Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

District of Columbia Program Integrity Review

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 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) and visited the fiscal agent. The review team also conducted a phone interview with the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Health Care Accountability Administration (HCAA), a component of DHCF, which is responsible for Medicaid program integrity. This report describes two effective practices, five regulatory compliance issues, and six vulnerabilities in the District's program integrity operations.

The MIG also conducted a focused review during the week of June 30, 2009. The focused review surveyed the program integrity operations in DHCF sister agencies which serve Medicaid clients. Results from the focused review are addressed in a separate report.

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

Overview of the District's Medicaid Program

The DHCF administers the District of Columbia Medicaid program. In the District fiscal year ending September 30, 2008, the program served 155,000 recipients, with Medicaid expenditures totaling $1,486,094,392. Approximately 101,000 recipients were enrolled in 4 managed care organizations (MCOs). The remaining 54,000 recipients were served on a fee-for-service (FFS) basis. The District had approximately 6,600 FFS participating providers and 9,000 MCO providers. During Federal fiscal year 2008, the Federal medical assistance percentage for the District was 70.00 percent.

The District's Medicaid program reorganized in October 2008 when it converted from the status of a component (the Medical Assistance Administration) within the Department of Health to an independent department (DHCF). At the time of this review, DHCF was undergoing an internal realignment of positions and duties. The HCAA management indicated that due to the reorganization of the Medicaid program, data and statistics prior to District fiscal year 2007 were not available for inclusion in this report.

Program Integrity Section

The Office of Program Integrity (OPI) and the Office of Utilization Management (OUM) within HCAA are the organizational components dedicated to the prevention and detection of provider fraud and abuse. At the time of the review, OUM had 10 authorized full-time equivalent staff and OPI had 8, including 2 vacant staff positions. The authorized positions include three auditors, six investigators, three data analysts, three nurses, one administrative assistant, and two managers. In District fiscal years 2007 and 2008, the District recovered an average of nearly $455,000 per year as a result of program integrity activities. At the time of the review, District fiscal year 2009 total recoveries were $1,400,000.

Methodology of the Review

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

During the week of September 14, 2009, the MIG review team visited the offices of HCAA and the Health Care Operations Administration (HCOA). The team conducted interviews with numerous DHCF officials and staff from the District's Office of Procurement and Contracts. Finally, to determine whether the MCOs were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team interviewed District staff from the Health Care Delivery Management Administration, within DHCF, which oversees the Medicaid MCOs in the District. The team also reviewed the managed care contract provisions and gathered information through interviews with representatives of four MCOs. In addition, the team conducted sampling of provider enrollment applications, case files, selected claims, and other primary data to validate the District's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the HCAA, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, managed care and non-emergency medical transportation. The District's Children's Health Insurance Program (CHIP) operates as a Medicaid expansion program under Title XIX of the Social Security Act. The District's CHIP operates under the same billing and provider enrollment policies as the District's Title XIX program. The same findings, vulnerabilities, and effective practices discussed in relation to the Medicaid program also apply to the expansion CHIP.

Unless otherwise noted, the District 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 two practices that demonstrate its commitment to program integrity. These include a more stringent durable medical equipment (DME) supplier enrollment process and a more effective scrutiny of providers through staff specialization.

Durable medical equipment supplier enrollment process

In May 2008, the DHCF published new regulations designed to reduce fraud and abuse in DME by strengthening the District's DME supplier enrollment process.

The regulations require pre-enrollment site visits for all suppliers within a 30 mile radius of DHCF. The purpose of the onsite review is to verify information submitted on the provider application. All suppliers outside the 30 mile radius must have a telephone interview with DHCF staff. During both site visits and telephone interviews, the District's provider enrollment staff utilizes a checklist specifically developed for DME suppliers.

In addition, the regulations require providers to attend orientation before they can be enrolled in the District's Medicaid program. The orientation session includes fraud and abuse training. The DME suppliers within the 30 mile radius must send at least 2 representatives to attend the orientation in person. One representative must have the fiduciary authority to enter into a provider agreement with the District, and the other must have responsibility for Medicaid billing or claims processing. Suppliers based outside the 30-mile radius must send two similar representatives plus a third that must be the registered agent listed in the approved supplier application. In addition to the initial enrollment screening and orientation procedures, all DME suppliers serving Medicaid recipients are required to reenroll every three years.

More effective scrutiny of different provider types through staff specialization

Within DHCF, all OUM professional staff are assigned to specific provider and service types in addition to serving as backup to a co-worker. Staff persons are responsible for knowing the specific program eligibility and billing policies in their areas of concentration. This has helped improve staff effectiveness in conducting claims payment reviews. Staff specialists are also responsible for conducting provider training when issues are identified during the review process. As an incentive to improve performance, HCAA has set a $250,000 annual recovery goal for each staff member. According to the District's program integrity director, the goal is expected to increase to $1 million once the new Medicaid Management Information System (MMIS) is in place.

Regulatory Compliance Issues

The District is not in compliance with Federal regulations regarding referrals to law enforcement, certain disclosures, and notification activities.

The DHCF does not refer cases of recipient Medicaid fraud to the appropriate law enforcement authorities.

The Federal regulation at 42 CFR § 455.15(b) requires State Medicaid agencies to refer suspected cases of recipient fraud to an appropriate law enforcement agency.

The DHCF does not refer cases of suspected recipient fraud to law enforcement, but instead refers these cases to the Income Maintenance (IM) Section in the Department of Human Services (DHS), which determines eligibility. This section investigates cases; and the extent to which they are referred for prosecution is unclear to DHCF.

Recommendation: Develop a written agreement with DHS' IM unit describing how the two units will work together to ensure the referral of all suspected cases of recipient fraud to an appropriate law enforcement agency. Implement policies and procedures for referring suspected recipient fraud cases to an appropriate law enforcement agency.

The District does not capture all required ownership, control and relationship information from the fiscal agent, the transportation broker, and MCOs.

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.

Based on District responses to the review guide and interviews with DHCF provider enrollment and contracting and procurement staff, the team determined that the ownership, control and relationship information required under 42 CFR § 455.104 is not collected for the District's fiscal agent, transportation broker and MCOs.

Recommendations: Modify the fiscal agent, transportation broker and MCO contracts to require submission of all required ownership and control information.

The DHCF does not require MCO contractors to disclose required business transaction information upon request.

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.

While DHCF's MCO contracts do contain some financial reporting provisions, they do not require MCOs to report business transactions upon request in accordance with the requirements of 42 CFR § 455.105. In addition, the contracts do not require the MCOs to provide the necessary information within the specified 35-day time frame. During interviews with the review team, managed care staff indicated that they are drafting policies to satisfy this requirement.

Recommendation: Modify the MCO contracts to require disclosure, upon request, of the business transaction information specified in 42 CFR § 455.105.

The District does not request health care-related criminal convictions from all required parties in the managed care contracting process.

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.

The DHCF managed care contracts do not require agents and managing employees of the MCO to disclose health care-related criminal convictions. Based on managed care staff responses during interviews, complete disclosure information for all required parties was not collected by the Office of Procurement and Contracts and passed on to DHCF as part of the pre-contracting Request for Proposals process.

Recommendations: Modify the MCO contracts to require the health care-related criminal conviction disclosure information on agents and managing employees specified in 42 CFR § 455.106. Monitor MCO compliance and timely reporting of such disclosures to DHCF. Refer any such disclosures to HHS-OIG within the timeframe specified by the regulation.

The District's managed care contracts do not require reporting of adverse actions taken on provider applications for participation in the program.

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 DHCF umbrella contract for MCOs requires the reporting of network provider terminations, and the MCOs indicated during interviews that they do report such terminations to DHCF. However, the contract does not require Medicaid MCOs to report adverse actions taken on provider applications for participation in the MCO Medicaid network, and there is no evidence that the MCOs are doing so in practice. During interviews, the HCAA director indicated that DHCF does report denials of FFS provider applications made for program integrity reasons. The failure of MCOs to notify the Medicaid agency of adverse actions precludes DHCF from fully meeting the regulatory requirement at 42 CFR § 1002.3(b). During interviews with the review team, managed care staff indicated that they are drafting policies to come into compliance with the regulation.

Recommendations: Require contracted MCOs to notify the District when they deny providers credentialing for program integrity-related reasons. Develop and implement procedures for reporting these adverse actions to HHS-OIG.

Vulnerabilities

The review team identified six areas of vulnerability in the District's program integrity practices. These related to a lack of adequate written policies and procedures, incomplete exclusion search procedures, managed care disclosures, and verification of receipt of managed care services.

Lack of adequate written policies and procedures.

The DHCF is in the process of writing policies and procedures. The DHCF supplied several draft policies to the review team, and its managers discussed the full range of policies which they envisioned in different program areas. However, at the time of the review, only one new policy and procedure had been finalized for OPI and six for OUM.

The policies awaiting drafting or finalization affect DHCF program integrity, managed care, and provider enrollment operations. The activities they will cover include the broad gamut of FFS and managed care program integrity and provider enrollment activities. The temporary absence/shortage of written policies and procedures leaves the District vulnerable to inconsistency in its operations.

Recommendation: Develop, compile, implement and update, as necessary, written policies and procedures addressing all program integrity, provider enrollment and managed care functions.

Not conducting complete or consistent searches for excluded individuals

On June 12, 2008, CMS issued a 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 to screen their own staff and subcontractors for excluded parties. The review team observed that the District's exclusion checking procedures are internally inconsistent and did not adhere to the guidance provided in the SMDLs.

The District's FFS provider enrollment is handled by two DHCF offices and the fiscal agent. While the HCOA Provider Enrollment Unit processes applications and conducts exclusion checks for most provider types after an initial fiscal agent review, OUM staff reviews pharmacy, nursing home and DME applications before approving enrollments.

During a walkthrough of the provider enrollment process, the team noted that OUM staff checks all names, including managing employees, against HHS-OIG's List of Excluded Individuals/Entities (LEIE) during the enrollment process, while HCOA staff only checks the names of the provider and members of a practice if the provider is part of a group practice. The inconsistent checking of individuals listed on the application leaves the District vulnerable to allowing excluded individuals who work for providers into the program.

In addition, the office that contracts with entities to provide services to Medicaid recipients does not adequately check potential contractors for exclusions. The Office of Contracts and Procurements, which is outside DHCF, does the actual contracting with the fiscal agent, pharmacy benefits manager, transportation broker, and MCOs. While the contracting process includes licensure, tax law compliance, Federal debarment list and state exclusion list checks, the searches are performed on the company name and Federal Tax Identification number or a partner name if there is one. Even though owners, directors and other principals may be listed in the contract, they are not searched or reported to HCOA where they could potentially be captured in a database like the MMIS for ongoing exclusion checks. For its part, the Medicaid agency also does not maintain complete information on owners, officers and managing employees in the MMIS or an equivalent repository. Therefore, DHCF cannot conduct adequate monthly searches of the LEIE or the Medicare Exclusion Database (MED).

Providers likewise do not always screen their staff and contractors for excluded individuals. For example, during various interviews, the review team inquired if FFS provider enrollment, managed care, MCO, and contracting staff were familiar with the guidance in SMDL #09-001 that providers should check their staff and contractors for exclusions on an ongoing basis. In all instances the response was negative. There were no indications that this SMDL was transmitted internally within DHCF to program personnel and the fiscal agent, and externally to FFS and managed care providers.

In the managed care credentialing process specifically, the review team also found that owners and managing employees are not always checked for exclusions at the time of or after enrollment. One MCO stated it checks only the practitioner and requires providers to warrant they have no excluded staff. Another MCO indicated that it only checks administrative staff and licensed individuals at the time of enrollment. Consequently, MCO owners, directors, managing employees and sub-contractors are not scrutinized for exclusions on a periodic basis and in some cases may not be checked at all.

Recommendations: Develop policies and procedures for appropriate collection and maintenance of disclosure information, including health care-related criminal convictions, about disclosing entities, and about any person with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or

managerial control over the disclosing entity. Conduct exclusion searches on key contractor, fiscal agent, and disclosing entity personnel using the LEIE or the MED at the time of enrollment and at least monthly thereafter. Instruct FFS and MCO network providers to do the same with their own employees. For guidance, refer to SMDLs #08-003 and #09-001, which can be found on the CMS website.

Not collecting all required ownership and control disclosure information from MCO network providers.

Neither the DHCF umbrella contract nor existing policies and procedures require the District's Medicaid MCOs to collect the full range of ownership and control disclosures from MCO network providers that Federal regulations at 42 CFR § 455.104 would otherwise require from FFS providers. In their internal credentialing process, the District's MCOs use the Council for Affordable Quality Healthcare (CAQH) provider application form which does not ask for information on persons with ownership and control interests in the provider, family relationships among such persons, and interlocking relationships of ownership and control with subcontractors. This leaves the District vulnerable to having excluded parties in ownership and control positions of providers or subcontractors serving Medicaid managed care enrollees.

Recommendation: Modify the managed care contracts to require the disclosure of complete ownership, control, and relationship information from all MCO network providers.

Not requiring MCO providers to disclose business transaction information, upon request.

Neither the DHCF contract with MCOs nor the MCO provider agreements require network providers to disclose the business transaction information on request, as stipulated at 42 CFR § 455.105.

Recommendation: Modify the District's MCO contracts and MCO network provider agreements to require disclosure of business transaction information upon request.

Not requiring the disclosure of health care-related criminal conviction information during the managed care credentialing process.

The DHCF contract with the MCOs does not require MCO provider personnel to disclose the health care-related criminal conviction information which Federal regulations at 42 CFR § 455.106 would otherwise require of FFS providers. The CAQH application used by the MCOs during provider credentialing does not contain language with sufficient specificity to meet the regulatory requirement. Section 8 of the CAQH provider application asks if the practitioner has been convicted of any felony or pled guilty or nolo contendere to a misdemeanor for any civil offense that is reasonably related to qualifications, competence, functions, or duties as a medical professional or for fraud. Owners, directors and managing employees are not asked for similar disclosures.

Recommendation: Modify MCO contracts to require the collection and reporting of health care-related criminal conviction disclosure information from all MCO network providers and affiliated parties as specified in 42 CFR § 455.106.

Not verifying with enrollees whether managed care services billed by providers were received. The District's contracts with the MCOs contain a provision from the Federal regulation at 42 CFR § 455.20 requiring State Medicaid programs to verify with recipients that reimbursed services were actually provided. However, the District is not enforcing this requirement with its contracted MCOs. The MCOs currently interact with enrollees about the quality of services received but do not verify that billed services were actually provided. During interviews with the review team, managed care officials said that they were having discussions with the MCOs about the possibility of using Explanations of Medicaid Benefits for this purpose.

Recommendation: Develop and implement policies and procedures to monitor MCO compliance with contract provisions requiring verification with recipients that services billed by network providers were actually received.

CONCLUSION

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

- a rigorous DME supplier enrollment process that included site visits, orientation classes, and routine re-enrollment, and
- use of staff specialization to more effectively conduct claims payment reviews and provider training

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

However, the identification of five areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, six areas of vulnerability were identified. The CMS encourages DHCF 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 DHCF 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 District 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 District of Columbia 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 regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If the District 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 District of Columbia on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.