Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Colorado Program Integrity Review

Final Report

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Reviewers:
Lauren Reinertsen, Review Team Leader
Barbara Davidson
Eddie Newman
Edward Sottong

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Colorado Medicaid Program. The MIG review team conducted the onsite portion of the review at the Colorado Department of Health Care Policy and Financing (HCPF). The review team also met with the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of HCPF's Program Integrity (PI) Unit which is responsible for Medicaid program integrity in Colorado. This report describes four effective practices, three regulatory compliance issues, and three vulnerabilities in the State's program integrity operations.

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 Colorado improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Colorado's Medicaid Program

The HCPF administers the Colorado Medicaid program. In the State fiscal year (SFY) ending June 30, 2009, the program served a total of 436,812 recipients. A total of 81,515 recipients were enrolled in 2 physical health managed care organizations (MCOs) and 1,311 recipients were enrolled in 3 Programs of All-inclusive Care for the Elderly. All Medicaid eligible recipients were enrolled in one of five behavioral health MCOs. Total Medicaid expenditures during SFY 2009 were $2,526,991,443. This figure includes $405,986,600 in payments to MCOs. The State had 31,674 fee-for-service (FFS) participating providers, 22,927 MCO physical health providers, and 4,092 MCO behavioral health providers. The Federal medical assistance percentage (FMAP) for Colorado was 50.00 percent during this time period. However, with adjustments attributable to the American Recovery and Reinvestment Act of 2009, the State's effective FMAP was 58.78 percent in the first quarter of Federal fiscal year 2009, 58.78 percent in the second quarter, and 61.59 percent in the third quarter.

Program Integrity Section

In Colorado, the PI Unit is the organizational component dedicated to fraud and abuse activities. It is located in the Legal Division of the Administration and Operations Office of HCPF. At the time of the review, the PI Unit had 11 full-time equivalent (FTE) staff focusing on Medicaid program integrity. The table below presents the total number of investigations, identified overpayments, and amounts recouped in the past four SFYs as a result of program integrity activities.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified	Amount of Overpayments Collected
2005	63	1,103	$6,380,342	$7,742,601
2006	86	390	$4,548,284	$6,140,343
2007	101	965	$9,433,606	$5,607,665
2008	78	184	$6,385,944	$3,591,114

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation. **Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition.

The excess in overpayments collected for SFYs 2005 and 2006 reflects additional dollars coming to the State from earlier settlements and previously initiated recoveries. It does not include MFCU and national settlements.

Methodology of the Review

In advance of the onsite visit, the review team requested that Colorado 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 August 17, 2009, the MIG review team visited the HCPF and MFCU offices. The team conducted interviews with numerous HCPF officials, the State's provider enrollment and non-emergency medical transportation (NEMT) contractors, and the MFCU director. Finally, to determine whether MCOs were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team interviewed HCPF staff. The team also reviewed the managed care contract provisions and gathered information through interviews with representatives of four MCOs providing physical health and behavioral health services. In addition, the team conducted sampling of provider enrollment applications, FFS and managed care 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 HCPF as they relate to program integrity but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, managed care and NEMT.

Colorado operates a stand alone Children's Health Insurance Program which operates under the authority of Title XXI of the Social Security Act and was, therefore, excluded from this review.

Unless otherwise noted, Colorado 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 HCPF provided.

RESULTS OF THE REVIEW

Effective Practices

The State of Colorado has highlighted several practices that demonstrate its commitment to program integrity. These practices include the PI Unit's involvement in a statewide Health Care Fraud Task Force, establishment of a mechanism to cut off provider payments within a shortened timeframe, and proactive provider education on hospital audits.

Health Care Fraud Task Force

The two year old Colorado Health Care Fraud Task Force is a multi-agency task force of all Federal and State Medicaid program integrity partners in which the HCPF PI Unit plays a major role. The task force meets on a quarterly basis, or bi-monthly when necessary, and provides the State's program integrity director and other task force members a useful venue in which they can share ideas and information on fraud issues. The program integrity director indicated that this communication has led to both the identification and referral of numerous alleged fraud cases. The director also noted that the quality of fraud cases now being prepared has improved due to the greater variety of partners and increased sharing of resources. Additionally, the partnering efforts of the Health Care Fraud Task Force have enhanced communications with bordering States. In one instance, HCPF was able to quickly identify a mobile provider which had been making false claims in Colorado and communicated this promptly to a bordering State which was able to shut the provider down within hours. Another outcome of the Health Care Fraud Task Force is a large investigation currently in progress under the auspices of the Racketeer Influenced and Corrupt Organizations Act. This investigation was initiated as a result of a PI Unit referral.

Ability to cut off provider payments within a short timeframe

Through its collaboration and coordination with the State Controller, Colorado is able to execute a payment withhold on Medicaid providers within 6 to 10 minutes of receipt of a notice of determination of fraud or willful misrepresentation. This effectively shortens the timeframe in which providers can receive payments for false claims. Since January 2008, Colorado has used this expedited withhold 14 times. A Colorado statute (10 CRR 2505-10 Section 8.076.4 a-c) reinforces this short timeframe when there is reliable evidence of fraud by allowing a withhold without notifying the Medicaid provider until after the withhold is in effect. Colorado complies with the provisions of 42 CFR § 455.23 for payment withholds in cases of fraud or willful misrepresentation.

Proactive provider education on hospital audits

As a result of experiences with Medicare's Recovery Audit Contractors, the PI Unit reported that Medicaid FFS acute care providers expressed numerous concerns about a Diagnosis Related Group (DRG) audit which began in the State in 2008. To address these concerns, the PI Unit increased its communication with the hospital trade association in Colorado and worked with the association to schedule meetings and presentations with acute care providers. In addition to direct presentations to its acute care providers on the DRG auditing and recovery process, the PI Unit has also arranged for fraud and abuse

information to be inserted into the trade association's regularly scheduled provider bulletins.

Additionally, the MIG review team identified one practice that is particularly noteworthy. The MIG recognizes the development and use of two fraud detection databases as further evidence of the State's program strengths.

Improvement in fraud detection methods

Colorado has added to its fraud detection methods two databases which have been created and maintained by its PI Unit: a master Transaction Control Number (TCN) database and a critical events database. These program integrity databases have proven to be effective tools which supplement the existing Surveillance and Utilization Review Subsystem (SURS) within the State's Medicaid Management Information System (MMIS).

Colorado, which has several contractors doing post-payment claims review, uses the master TCN database to avoid the review of claims for which recovery of overpayments has already occurred. The database assigns each claim a unique claim control number based on the date of service. This allows the PI Unit to match claims previously acted on with claims in current and future reviews. This helps the State and its contractors avoid wasting time on redundant reviews and attempts to collect overpayments which have already been recovered.

The PI Unit has also created a critical events database, referred to as the Sentry database, to assist in fraud detection. The database was established by the PI Unit as a result of a project that the State termed "Bad Blizzard Billers". In this database, information is collected about significant weather conditions, dates of major legislation and rule changes, and other events which might influence billing. The PI Unit uses information stored in the database, in conjunction with its SURS and billing analyses, to look for billing abnormalities such as billing levels which could not be reasonably supported because of weather events or significant increases in billing compared to historic averages.

The Bad Blizzard Billers project focused on the increase in home health agencies' billings during a major winter blizzard when logic dictated billings would be decreased because of transportation difficulties. Using the Sentry database to specify dates and locations of the storm conditions, the PI Unit found ten providers who actually increased billing during the harsh blizzard period. The PI Unit also linked with the National Weather Service to determine which counties were hit the worst during that period and conducted a bad blizzard billing analysis to include other providers, such as dentists, to determine if they acted similarly to the home health agencies during the blizzard. Based on a later fraud allegation and investigation, the case against one of the original bad blizzard billers escalated into a MFCU referral which exposed falsified visits and resulted in caregiver prosecution. Colorado has also used the Sentry database in a similar project which tracks questionable billings in the aftermath of severe tornadoes impacting specific counties.

Colorado's commitment to continuing improvement of Medicaid fraud detection is further evidenced through recent additional State funding for five FTE investigative positions in the PI Unit as well as additional funding for a proprietary software product to improve and expedite claims reviews and investigations. The latter will allow the PI Unit to do user-friendly desk queries using data which is only a week old and perform case tracking in a timelier manner.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to required disclosure and notification activities.

The State does not capture all required ownership, control, and relationship information from its fiscal agents.

Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, 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. A 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 or control information required under this section.

The State was unable to provide evidence that it is collecting from its fiscal agent and the contracted NEMT broker, which acts as a quasi-fiscal agent, the names and addresses of each person with a 5 percent or greater ownership stake and their relationships before the State enters into a contract or renews a contract with these entities.

***Recommendations*:** Modify all fiscal agent and broker contracts to capture the required ownership, control, and relationship information. Obtain necessary disclosures from all fiscal agents and brokers.

Colorado's FFS provider enrollment agreement and MCO contracts do not require the disclosure of 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 and Human Services (HHS) information about certain

business transactions with wholly owned suppliers or any subcontractors. Providers must submit such information within 35 days of the date on a request by the Secretary or the Medicaid Agency.

The State's contracts with its MCOs and the FFS provider agreements do not include a statement that the provider agrees to furnish business transaction disclosures within 35 days of a request by the Medicaid agency or HHS.

Recommendation: Modify the FFS provider agreements and MCO contracts to require disclosure upon request of the information identified in 42 CFR § 455.105(b).

Colorado does not collect criminal conviction information on FFS managing employees.
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 disclosures are made.

Colorado does not collect health care-related criminal conviction information on managing employees affiliated with FFS Medicaid providers and therefore cannot notify HHS-OIG of such disclosures as required by the regulation.

Recommendation: Modify the FFS provider application to include the disclosure and reporting of health care-related criminal convictions from managing employees as required by 42 CFR § 455.106.

Vulnerabilities

The review team identified three areas of vulnerability in Colorado's program integrity practices. These include the failure to conduct sufficient monthly exclusion checks, failure to verify managed care services with recipients, and absence of a requirement that MCO network providers disclose business transaction information upon request.

Not checking exclusion databases for all FFS owners and managing employees on a monthly basis and not requiring MCOs to conduct monthly exclusion checking.
Colorado's PI Unit checks FFS providers for exclusions against the HHS-OIG List of Excluded Individuals/Entities (LEIE) on a monthly basis. However, the MMIS only lists the names of providers. Information on associated owners and managing employees is not entered in the MMIS or another data repository. This precludes automated exclusion checks on such individuals from being undertaken on an ongoing basis. Additionally, three of the four interviewed MCOs indicated that they do not conduct exclusion checks on a monthly basis.

These practices do not follow the directives on exclusion checking issued in two CMS State Medicaid Director Letters dated June 12, 2008 (#08-003) and January 16, 2009 (#09-001), respectively. The former directed States to conduct monthly exclusion checks on providers,

owners and managing employees within the FFS program, while the latter directed State Medicaid agencies to require their providers, including MCOs, to perform similar checks on employees within their businesses.

Recommendations: Develop and implement policies and procedures to perform monthly checks of the LEIE in the FFS Medicaid program. Revise State-MCO contracts and MCO provider agreements to require monthly exclusion checks by MCOs and network providers.

Not requiring MCOs to verify with recipients whether services billed by providers were received.

While Colorado meets the requirements of 42 CFR § 455.20 by sending Explanations of Medical Benefits to FFS recipients, the State's MCO contracts do not require recipient verification of services. The four MCOs interviewed indicated that they do not currently verify receipt of Medicaid services with their recipients.

Recommendation: Revise MCO contracts to require verification that services billed by providers were received and monitor compliance with the requirement.

Not requiring disclosure of business transaction information from MCO network providers.

Colorado's MCOs do not require network providers to agree to disclose the full business transaction information upon request which is required from FFS Medicaid providers. Managed care provider agreements and contracts also do not have language which requires providers to furnish this information to the Medicaid agency or the HHS Secretary within 35 days of the request.

Recommendations: Modify the MCO provider contracts to require disclosure of the required business transaction information upon request. Include in the contracts language requiring the MCOs to notify the Medicaid agency of such disclosures within the appropriate timeframe.

CONCLUSION

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

- involvement in a statewide Health Care Fraud Task Force,
- ability to cut off provider payments within a short timeframe,
- proactive provider education on hospital audits, and
- improvement in Medicaid fraud detection methods.

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

However, the identification of three areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, three areas of vulnerability were identified. The CMS encourages HCPF to closely examine the vulnerabilities that were identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require HCPF 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 Colorado 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. 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 Colorado 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 Colorado on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.