Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

District of Columbia Focused Program Integrity Review

Final Report

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TABLE OF CONTENTS

INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a focused program integrity review of the District of Columbia (the District) Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Department of Health Care Finance (DHCF). The review team also visited the offices of the Child and Family Services Agency (CFSA), District of Columbia Public Schools (DCPS), and Department of Mental Health (DMH).

This review focused on the activities of three of DHCF's partner agencies which provide or arrange for Medicaid covered services. Specifically, the purpose of the review was to assess whether DHCF and its partner agencies had processes in place to prevent serious program integrity deficiencies and safeguard Medicaid dollars. This report describes three effective practices and two vulnerabilities. It also contains several other recommendations for strengthening the District's oversight of partner agencies in its program integrity operations.

The onsite portion of this review took place from June 30 to July 2, 2009. As a focused review, it was a separate and distinct undertaking from a September 2009 comprehensive review of the District's Medicaid program integrity operations that was also conducted by MIG.

THE REVIEW

Objectives of the Review

1. Determine District partner agency compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help the District improve its overall oversight of partner agencies; and
4. Consider opportunities for future technical assistance.

Overview of the District of Columbia's Medicaid Program

The DHCF administers the District of Columbia Medicaid program. Formerly known as the Medical Assistance Administration (MAA) within the District's Department of Health, the DHCF was created as an independent department in October 2008. As of July 2009, the program served 155,264 recipients, with Medicaid expenditures totaling $1,486,094,392. The Federal medical assistance percentage for the District during that same time period was 70 percent.

The District's partner agencies provide services either directly or through providers over whom they have oversight responsibility. The CFSA is the public agency that protects child victims and children at risk for abuse and neglect. The CFSA is the provider of targeted case management and rehabilitative services for Medicaid enrolled children in its custody. At the time of the review team's onsite visit, CFSA was not claiming Medicaid funds but planned to

begin as soon as it has completed the restructuring of its internal controls, quality assurance, service delivery, and billing processes.

The DMH provides comprehensive mental health services to adults, children, youths, and their families through a network of certified providers and through its Mental Health Services Division. The DMH also provides inpatient mental health services through a publicly owned psychiatric facility. In addition, the DMH certifies the clinical competence and physical practice setting of prospective mental health service providers before they are permitted to apply for enrollment in the Medicaid program. The DMH providers billed Medicaid for almost $28,300,000 in State fiscal year 2008.

The DCPS is a provider of school based health care to students within the District. The DCPS provides the basic Individuals with Disabilities Education Act Health-related services, such as speech, occupational, and physical therapy. The DCPS employs approximately 340 staff who deliver these services, along with 7 contractors with approximately 90 employees.

All claims for services overseen or provided by the actively billing partner agencies are captured by the District's Medicaid Management Information System.

Health Care Accountability Administration

The Office of Program Integrity and the Office of Utilization Management, located within the Health Care Accountability Administration (HCAA), are dedicated to the program integrity function within DHCF. Each unit is headed by a full-time associate director. The HCAA maintains an array of responsibilities that includes authority to enforce all Medicaid laws and rules in the District, perform retroactive (i.e., postpay) claims reviews, and conduct onsite chart reviews to determine whether documentation supports provider billings.

Methodology of the Review

In advance of the onsite visit, the review team requested that DHCF and its partner agencies (CSFA, DCPS and DMH) each complete a focused review guide and supply documentation in support of its answers. The review guide included queries concerning such areas as program integrity, provider enrollment/disclosure, and service delivery. A two-person review team reviewed the responses and materials that the District provided in advance of the onsite visit.

During the week of June 29, 2009 the MIG review team visited the offices of DHCF and its partner agencies. The team conducted interviews with numerous DHCF officials, as well as with staff from the partner agencies.

Scope and Limitations of the Review

This review focused on the District's efforts to ensure the program integrity and administrative accountability of Medicaid programs operated or overseen by DHCF's partner agencies. Unless otherwise noted, DHCF 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 DHCF provided.

RESULTS OF THE REVIEW

Effective Practices

The District has highlighted three practices that demonstrate its commitment to program integrity. These include a liaison unit that assists the partner agencies with Medicaid-related issues; a comprehensive provider audit program implemented by one of the District's partner agencies; and a comprehensive program integrity training program created by one partner agency for its providers.

DHCF Public Provider Liaison Unit

The Public Provider Liaison Unit (PPLU) serves as liaison for DHCF to those District agencies responsible for providing or overseeing the provision of Medicaid services. The PPLU is responsible for understanding the mission, functions, and priorities of all partner agencies and assisting those agencies with applying departmental policies. The unit comprises seven staff. As the partner agencies have begun to implement significant changes in their methods of operating Medicaid service programs, the PPLU has been successful thus far in providing them with a clear point of contact in DHCF and in facilitating effective communications between the department and its partner agencies. For example, the PPLU has convened weekly calls with mental health providers, DHCF, and DMH in order to facilitate a smoother transition to the new Medicaid billing process.

DMH comprehensive provider audit program

During the past 18 months, DMH has instituted frequent onsite audits of provider claims, using U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG) public domain software for sampling and a new comprehensive audit tool designed to test compliance of provider documentation with Federal and District laws, regulations, and policies. Providers with a 15 percent or greater failure rate after the initial claims audit are subjected to a second, expanded audit. The audit program is one component of a systematic revamping of DMH's compliance program.

Mandatory DMH program integrity provider training

The DMH uses a contractor to provide mandatory annual Medicaid Integrity/Compliance training to all network providers. The training focuses on Deficit Reduction Act requirements, exclusion screenings, required internal compliance processes, fraud and abuse issues, required claims documentation, False Claims Act provisions, and quality improvement issues.

Vulnerabilities

While there were no compliance issues identified during the focused review, the review team identified two areas of vulnerability in the District's partner agency practices. The first relates to the disclosure of business transaction information. The second vulnerability involves a failure to properly screen for excluded persons and represents a significant shortcoming in the District's efforts to protect the Medicaid program.

Not requesting disclosure of business transaction information from DCPS subcontractors.
The provider agreement used by DCPS does not solicit disclosure of ownership information from subcontractors that have at least $25,000 in business transactions. Thus, its subcontracted providers do not agree to disclose the full business transaction information, upon request, which is required from Medicaid providers in accordance with 42 CFR § 455.105.

Recommendation: As a condition for claiming Medicaid payments, modify the DCPS Medicaid Provider Agreement to mandate the disclosure of business transaction information, upon request as required in 42 CFR § 455.105(b). Stipulate that DCPS also require its subcontractors do the same at enrollment.

Not conducting exclusion searches for DCPS subcontractors.
The DCPS does not search either the Medicare Exclusion Database (MED) or the HHS-OIG List of Excluded Individuals/Entities (LEIE) databases to screen for excluded employees, nor does it require its contractors to screen their own employees for exclusions. 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 fee-for-service (FFS) program, while the latter directed State Medicaid agencies to require their providers to perform similar checks on employees within their businesses.

Recommendations: As a condition for claiming Medicaid payments, modify the DCPS Medicaid Provider Agreement to require DCPS to search the MED or LEIE for employees providing direct services. Stipulate that DCPS also require its subcontractors do the same for their employees at the initial start of service provision and on a monthly basis thereafter.

OTHER CMS OBSERVATIONS AND RECOMMENDATIONS

On July 13, 2009, DHCF issued a Request for Proposals for an Administrative Services Organization (ASO) to develop, implement and operate a claims and payment management system and perform other administrative functions on behalf of various District agencies, including those subjected to this review. If ultimately engaged, an ASO will likely have a dramatic effect on the partner agencies' Medicaid billing process and on other aspects of their program integrity functions as well. Among other roles, DHCF expects that the ASO will conduct quality assurance reviews on the substance of those documents supporting a claim before it sends a claim on for payment. The DHCF should work closely with partner agencies as it moves forward in planning to contract with an ASO to conduct prepayment reviews of Medicaid claims.

Additional recommendations for strengthening DHCF's program include:

- Consider requiring the ASO to capture the name of the rendering caregiver/provider on all claim forms. This would facilitate the agency's tracking of problematic providers and other health care staff, who can otherwise easily move between various providers without the knowledge of the agency.
- Ensure that all partner agencies report to DHCF or directly to HHS-OIG any exclusion information that is disclosed to them by a provider about an individual who has or had an ownership or control interest in a provider entity or who is a managing employee of a provider entity within 20 business days after receipt of such information.
- Ensure that all partner agencies notify DHCF or HHS-OIG promptly of any administrative actions it takes to limit a provider's participation in the Medicaid program that might lead to exclusion.
- Require all partner agencies to solicit information from providers about individuals with ownership or control interests in the provider entity and from individuals who work as agents or managing employees for the provider entity.
- Encourage all partner agencies to refrain from processing provider applications if they do not appear complete and until the agencies can verify the accuracy and completeness of the information furnished.
- Require that all partner agencies develop an internal pre-payment review process to avoid inaccurate claim submissions until such time as the ASO can be brought on board to perform this function.
- Require all partner agencies to conduct post-payment reviews of provider claims.
- Consider requiring all providers who provide a Medicaid service to be enrolled through the department's FFS Medicaid provider enrollment process to ensure that all disclosure checks and screenings are consistent.

CONCLUSION

The DHCF (unlike MAA, its predecessor agency) is endowed with a measure of enforcement and oversight authority over its partner agencies. With that newfound authority, DHCF has stated that it plans to create a corrective action plan process that each partner agency will be required to follow whenever program integrity vulnerabilities are discovered. The DHCF is also working with CFSA and George Washington University to ensure that the targeted case management and rehabilitation services programs that CFSA oversees comply with Federal regulations and the District's own State Plan amendment requirements.

The DHCF and its partner agencies apply some effective practices that demonstrate program strengths and the District's commitment to program integrity. These effective practices include:

- effective use of a Public Provider Liaison Unit in facilitating communication between DHCF and partner agencies,
- development and implementation of a comprehensive audit program by DMH, and

- mandatory annual Medicaid program integrity and compliance training for DMH providers.

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

However, two areas of vulnerability were identified. The CMS encourages the District 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 request DHCF to provide a corrective action plan describing how it will address the vulnerabilities identified in this report, within 30 calendar days from the date of the final report letter.

The corrective action plan should address how DHCF will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the District expects will occur. Please provide an explanation if correcting any of the vulnerabilities will take more than 90 calendar days from the date of the letter. If DHCF has already taken action to correct these deficiencies, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the District of Columbia in eliminating its areas of vulnerability and building on its effective practices.