restitution ordered to be reimbursed, and other required information on provider investigations closed by the MFCU, are not reported. The MFCU provides the PIU documentation regarding damages and restitution ordered to be reimbursed on cases referred to the MFCU by the DSS.

The DSS should consider reporting the information regarding damages and restitution on cases referred to the MFCU and closed by the MFCU during the reporting period.

D. Some monetary recoveries (collections) resulting from completed investigations, reviews, or audits are not reported. Although the report lists the total amount of recoveries for the PIU and CRU, the monetary recoveries for the WIU are not reported. According to WIU records, recoveries totaled over $186,000 for the year ended June 30, 2008.

The DSS should include the WIU's monetary recoveries in the report.

The DSS needs to ensure all information required by Section 191.909.2, RSMo, is included and accurately reported in its annual report submitted to the General Assembly and Governor. These conditions were noted in our prior report. At that time, the DSS indicated corrective action for portions of the conditions noted in A, B, and D would be taken beginning with the preparation of the 2009 annual report.

WE RECOMMEND the DSS through the PIU:

A. Include the number of all participant and provider investigations completed by DSS units and MFCU in the annual report. Additionally, information about the age and type of completed investigations should be included.

B. Include the total amount of overpayments identified by all DSS units in the annual report.

C. Include damages, restitution ordered, and other required information resulting from DSS referrals to the MFCU in the annual report.

D. Include the total amount of monetary recoveries received as a result of completed investigations, reviews, or audits by all DSS units in the annual report.

AUDITEE'S RESPONSE

A. We partially agree with this recommendation. We do not agree that DSS should report provider investigations completed by the Attorney General's Medicaid Fraud Control Unit (MFCU). That data is reported by the MFCU as prescribed in Section 191.909.1 RSMo.

This recommendation was made in the prior State Auditor's Office audit (Report No. 2009-26) that covered the DSS's annual report for the fiscal year ended June 30, 2007. Report No. 2009-26 was issued after completion of the state fiscal year 2008 annual report and therefore the agency had no opportunity to incorporate this recommendation in the state fiscal year 2008 annual report. All DSS cases, including the MO HealthNet Investigation Unit (MHIU), are shown in the report for state fiscal year 2009.

B. We agree with this recommendation. The Cost Recovery Unit (CRU) does not currently have a database necessary to report identified overpayments. With the reengineering of the Medicaid Management Information System (MMIS), system enhancements will allow CRU to systematically report out the total identified overpayments. The implementation date of the enhancement has been rescheduled to state fiscal year 2011.

This recommendation was made in the prior State Auditor's Office audit (Report No. 2009-26) that covered the DSS's annual report for the fiscal year ended June 30, 2007. Report No. 2009-26 was issued after completion of the state fiscal year 2008 annual report and therefore the agency had no opportunity to incorporate this recommendation in the state fiscal year 2008 annual report. For the annual report for state fiscal year 2009, DSS included the overpayment amounts identified separately from the recovery amounts for PIU and MHIU.

C. We disagree with this recommendation. As noted in response to 1.A., MFCU reports its performance separately.

D. We agree with this recommendation. This recommendation was made in the prior State Auditor's Office audit (Report No. 2009-26) that covered the DSS's annual report for the fiscal year ended June 30, 2007. Report No. 2009-26 was issued after completion of the state fiscal year 2008 annual report and therefore the agency had no opportunity to incorporate this recommendation in the state fiscal year 2008 annual report. DSS included the total amount of monetary recoveries by all DSS units in the annual report for state fiscal year 2009.

2. Internal Controls, Procedures, and Records

The DSS needs to improve its internal controls, procedures, and records. Some amounts in the annual report were incomplete or mislabeled and the cost avoidance portion of the amounts reported as overpayments may not be accurate. In addition, adjustments to overpayment amounts identified and reported are not tracked and reported in the annual report.

A. The DSS has not established adequate procedures to ensure the accuracy of amounts included in the annual report and some amounts were not accurately reported. In addition, data reconciliations are not always performed, and supervisory reviews over information included in the report are not adequate.

1) Some of the amounts entered in the supporting documents for the annual report are not accurate.

The amount reported for cost avoidance originates from cost avoidance worksheets which are maintained in the individual case files and then entered in an overall cost avoidance spreadsheet. The total amount from this spreadsheet is reported in the annual report (over $162 million for

fiscal year 2008). A review of 25 of the 182 case files from fiscal year 2008 revealed the following concerns:

- Cost avoidance worksheets were not in the case files for 2 of the 25 (8 percent) case files tested.

- Information was not accurately entered in the overall cost avoidance spreadsheet for 3 of the 25 (12 percent) case files tested.

To ensure information is accurately reported, the DSS needs to retain supporting documentation and ensure data is correctly entered in supporting spreadsheets.

2) Supervisory reviews of information included in the report are not adequate.

MHD case information is initially entered into the Medicaid Management Information System (MMIS) by various DSS personnel from case cards in the case files. The PIU uses the MMIS information to create reports in the Surveillance and Utilization Review Subsystem (SURS), which are then entered in spreadsheets for the annual report; however, there is no reconciliation between the MMIS and the spreadsheets to ensure the information was transferred correctly. In addition, there are no supervisory reviews performed to ensure the information contained in the annual report is accurate.

For example, a report identifying $4,929,379 in overpayments received was entered into the MMIS and then spreadsheets that support the annual report. To verify the accuracy of the $4.9 million entry, we reviewed 25 of the 677 cases used to enter MMIS information into spreadsheets supporting the annual report and noted 21 cases, or 84 percent, did not contain evidence of a supervisory review.

The DSS should establish adequate procedures to ensure supervisory reviews of annual report data are performed.

3) The DSS has not established adequate procedures to ensure the correct amounts are brought forward from the supporting data to the annual report and some amounts were not accurately reported.

Each month, from various supporting documentation, amounts for the annual report are recorded on monthly spreadsheets. The spreadsheets are then used to prepare the annual report. However, a reconciliation of the documentation to the spreadsheets is not performed. We tested supporting documentation for one monthly spreadsheet and found one participant

case reviewed by the PIU was included on the spreadsheet but not on the annual report.

The failure to develop procedures to ensure amounts are complete and accurate reduces the reliability of the report. If the amounts recorded on monthly spreadsheets were periodically reconciled to supporting documentation, the DSS would have more assurance the annual report was complete and accurate.

Supervisory reviews and periodic data reconciliations are necessary to help ensure the accuracy of amounts presented in the annual report.

B. Some amounts in the annual report were either incomplete and/or mislabeled. Also, the use of estimates for cost avoidance is not disclosed.

1) The annual report identified overpayments, collections, and costs; however, these amounts were incomplete and/or misclassified.

For each year from fiscal years 2004 to 2008, a table presented the combined cost avoidance and cost recovery (actual collections) amounts for the PIU/CRU, the number of investigations and cost recovery amounts for the MHIU/WIU, the cost avoidance amount for any reinvestigations, and a grand total for each year. However, the amounts identified as cost recovery for the MHIU/WIU were actually the overpayment amounts. Thus, the actual cost recovery amounts for the MHIU/WIU were not reported.

The DSS should ensure overpayment, collection, and cost information reported is complete, accurate and properly classified. In this regard, the DSS should consider reporting the overpayments, cost recoveries and cost avoidances separately for the PIU, CRU, MHIU, and WIU, as applicable.

2) The DSS does not disclose in the annual report that some amounts included in the cost avoidance total were estimates. When the PIU identifies an amount as an overpayment to a provider, this overpayment is used to estimate a projected cost avoidance for the next 12 months for that provider. For the year ended June 30, 2008, the estimated cost avoidance for providers totaled approximately $20 million, which makes up a portion of the total cost avoidance of $162.3 million presented in the annual report.

For greater accountability and full disclosure, the DSS should consider disclosing when cost avoidance estimates are utilized.

C. Adjustments to overpayment amounts identified and reported are not tracked and reported in the annual report.

Adjustments to overpayments amounts may occur due to the conclusion of an appeal process, or due to a mathematical error in the original overpayment calculation. By not accounting for these adjustments, overpayments may be reported incorrectly. To help ensure overpayments are correctly reported, the DSS should establish procedures to include subsequent adjustments in the annual report.

Conditions A3, B, and C were noted in our prior report. At that time, the DSS indicated corrective action for B and C would be taken beginning with the preparation of the 2009 annual report.

WE RECOMMEND the DSS through the PIU:

A.1. Ensure necessary supporting documentation is maintained in case files and amounts are accurately entered in supporting spreadsheets.

2. Establish adequate procedures to ensure supervisory reviews of reported amounts.

3. Establish procedures to reconcile supporting documentation to monthly spreadsheets and the annual report.

B.1. Ensure the amounts for overpayments, collections and cost recovery are accurately reported and properly identified. The DSS should also consider reporting these amounts separately for the PIU, CRU, MHIU, and WIU as applicable.

2. Disclose the use of cost avoidance estimates in the annual report. The DSS should also report the total estimates calculated.

C. Establish procedures to track and report subsequent adjustments to overpayment amounts initially identified.

AUDITEE'S RESPONSE

A.1 We agree with this recommendation. Cost avoidance is reported for the first consecutive twelve-month period following the provider's education regarding the aberrant behavior. The first error was a provider self-disclosure case reported in October 2007 for an overpayment in fiscal year 2002. For the second error, the documentation in the file, approved by the supervisor, noted that cost avoidance was not calculated for this case. Due to the elapsed time frame between the disclosure and the error (more than three years), cost avoidance was not calculated for either of these cases. DSS agrees with the finding on the third error.

A.2. We disagree with this recommendation. DSS does have established procedures to ensure supervisory review of reported amounts. These procedures were followed on all but one of the 21 cases included in the error.

A.3 We agree with the recommendation. This recommendation was made in the prior State Auditor's Office audit (Report No. 2009-26) that covered the DSS's annual report for the fiscal year ended June 30, 2007. Report No. 2009-26 was issued after completion of the state fiscal year 2008 annual report and therefore the agency had no opportunity to incorporate this recommendation in the state fiscal year 2008 annual report. DSS implemented a process in March 2009 to reconcile the monthly report with supporting documentation to ensure the annual report also reconciles to the supporting documentation.

B.1 We agree with this recommendation. DSS will report overpayment, collection and cost recovery amounts as applicable. The MHIU investigations generally result in administrative actions with no associated cost recovery amounts but potential costs avoidances. An example of an administrative action is to restrict a participant to a specified pharmacy or primary care provider to prevent over utilization of services, resulting in cost avoidance of future expenditures.

This recommendation was made in the prior State Auditor's Office audit (Report No. 2009-26) that covered the DSS's annual report for the fiscal year ended June 30, 2007. Report No. 2009-26 was issued after completion of the state fiscal year 2008 annual report and therefore the agency had no opportunity to incorporate this recommendation in the state fiscal year 2008 annual report. DSS separately reported overpayments, collections and cost recovery amounts for each of the other DSS units in the annual report for state fiscal year 2009.

B.2. We agree with this recommendation. This recommendation was made in the prior State Auditor's Office audit (Report No. 2009-26) that covered the DSS's annual report for the fiscal year ended June 30, 2007. Report No. 2009-26 was issued after completion of the state fiscal year 2008 annual report and therefore the agency had no opportunity to incorporate this recommendation in the state fiscal year 2008 annual report. DSS disclosed the use of cost avoidance estimates and the calculated totals in the annual report for state fiscal year 2009.

C. We agree with this recommendation. This recommendation was made in the prior State Auditor's Office audit (Report No. 2009-26) that covered the DSS's annual report for the fiscal year ended June 30, 2007. Report No. 2009-26 was issued after completion of the state fiscal year 2008 annual report and therefore the agency had no opportunity to incorporate this recommendation in the state fiscal year 2008 annual report. The amount reported in the annual report for state fiscal year 2009 is the net of identified overpayments minus any adjustments that occurred during the reporting year.

3. Accounting Policies and Procedures

The DSS does not deposit monies recovered by the MFCU in the proper funds as provided by state law. According to Section 191.905.11, RSMo, restitution should be deposited in the MO HealthNet Fraud Reimbursement Fund and reimbursements of

investigation/prosecution costs should be deposited in the MO HealthNet Fraud Prosecution Revolving Fund. Monies in the reimbursement fund are to be used to refund the federal government and state agency(s) for amounts overpaid. Monies in the revolving fund are to be used to refund the Attorney General's and prosecuting and circuit attorneys' costs of prosecution and investigation. However, these funds have not had receipt or disbursement activity since at least fiscal year 2000.

Restitution and investigation/prosecution costs recovered by the MFCU are transmitted to the DSS, Division of Finance and Administrative Services (DFAS) for depositing and recording in the state accounting system (SAM II). The DFAS deposits these monies to the General Revenue Fund, or Title XIX-Federal and Other Fund, even though the MFCU instructs the DSS to deposit the monies in the MO HealthNet Fraud Reimbursement and Fraud Prosecution Revolving Funds. According to DSS personnel, the monies are deposited in this manner because payments were originally made from these funds.

The DSS should ensure monies recovered by the MFCU are deposited in the appropriate funds as prescribed by law. This condition was noted in our prior report and the DSS indicated it would work with the MFCU to implement the audit recommendation; however, corrective action has not yet been taken.

WE AGAIN RECOMMEND the DSS deposit and record monies received by the MFCU for restitution and investigation/prosecution costs reimbursements in accordance with state law.

AUDITEE'S RESPONSE

We agree with this recommendation. The DSS interpretation is that restitution paid by a person convicted of a violation under RSMo 195.905 should be deposited into the MO HealthNet Fraud Reimbursement Fund. Most MFCU recoveries do not fall within this requirement. DSS will work with MFCU to identify recoveries from restitution paid by a person convicted of a violation under RSMo 195.905 and deposit these as required under RSMo 195.905.11. The Division of Finance and Administrative Services (DFAS) will deposit monies into the MO HealthNet Fraud Prosecution Revolving Fund as reported by MFCU.

HISTORY AND ORGANIZATION

DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION
PROGRAM INTEGRITY UNIT
HISTORY AND ORGANIZATION

The Department of Social Services (DSS) is officially designated as the single state agency charged with the administration of the Missouri Medicaid program. The Division of Medical Services was established within the DSS in February 1985 by a Governor's executive order. Pursuant to Senate Bill 577, The Missouri Health Improvement Act of 2007, effective September 1, 2007, the division's name changed to the MO HealthNet Division (MHD). The Program Integrity Unit (PIU), organizationally located within the MHD, is responsible for monitoring compliance by providers and participants as described in federal regulations by conducting post payment reviews to determine the propriety of claims reimbursed by the Medicaid program. The Family Support Division within DSS determines participant eligibility for the Medicaid program. The Code of Federal Regulations, at 42 CFR 455.13, requires a state Medicaid agency to have "a) methods and criteria for identifying suspected fraud cases; b) methods for investigating these cases. . . ; and c) procedures, developed in cooperation with state legal authorities, for referring suspected fraud cases to law enforcement officials."

A post-payment review of Medicaid claims reimbursed is performed on selected providers or projects in order to determine program compliance. Providers are selected to be reviewed from referrals, exception reports and/or other system generated reports. Referrals concerning possible misutilization may be received from providers, recipients, consultants, and division employees, as well as staff from other agencies. Exception reports are produced on providers that have unusual patterns of utilization, or that deviate from established norms. This review is completed by either a desk or field review. Programs are evaluated for adequate documentation and the appropriateness and quality of service. Reviews of allegations of participant fraud or abuse are completed for all referrals received. Participants committing fraud or abuse may be limited to using one provider, or referred to local authorities for legal action, or both.

Based on a preliminary review of reports and referrals, the PIU makes the determination on what enforcement activities to pursue. These enforcement activities may include one or more of the following administrative actions or sanctions: 1) provider education, 2) demand of repayment, 3) suspension or termination of the provider's Medicaid participation agreement, 4) transfer to closed-end agreement, 5) placement on prepayment review status, 6) participant lock-in, and 7) referral to another state agency.

If a question of potential fraud exists regarding a provider, the case is referred to the Attorney General, Medicaid Fraud Control Unit (MFCU). The PIU meets regularly with the MFCU to discuss providers suspected of fraud. In fiscal year 2008, the PIU referred 25 cases to the MFCU.

At June 30, 2008, the PIU consisted of 24 employees.