Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Alabama Comprehensive Program Integrity Review

Amended Final Report

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Alabama Medicaid Program. The MIG review team conducted the onsite portion of the review at the Alabama Medicaid Agency (AMA) offices. The MIG also visited the office of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Program Integrity Division within AMA. The Program Integrity Division is responsible for Medicaid program integrity activities. This report describes four effective practices, six regulatory compliance issues, and four vulnerabilities in the State's program integrity operations.

In its comments on the draft review report, Alabama indicated that it had corrected or was taking actions to correct all areas of non-compliance and vulnerability.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Alabama improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Alabama's Medicaid Program

The AMA administers the Alabama Medicaid program. As of December 2008, the program served 813,141 recipients. Alabama has enrolled 456,653 recipients, or 56.2 percent of its Medicaid population in Patient 1st, a primary care case management program. Alabama also delivers hospital services through eight prepaid inpatient health plans (PIHPs), known as the Partnership Hospital Program (PHP), with 543,547 enrolled recipients.

At the time of the review, AMA had 23,005 enrolled Medicaid providers. Approximately 1,149 providers are enrolled in Alabama's Patient 1st program. Medicaid expenditures in Alabama for the State fiscal year (SFY) ending September 30, 2008, totaled $4,295,200,053. The Federal medical assistance percentage for Alabama for Federal fiscal year 2008 was 67.62 percent.

Program Integrity Division

The Program Integrity Division, within the Administrative Services section of AMA, is the organizational component dedicated to fraud and abuse activities. At the time of our review, the Program Integrity Division had approximately 39 full-time equivalent employees focusing on Medicaid program integrity. During SFY 2005 through SFY 2008, Division staff conducted an annual average of 296 preliminary investigations and 216 full investigations. The table below presents the total number of investigations and overpayment amounts identified for the last four

SFYs as a result of program integrity activities. The amount of overpayments collected includes global settlements, outside litigation judgments, and program integrity activities.

Table 1

SFY	Number of Preliminary Investigations	Number of Full Investigations	Amount of Overpayments Identified	Amount of Overpayments Collected
2005	765	652	$6,385,458	$3,740,809
2006	826	704	$4,494,575	$4,311,870
2007	773	718	$1,036,279	$978,047
2008	1008	979	$1,119,154	$5,503,721*

*This amount includes settlements from various providers.

Methodology of the Review

In advance of the onsite visit, the review team requested that Alabama complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosures, managed care, and the MFCU. A four-person team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of January 12, 2009, the MIG review team visited the AMA and MFCU offices. The team conducted interviews with numerous AMA officials, as well as with staff from the State's provider enrollment contractor, the PHP contractor, and the MFCU. The team also conducted sampling of provider enrollment applications, case files, selected claims, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the Program Integrity Division. Alabama's Children's Health Insurance Program operates under Title XXI of the Social Security Act and was, therefore, not included in this review.

Unless otherwise noted, AMA provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that AMA provided.

RESULTS OF THE REVIEW

Effective Practices

The State of Alabama has highlighted several practices that demonstrate its commitment to program integrity. These practices include anti-fraud safeguards in mobile dentistry, a procedure for routinely checking for excluded providers, and a high level of cooperation between the State agency and the MFCU.

Anti-fraud safeguards in mobile dentistry
Recent Alabama legislation on mobile dentistry included several requirements for mobile or portable dental operations aimed at prevention of fraud and abuse. Requirements include a provision for a patient information sheet which is given to each patient at the conclusion of his/her visit. The information sheet notes treatment, billing service codes, fees, and tooth numbers when appropriate. In addition, providers are required to have an official business address within the state and be associated with an established dental facility which has an official business address on record with the Board of Dental Examiners. Providers are also required to maintain records at the business address.

Routine checking for excluded providers
The AMA runs its Medicaid provider list, through its fiscal agent, against the List of Excluded Individuals/Entities each month.

Soon after the MIG review, AMA began checking its state list of excluded providers with the Department of Industrial Relations to see if any excluded persons are working elsewhere, for example, as managing employees. The state exclusion list includes both the Medicare Exclusion Database and Alabama-initiated exclusions.

A high level of cooperation between the State agency and the MFCU
The AMA and the MFCU meet monthly and frequently talk on the phone to maintain open communication. The entities work together in a cooperative effort to develop referrals, discuss cases and improve fraud detection.

Additionally, the CMS review team identified one practice that is particularly noteworthy. The CMS recognizes Alabama's efforts in the deactivation of provider numbers when the address is unknown.

Deactivation of the Medicaid provider number when the address is unknown
The AMA deactivates a provider's Medicaid provider number when mail is returned due to a problem with the provider's address and an attempt to find the correct information has failed. The provider number stays deactivated until the address issue is resolved.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations regarding managed care program integrity requirements, verification of receipt of billed services, disclosures, and reporting requirements.

The State's PIHPs do not meet all managed care program integrity requirements.
The managed care regulation at 42 CFR § 438.608 requires that managed care organizations (MCOs) and PIHPs have specific administrative and management procedures designed to guard against fraud and abuse, which must include written policies, procedures, and standards of conduct regarding the MCO's or PIHP's commitment to compliance; the designation of a compliance officer; training and education for all employees; effective lines of communication;

enforcement of standards through well-publicized disciplinary guidelines; internal monitoring and auditing; and prompt response to detected offenses and corrective action.

Interviews with State staff that oversee the managed care programs and Alabama Hospital Association representatives indicated that each PIHP hospital has a compliance plan. However, based on review of submitted documents, the PIHPs are not in compliance with requirements related to 42 CFR §438.608 (b)(3),(4) and (6). The review team found no evidence of training for PIHP hospital employees related to compliance, no evidence of lines of communication between the PIHP compliance officers and hospital employees responsible for direct care of Medicaid recipients, and no evidence of provisions for internal monitoring and auditing.

Recommendation: Develop and implement policies and procedures for a fraud and abuse training and education program, ensuring effective lines of communication between the PHP's compliance officers and hospital employees, and implementing internal monitoring and auditing as required by the regulation.

The State does not verify with recipients whether services billed by providers were received.
The regulation at 42 CFR §455.20(a) requires that the State agency have a method for verifying with recipients whether services billed by providers were received. Alabama does send out Recipient Explanation of Medicaid Benefits (REOMBs) but these are used only to gain recipient input on quality of care issues. The REOMBs are not used to verify that services billed were actually delivered.

Recommendation: Develop and implement a method for verifying with recipients whether billed services were received.

The State does not capture all required ownership, control, and relationship information in its fee-for-service (FFS) operations from providers and from the fiscal agent.
Under 42 CFR §455.104(a)(1), a provider, or "disclosing entity," that is not subject to periodic survey under §455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under §455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under §455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under §455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership and control information required under this section.

Enrollment applications for all disclosing entities do not request required disclosure information regarding subcontractors.

Enrollment files for disclosing entities enrolled prior to 1999 and AMA's fiscal agent do not include required information regarding the name, address and relationship of each person with ownership or control interest in the disclosing entity. The files also lack required disclosure of the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity has an ownership or controlling interest. The only disclosure from the fiscal agent was regarding ownership, indicating that the fiscal agent was acquired by another company.

Recommendations: Modify all provider enrollment applications and contracts to capture the required ownership, control, and relationship information. Obtain necessary disclosures from all providers and from the fiscal agent.

Alabama's out-of-state provider agreement does not require providers to disclose certain business transactions.

The regulation at 42 CFR §455.105(b)(2) requires that, upon request, providers furnish to the State or the U.S. Department of Health & Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors. Providers must submit business information within 35 days of the date on a request by the Secretary or the Medicaid agency.

The current AMA out-of-state provider agreement does not include a statement that the provider agrees to furnish business transaction disclosures within 35 days of a request by AMA or HHS.

Recommendation: Modify the provider agreement to require disclosure upon request of the information identified in 42 CFR § 455.105(b).

Alabama's provider enrollment applications do not capture required criminal conviction information.

The regulation at 42 CFR §455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify the HHS Office of Inspector General (HHS-OIG) whenever such disclosure is made.

Provider enrollment applications for out-of-state practitioners and out-of-state institutional providers used by the State's enrollment contractor do not ask for disclosure of criminal conviction information. Because the enrollment contractor is not collecting the information, such disclosures cannot be reported to the HHS-OIG, as required by the regulation.

Recommendations: Modify provider enrollment applications to meet the full criminal conviction disclosure requirements of the regulation. Develop and implement a procedure to report criminal conviction information to HHS-OIG within 20 working days.

The State does not report to HHS-OIG adverse actions taken on provider applications.
The regulation at 42 CFR §1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. The State Medicaid agency does not report to the HHS-OIG when it denies enrollment of a provider.

Recommendation: Develop and implement procedures to report to HHS-OIG all adverse actions taken against and limits placed on providers applying to participate in the program.

Vulnerabilities
The review team identified four areas of vulnerability in Alabama's practices regarding lack of provider agreements, non-verification of provider licenses, and lack of disclosure information in the managed care contracting process.

Not having current provider agreements.
Files for providers enrolled prior to 1999 do not include a current AMA Medicaid provider agreement. When a current agreement is lacking, a provider has not indicated it would comply with the requirement to provide disclosure of business transactions upon request of AMA or HHS-OIG, report any changes in ownership or control, report any restrictions on the provider's license, and comply with all applicable provisions of State and Federal law.

Recommendation: Require that every Medicaid provider have a current provider agreement.

Not verifying provider licenses.
AMA's provider enrollment contractor accepts a photocopy of a provider's license and does not check the license with the licensing board for accuracy, suspension or disciplinary actions. Therefore, the program may be vulnerable to billings for services that are beyond the limitations imposed on a provider's license. The licensing authority does inform AMA about disciplinary actions as they occur.

Recommendation: Perform a routine data match with the appropriate licensing board before enrolling providers.

Not capturing ownership, control, and relationship information in the managed care contracting process.
The AMA contracts with eight PIHPs to provide hospital care to Medicaid recipients in the State of Alabama. Each PIHP is called a Board. Each Board has representatives from the hospitals in the district the Board serves, and no hospital is unrepresented. The Boards are collections of the hospitals in the geographical districts rather than true Boards of Directors.

The MIG review team found no evidence that the hospitals in the PIHPs or Board members provided AMA with disclosures regarding ownership or control of the PIHPs, or regarding the relationships between persons with ownership or control of the PIHPs.

Recommendation: Modify the managed care contract to require disclosure of ownership and control, and relationship information from each of the PIHPs, including the constituent hospitals and the individual representatives to the Boards.

Not capturing criminal conviction information in the managed care contracting process.
The AMA contracts with eight PIHPs to provide hospital care to Medicaid recipients in the State of Alabama. Each PIHP is called a Board. Each Board has representatives from the hospitals in the district the Board serves, and no hospital is unrepresented. The Boards are collections of the hospitals in the geographical districts rather than true Boards of Directors.

The MIG review team found no evidence that hospitals in the PIHPs or the Board members provided AMA with any disclosures regarding the criminal convictions of their agents or managing employees or persons with ownership or control of the PIHPs.

Recommendation: Modify the managed care contract to require disclosure of criminal convictions from each of the PIHPs, including the constituent hospitals and the individual representatives to the Boards.

CONCLUSION

The State of Alabama applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. These effective practices include:

- anti-fraud safeguards in mobile dentistry,
- routine checking for excluded providers,
- a high level of cooperation between the State agency and the MFCU, and
- prompt deactivation of the Medicaid provider number when the provider's address is unknown

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of six areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, four areas of vulnerability were identified. The CMS encourages AMA to closely examine each area of vulnerability that was identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require AMA to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Alabama will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. While the State's comments on the draft report address plans and actions to correct the findings and vulnerabilities, we request that you provide additional information concerning each finding and vulnerability within 30 calendar days of the date of this letter. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If Alabama has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Alabama on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.