Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Connecticut Comprehensive Program Integrity Review

Final Report

August 2011

Reviewers:
Debra Tubbs, Review Team Leader
Gretchen Kane
Lauren Reinertsen
Eddie Sottong

TABLE OF CONTENTS

Introduction 1

The Review 1
Objectives of the Review 1
Overview of Connecticut's Medicaid Program 1
Program Integrity Division 1
Methodology of the Review 2
Scope and Limitations of the Review 2

Results of the Review 3
Effective Practices 4
Regulatory Compliance Issues 4
Vulnerabilities 8

Conclusion 13

Official Response from Connecticut A1

INTRODUCTION

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

This review focused on the activities of the Office of Quality Assurance (OQA) within DSS which is responsible for Medicaid program integrity activities. This report describes one noteworthy practice, two effective practices, six regulatory compliance issues, and nine 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 Connecticut improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Connecticut's Medicaid Program

The DSS administers the Connecticut Medicaid program. As of January 1, 2010, the program served 426,609 beneficiaries. Connecticut has 98,313 enrolled beneficiaries in fee-for-service (FFS) and 357,529 unduplicated beneficiaries in its managed care programs. Connecticut has three managed care plans serving Medicaid beneficiaries.

At the time of the review, the State had 18,574 participating managed care providers and 6,607 providers participating in the FFS program. Medicaid expenditures in Connecticut for the State fiscal year (SFY) ending June 30, 2010, totaled $4,536,587,539.24. The Federal medical assistance percentage for Connecticut was 61.59 percent for Federal fiscal year 2010.

Program Integrity Division

The OQA, within the DSS, is the organizational component dedicated to fraud and abuse activities. At the time of our review, the DSS had 51 authorized full-time equivalent (FTE) employees focusing on Medicaid program integrity with one auditor position vacant. The tables below present the number of investigations and overpayment amounts identified and collected for the last four SFYs as a result of program integrity activities. Connecticut indicated that preliminary and integrity reviews are conducted by the OQA-Special Investigations Unit (SIU), while full scale audits are conducted by the OQA-Audit Division.

Table 1

SFY	Number of Preliminary Reviews*	Number of Integrity Reviews	Overpayments Identified	Preliminary and Integrity Reviews Referred to MFCU	Number Referred for Full Scale Audit
2007	23	286	$899,270	2	7
2008	26	50	$263,194	5	13
2009	65	45	$530,236	9	9
2010	122	12	$40,569	7	8

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.

Table 2

SFY	Number of Administrative Actions	Dollars Recouped Administratively	Number of Full Scale Audits**	Overpayments Identified from Full Scale Audits	Overpayments Collected from Full Scale Audits
2007	1	$1,200,000	179	$9,916,964	$10,491,961
2008	0	not available	190	$6,133,369	$7,232,358
2009	3	$592,000	127	$8,468,705	$8,059,120
2010	2	not available	67	$10,394,973	$10,804,090

**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.

Methodology of the Review

In advance of the onsite visit, the review team requested that Connecticut 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 16, 2010, the MIG review team visited the DSS and MFCU offices. The team conducted interviews with numerous DSS officials, as well as with staff from the State's provider enrollment area, fiscal agent, transportation contractor, and the MFCU. To determine whether the contracted Medicaid managed care organizations (MCOs) were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team interviewed State staff responsible for managed care oversight. The team also reviewed the managed care contract provisions and gathered information through interviews with representatives of three MCOs. 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 DSS. Connecticut'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, DSS 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 DSS provided.

RESULTS OF THE REVIEW

Noteworthy Practice

As part of its comprehensive review process, the CMS review team has identified one practice that merits consideration as a noteworthy or "best" practice. The CMS recommends that other States consider emulating this activity.

Use of client surveys to supplement investigations/audits

During 2010, OQA's SIU developed a targeted and innovative written questionnaire and phone survey to use in conjunction with audits of targeted providers which has been very successful in eliciting detailed beneficiary response to verify services received. This technique has yielded a response rate between 31 to 44 percent. The process of randomly sending Recipient Explanation of Medical Benefits forms to FFS beneficiaries yielded no responses indicating suspected fraud for the last SFY.

The targeted process of questionnaires or phone interviews has been very effective in the audit of individual and group dental providers and an orthotic and prosthetic provider. The process includes either questionnaires with actual illustrations and detailed descriptions of the products or devices, or phone interviews with detailed description of the product or device to determine if:

- services and products billed as provided and documented by the provider were rendered to the beneficiary,
- services and products were delivered in the quantity and level billed,
- out-of-pocket payments by the beneficiary were required for any covered services, and
- additional information is available that might indicate fraud.

The orthotic and prosthetic questionnaire lists services billed by the provider with four key procedure codes, poses additional questions regarding billed services, and includes a picture of the types of orthotic and prosthetic devices for which the provider billed. Of 68 beneficiaries queried, 29 responses were received including those from 18 beneficiaries who reported that services were not provided as billed. The OQA projects potential recoveries in this case at $157,103. This case was referred to the MFCU.

The dental questionnaire survey for individual and group dental providers includes a detailed listing of the services billed by the provider for specific procedures such as fillings, crowns, and dentures which could be easily identified by the beneficiary. It also poses additional questions regarding billed services and includes a diagram illustrating the teeth (with corresponding tooth numbers) with the specific restoration and prosthodontic procedures performed by the provider highlighted. In OQA's investigation of an individual dentist, 100 beneficiaries were contacted and 31 responses were received including those from 23 beneficiaries who indicated specific services

were not performed or were inadequately delivered. The OQA projects potential recoveries in this case at $697,200. This case will be referred to the MFCU pending finalization of the audit findings.

In another OQA investigation of approximately $60,000 of suspect claims from 3 dental provider groups owned by 1 dentist, 154 beneficiaries were contacted and 68 responses were received including 15 from beneficiaries who cited services were either not delivered or were of poor quality. Beneficiary survey results in this case, however, did not clearly establish enough evidence to support the suspected fraud. Currently, OQA reports that six dental provider audits are in process using this supplemental beneficiary survey process and that the use of surveys will be expanded.

Effective Practices

As part of its comprehensive review process, the CMS also invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Connecticut's OQA has developed an enhanced comprehensive fraud referral process for its referrals to the MFCU and has developed and implemented a comprehensive checklist to assist with provider enrollment.

Enhanced comprehensive fraud referral package for referrals to MFCU

The OQA has developed an enhanced referral package for use in fraud referrals from the State Medicaid agency to the MFCU. Fraud cases, which have been fully investigated by OQA, are prepared in a very complete manner prior to referral to the MFCU. Often a case is contained in two or three large looseleaf binders with clear sections containing preliminary investigation and summary, discovered evidence, interviews, and applicable billing history. This complete investigation has resulted in the MFCU receiving referrals in a very complete and compelling format as evidenced by the MFCU's acceptance of all referrals submitted. Although this enhanced referral package is both comprehensive and of high quality, there are serious concerns with OQA's process of referring suspected fraud to the MFCU as noted in this report in the finding related to 42 CFR § 455.21. The State has the opportunity to further improve its collaborative efforts with the MFCU.

Provider enrollment questionnaire

The Provider Enrollment Disclosure Questionnaire completed by providers has made the provider enrollment process more efficient. Providers are required to answer all questions that are on the questionnaire. This provider questionnaire is both comprehensive and of high quality. The fiscal agent receives the application and checks to see if all applicants have filled out the questionnaire. If the required information is complete, the file is sent to the onsite State staff that rechecks the file and gives approval to the fiscal agent to complete the enrollment.

Regulatory Compliance Issues

The State is not in compliance with six Federal regulations regarding fraud referrals to the MFCU, an incomplete payment withhold letter, business transactions disclosures, State-

initiated exclusion notifications, and reporting issues.

The State does not refer all suspected provider fraud cases to the MFCU.
The regulation at 42 CFR § 455.21 requires the State Medicaid agency to refer all cases of suspected provider fraud to the MFCU. The DSS memorandum of understanding (MOU) with the MFCU confirms that DSS must refer to the MFCU any matter in which DSS suspects criminal fraud or abuse involving the Connecticut Medicaid program.

It is notable that Connecticut has improved its previously problematic relationship between OQA and the MFCU. Both the new MFCU director and new OQA director acknowledge that interactions and communication between the two units have greatly improved and regular bimonthly meetings have been established to discuss cases and issues. The MFCU director indicated, however, that while the seven cases referred by OQA during SFY 2010 were of high quality and detail, the quantity of referrals continues to be low for a program with expenditures totaling more than $4.5 billion. Moreover, the OQA reported it investigated suspected provider fraud and abuse complaints prior to referral to the MFCU. Over the past four SFYs, the SIU conducted 122 preliminary reviews and 12 integrity reviews with 7 referrals to the MFCU in SFY 2010, 65 preliminary and 45 integrity reviews with 9 referrals in SFY 2009, 26 preliminary and 50 integrity reviews with 5 referrals in SFY 2008, and 23 preliminary and 286 integrity reviews with 2 referrals in SFY 2007.

Concerns with the processing of some of the case referrals to the MFCU were identified during sampling conducted by the review team onsite. Some cases appeared to be delayed in referral to the MFCU because OQA's SIU sends them internally to its well-developed 30 FTE audit unit for more complete investigation. This process, which was explained by the OQA director as a method of determining if cases were indeed suspected fraud, delayed the referral of cases to the MFCU up to a year. The State contends that it meets the requirements of the regulation because the definition of "suspected fraud" is not clear, and in many situations they do not consider it "suspected fraud" until it has been appropriately vetted by the audit unit.

Interviews with two of three MCOs revealed that suspected MCO network provider fraud cases are not referred to the MFCU. One MCO, which periodically gives the OQA a list of suspected cases, had a case which was referred directly to the U.S. Department of Health and Human Services—Office of Inspector General (HHS-OIG) and the Federal Bureau of Investigation rather than either the MFCU or the OQA. Another MCO notifies the managed care unit of DSS' Office of Medical Administration (which manages the Medicaid program) of suspected Medicaid fraud in its network but DSS' OQA stated it had no knowledge of suspected fraud reported by that MCO.

In the 2007 MIG program integrity review, Connecticut was cited for not complying with 42 CFR § 455.21(a)(1) because of wording in the MOU. This was revised satisfactorily in the MOU revision dated June 2007. The current issue concerns referral of all suspected fraud cases to the MFCU.

NOTE: The program integrity regulation at 42 CFR § 455.23 has been substantially revised and the amendment was effective March 25, 2011. The regulation as amended requires

payment suspension pending investigations of credible allegations of fraud and referral to the MFCU, or other law enforcement agency if there is no certified MFCU in the state. It will be critical that the state make referrals timely and correctly to be in compliance with this requirement.

Recommendations: Modify the process of referral of suspected fraud to the MFCU so that referrals are made as soon as OQA's preliminary investigation reveals an issue which needs further investigation, including strengthening procedures related to MCO reporting of all suspected network provider fraud to the OQA. This could be simultaneous with a referral to its internal audit unit, but the audit unit would need to clear any action with the MFCU before proceeding with investigation or recovery action. Continue the progress made in communication and collaboration since MIG's 2007 review.

The State withholding letter for payments does not reference the required Federal regulation.
The regulation at 42 CFR § 455.23(b) stipulates that the Medicaid agency's notice of withholding state that payments are being withheld in accordance with the Federal regulation.

Although the State Medicaid agency sends providers a notice of withholding of payments within five days of the effective date of the withholding, OQA's withholding letter does not meet the requirements of 42 CFR § 455.23(b) because it does not contain any reference to the Federal regulation. The review team reviewed a copy of a withhold letter provided by OQA that supports this finding.

NOTE: The program integrity regulation at 42 CFR § 455.23 has been substantially revised and the amendment was effective March 25, 2011. The regulation as amended requires payment suspension pending investigations of credible allegations of fraud and referral to the MFCU, or other law enforcement agency if there is no certified MFCU in the state.

Recommendation: Modify the notice of withhold letter by adding the required language in accordance with this regulation.

The State does not require MCOs to disclose business transactions.
The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or U.S. Department of Health and Human Services information about certain business transactions with wholly owned suppliers or any subcontractors.

The State's MCO Request for Proposal (RFP) does not identify specifically that the MCO agrees to submit to DSS or the Secretary, within 35 days of the date of the request, information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the previous 12 month period and any significant business transactions between the provider and any subcontractor during the 5-year period ending on the date of the request.

Recommendation: Modify or amend all MCO RFPs to require MCOs to provide business transaction information upon request to DSS or the Secretary.

The State does not report all adverse actions taken on provider applications to HHS-OIG. (Uncorrected Repeat Finding)
The regulation at 42 CFR § 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

This is a repeat finding from the MIG program integrity review in March 2007. During the 2007 review, the review team noted that Connecticut did not report adverse actions it took on FFS provider applications and this issue is still unresolved.

Connecticut does report to HHS-OIG when it terminates a provider. However, Connecticut responded that it does not report when other reportable actions such as disenrollment and suspension or termination of a provider contract are taken. The DSS does not report to HHS-OIG adverse actions taken against FFS provider applications.

Recommendation: Develop and implement policies and procedures to report to HHS-OIG any adverse actions that DSS takes on a provider's application for participation.

Connecticut does not notify all required parties when there is a State-initiated exclusion.
Under the regulation at 42 CFR § 1002.212, if a State agency initiates exclusion pursuant to the regulation at 42 CFR § 1002.210, it must provide notice to the individual or entity subject to the exclusion, as well as other State agencies; the State medical licensing board, as applicable; the public; beneficiaries; and other provided in § 1001.2005 and 1001.2006.

When the State Agency initiates exclusion for any reason, it must provide exclusion notification to the individual and must notify State agencies, licensing boards, the public, and beneficiaries. During the provider enrollment and disclosure interview, the team was informed that the OQA sends a certified letter. The OQA reported that the notification is sent to HHS-OIG and posted on a website for public notice. There was no policy or procedure to ensure those parties required to receive notice are notified.

Recommendation: Develop and implement policies and procedures to ensure that all parties identified by the regulation are notified of a State-initiated exclusion.

The State does not report all convictions of crimes against Medicaid to HHS-OIG.
Under the regulation at 42 CFR § 1002.230, the State Medicaid agency must provide notice to HHS-OIG within specified timeframes, unless the MFCU has already provided such notice, when an individual has been convicted of a criminal offense related to the delivery of health items or services under the Medicaid program. If the State agency was involved in the investigation or prosecution, the State agency must provide notice to HHS-OIG within 15 days

after conviction, and if the State agency was not involved in the investigation or prosecution, the State agency must provide notice to HHS-OIG within 15 days after learning about the conviction.

Connecticut reported that the MFCU is responsible for reporting criminal convictions in accordance with the MOU. However, Connecticut does not receive any reports from the MFCU to ensure such convictions are reported to HHS-OIG. Moreover, the MOU between Connecticut and the MFCU does not address who is responsible for the reporting.

Recommendation: Modify the MOU to clearly identify who will report criminal conviction information to HHS-OIG.

Vulnerabilities

The review team identified nine areas of vulnerability in Connecticut's practices. These related to inadequate written policies and procedures, collection of managing employee information, and collection of ownership and control, business transaction and criminal conviction disclosures from MCO network providers. They also include the failure to verify receipt of provider services with beneficiaries, to conduct complete exclusion searches, and the lack of MCO oversight. Four of the nine vulnerabilities were identified in MIG's 2007 review and remain uncorrected.

Not having adequate written policies and procedures. (Uncorrected Repeat Vulnerability)
This is a repeat vulnerability from the MIG program integrity review in March 2007. Although the State has a number of processes which support its program integrity operations, there is no program integrity manual and a paucity of written program integrity procedures in such areas as Surveillance Utilization Review Subsystem, timely claims payment, identification, investigation and referral of fraud, reporting to the HHS-OIG, checking for excluded parties, and other key areas. Although the OQA director indicated during the review that a draft manual of program integrity procedures is currently in process, the current shortage of written policies and procedures leaves the State vulnerable to inconsistent operations and less effective functioning when the State loses experienced OQA staff. Connecticut has recently experienced employee turnover due to early retirement packages offered to long term employees. The reorganization of OQA's SIU resulted in the addition of three positions, and the addition of several positions to its already robust audit program.

Additionally, the provider enrollment section indicated it had policies in the form of a bulletin or included in its provider application and agreement and also reported that several policies were still in development.

In the 2007 MIG review, DSS had an area of vulnerability because of relatively few written program integrity and provider enrollment policies and procedures. Developing a program integrity manual to provide detailed procedures to support program integrity operations and agency developments would strengthen Connecticut's Medicaid program integrity operations.

Recommendation: Complete the development of policies and procedures covering all program

integrity processes to ensure compliance in accordance with Federal regulations.

Not capturing managing employee information on provider enrollment forms.
Under 42 CFR § 455.101, a managing employee is defined as "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency." The MCO provider enrollment forms do not solicit information on managing employees. Thus, the State would have no way of knowing if excluded individuals are working for providers or health care entities in such positions as billing managers and department heads.

Recommendations: Develop and implement policies and procedures to ensure that MCOs solicit and collect managing employee information during credentialing and on all enrollment forms or in some manner on attachments to those forms. This information should also be captured in the application database for comparison during the enrollment process and routinely thereafter.

Not collecting ownership and control disclosures from MCO network providers. (Uncorrected Repeat Vulnerability)
This is a repeat vulnerability from the 2007 MIG program integrity review. The MCOs do not obtain full ownership and control information as part of the provider enrollment process. The MCOs utilize the National Committee for Quality Assurance standards for enrollment forms which do not collect the full range of ownership and control disclosures that the Federal regulations at 42 CFR § 455.104 would otherwise require from FFS providers.

NOTE: The CMS reviewed the managed care enrollment forms and other provider agreements for compliance with 42 CFR § 455.104 as it was effective at the time of this review. That section of the program integrity regulations has been substantially revised and the amendment was effective on March 25, 2011. The amendment adds requirements for provision of Social Security numbers and dates of birth as well as more complete address information regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any actions the State takes to come into compliance with 42 CFR § 455.104 should be with that section amended.

Recommendation: Modify or amend the MCO RFPs to require the collection of ownership, control, and relationship information from MCO network providers.

Not requiring MCO providers to disclose business transaction information upon request.
The MCO provider agreements do not require network providers to disclose the required business transaction information as stipulated at 42 CFR § 455.105.

Recommendation: Develop and implement policies and procedures to ensure that managed

care providers disclose business transaction information upon request in accordance with 42 CFR § 455.105(b).

Not capturing the full range of criminal conviction information from MCO network providers.

The MCO enrollment applications and forms do not capture health care-related criminal conviction information for the full range of parties that would otherwise be required of FFS providers under 42 CFR § 455.106. These include persons with ownership and control interests in the provider as well as agents and managing employees. Additionally, the MCOs only require the providers to report convictions that have occurred in the last three years rather than since the inception of the program. This prevents DSS from complying with the regulation at 42 CFR § 455.106(b)(1) requiring that the State agency notify HHS-OIG of such disclosures within a 20 day timeframe.

Recommendation: Develop and implement policies and procedures to collect health care-related criminal conviction information from MCO network providers and to report relevant disclosures submitted by all providers to HHS-OIG as required.

Not verifying with beneficiaries whether managed care services billed by providers were received. (Uncorrected Repeat Vulnerability)

While Connecticut meets the requirements of 42 CFR §455.20 by sending explanations of medical benefits to FFS providers, it does not do so in its managed care program.

All three MCOs reported that verification of services for Medicaid beneficiaries is not the current practice. Two of the three MCOs reported that there is no contractual requirement to verify receipt of services. A review of the contract revealed that there is no language requiring that MCOs verify with beneficiaries whether services billed by providers were rendered. This vulnerability was also identified in the 2007 MIG review.

Recommendation: Develop and implement policies and procedures for verifying with beneficiaries whether billed managed care services were actually received.

Not reporting adverse actions taken on managed care provider applications to the State or HHS-OIG.

The DSS contractually requires the MCOs to report provider terminations to the Managed Care Unit. All three of the interviewed MCOs reported that neither the State nor HHS-OIG is notified whenever the MCO denies credentialing or enrollment of a provider where denial of credentialing or enrollment is due to the MCO's concern about provider fraud, integrity, or quality. One MCO reported that there was no contractual requirement to report denial of credentialing or enrollment where fraud, integrity, or quality was a concern.

The State is therefore unable to make the required report to the HHS-OIG, as the regulation at 42 CFR §1002.3(b)(3) would require in the FFS program.

Recommendation: Require MCOs to report all denials of enrollment or credentialing or terminations of providers based on program integrity concerns to HHS-OIG.

Not conducting complete exclusion searches.
On June 12, 2008, CMS issued State Medicaid Director Letter (SMDL) #08-003 providing guidance to States on checking providers and contractors for excluded individuals. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own staff and subcontractors for excluded parties, including owners, agents, and managing employees. A new regulation at 42 CFR § 455.436, effective March 25, 2011, now requires States to check enrolled providers, persons with ownership and control interests, and managing employees for exclusions in both the List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS) on a monthly basis.

The fiscal agent for Connecticut, which handles FFS provider enrollment, only checks the LEIE at enrollment and recredentialing and does not check it monthly.

Similarly, the NEMT broker and MCOs in Connecticut do not conduct exclusion searches that are fully consistent with CMS guidance. The DSS shared SMDL #09-001 in a bulletin on its website. The three MCOs interviewed reported that they were performing monthly checks of providers on the LEIE as required. However, the MCOs were not performing monthly checks of owners, employees, and subcontractors. All three MCOs do not collect the full range of required disclosures, such as owners, agents, and managing employees, and therefore cannot check all individuals monthly as required.

Recommendation: Develop and implement policies and procedures for appropriate collection and maintenance of disclosure information to ensure that the FFS program, contracted MCOs, the transportation broker, and network providers conduct exclusion searches using the LEIE (or the Medicare Exclusion Database) and the EPLS at the time of provider enrollment, re-enrollment, and monthly thereafter.

Lack of oversight of MCOs. (Uncorrected Repeat Vulnerability)
This is a repeat vulnerability from the March 2007 MIG review. Although some of the State's MCOs have effective practices, the State's oversight of the MCOs' program integrity activities was less than adequate. The issues include:

- The DSS Managed Care Unit relies on its contract and RFP to outline all policies and procedures.
- The DSS is not verifying MCOs' disclosures or processing disclosures through the Excluded Parties List System, and does not require MCOs to update the information. Therefore, the Division is not in a position to know whether an MCO is out of compliance with 42 CFR § 438.610.

- The DSS does require that MCOs submit encounter data and the data is entered into the Medicaid Management Information System. However, no utilization review processes are implemented to analyze the data.
- The MCOs are required by contract to report any potential fraud and abuse to the "Department". Although the Managed Care Unit staff stated that fraud and abuse should be reported to the OQA, MCO responses indicated that two were not reporting to OQA and one has never had any to report but would report to OQA.

Recommendation: Develop and implement policies and procedures to ensure adequate oversight, continuity and consistency in all activities related to the managed care organizations.

CONCLUSION

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

- client surveys to supplement investigations,
- an enhanced comprehensive fraud referral process, and
- a comprehensive provider enrollment checklist.

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, nine areas of vulnerability were identified. Four of the nine vulnerabilities were identified in MIG's 2007 review and remain uncorrected. The CMS encourages DSS 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 DSS 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 Connecticut 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 DSS 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 Connecticut on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

Official Response from Connecticut
April 2011

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
25 SIGOURNEY STREET • HARTFORD, CONNECTICUT 06106-5033

October 11, 2011

Via Email

Robb Miller
Director of the Division of Field Operations
Medicaid Integrity Group-Center for Program Integrity
Center for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore. MD 21244

RE: Connecticut Comprehensive Program Integrity Review
Revised Final Report -August 2011

Dear Mr. Miller:

This letter is in response to the above referenced report and contains the Department of Social Services' ("'Department") requested correction plan. The report identifies six (6) Federal regulatory compliance issues and nine (9) areas of vulnerability. I have organized my response to first address each regulatory compliance issue and then each area of vulnerability.

Regulatory Compliance Issues

The State does not refer all suspected provider fraud to the Medicaid Fraud Control Unit.
The Department disagrees with this finding. The Department refers all corroborated allegations of suspected provider fraud to the three parties covered under the applicable Memorandum of Understanding.

Allegations of fraud are reviewed by the Special Investigations Unit ("SIU"). The SIU has tailored its referral process to comply guidance provided by CMS's "BEST PRACTICES FOR MEDICAID PROGRAM INTEGRITY UNITS' INTERACTIONS WITH MEDICAID FRAUD COUNTROL UNITS". CMS recommends that a fraud referral should be made whenever there is reliable evidence that overpayments are the product of fraud. CMS defines reliable evidence as "evidence that has been corroborated". The SIU will not refer uncorroborated allegations of suspected fraud.

The Department is continually reviewing its process for identifying, corroborating and referring suspected fraud. The quality of the fraud referrals developed by the SIU has been excellent, but timeliness of some referrals can be improved and that has been made a priority.

An Equal Opportunity / Affirmative Action Employer
Printed on Recycled or Recovered Paper

The State withholding letter for payments does not reference the required Federal regulation.

The Department has modified the “notice of withhold” letter by adding the required language in accordance to regulation 42 CFR § 455.23(b).

The State does not require MCOs to disclose business transactions

The Department agrees with the finding. The Department will cease contracting with MCOs effective January 1, 2012. Due to the imminent termination of the MCO contracts, the Department is not at liberty to make any material changes to the current contracts.

The State does not report all adverse actions taken on provider applications to HHS-OIG.

The Department agrees to develop and implement policies and procedures to ensure compliance with 42 CFR § l002.3(b)(3).

Connecticut doesn’t notify all required parties when there is a State-initiated exclusion.

The Department agrees to develop and implement policies and procedures to ensure that all parties identified in 42 CFR §1002.212 are notified of a State-initiated exclusion.

The State does not report all convictions of crimes against Medicaid to HHS-OIG.

The Department agrees to modify the MOU to clearly identify which party will be responsible to report criminal conviction information to HHS-OIG.

Vulnerabilities

Not having adequate written policies and procedures.

The Department agrees to complete the development of written policies and procedures covering all program integrity processes to ensure compliance with Federal regulations. This has been an on-going process and the current draft does address such areas as the Surveillance Utilization Review Subsystem, identification. corroboration and referral of fraud.required reporting to the HHS-OIG, checking for excluded parties, and other key areas.

Not capturing managing employee information on provider enrollment forms.

The vulnerability relates to MCO provider enrollment forms. As stated previously, effective January 1, 2012, the Department will cease contracting with MCOs. Due to the imminent termination of the MCO contracts, the Department is not at liberty to make any material changes to the current contracts.

Not collecting ownership and control disclosures from MCO Network Providers.

Effective January 1, 2012, the Department will cease contracting with MCOs. Due to the imminent termination of the MCO contracts, the Department is not at liberty to make any material changes to the current contracts.

Not requiring MCO providers to disclosure business transaction information upon request.

Effective January 1, 2012, the Department will cease contracting with MCOs. Due to the imminent termination of the MCO contracts, the Department is not at liberty to make any material changes to the current contracts.

Not capturing the full range of criminal conviction information from MCO network providers.

Effective January 1, 2012, the Department will cease contracting with MCOs. Due to the imminent termination of the MCO contracts, the Department is not at liberty to make any material changes to the current contracts.

Not verifying with beneficiaries whether managed care services billed by providers were received.

Effective January 1, 2012, the Department will cease contracting with MCOs. Due to the imminent termination of the MCO contracts, the Department is not at liberty to make any material changes to the current contracts.

Not reporting adverse actions taken on managed care provider applications to the State or HHS-OIG.

Effective January 1, 2012, the Department will cease contracting with MCOs. Due to the imminent termination of the MCO contracts, the Department is not at liberty to make any material changes to the current contracts.

Mr. Robb Miller
Page 3
October 11, 2011

.Not conducting complete exclusion searches.

As of September 2010, the fiscal agent for the Department, which administers provider enrollment, checks the List of Excluded Individuals/Entities (LEIE) on a monthly basis along with checks prior to enrollment and on re-enrollment. In May 2010, a bulletin was sent to all FFS providers outlining their responsibilities to determine if their employees and contractors have been excluded from participation in federal health care programs. This bulletin was provided to the review team.

In regards to the MCOs, effective January 1, 2012, the Department will cease contracting with MCOs. Due to the imminent termination of the MCO contracts, the Department is not at liberty to make any material changes to the current contracts.

Lack of oversight of MCOs.

Effective January 1, 2012, the Department will cease contracting with MCOs.

Summary

The corrective action steps outlined in this letter will be implanted within ninety days, with the exception of the development of written policies and procedures. It is anticipated that that process will be completed within the next six months.

The Department appreciates the effort that you and your staff dedicated to the review of our program integrity functions. It is our goal to be in full compliance with all regulatory requirements and your oversight is invaluable. Please extend our appreciation to the review team.

Sincerely,

Mark Schaefer. Director
Medical Care Administration

MS/JFM/LP

cc: Roderick L. Bremby, Commissioner
John F. McCormick, Director, Office of Quality Assurance
Lynwood Patrick, Manager, Special Investigations Unit