Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Idaho Comprehensive 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 Idaho Medicaid Program. The MIG conducted the onsite portion of the review at the Idaho Department of Health and Welfare (DHW) offices. The review team also visited the office of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Division of Medicaid and the Division of Management Services within DHW. The Division of Medicaid is primarily responsible for Medicaid fee-for-service (FFS), primary care case management (PCCM), managed care entities, prepaid ambulatory health plans (PAHP), payments, and provider enrollment. The Division of Management Services is responsible for program integrity activities. This report describes one effective practice, three regulatory compliance issues, and six 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 Idaho improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Idaho's Medicaid Program

The DHW administers the Idaho Medicaid program. As of June 2007, the program served 184,508 recipients. Idaho has a PCCM program with 151,140 enrolled recipients, or 81.9 percent of Idaho's Medicaid population.

At the time of the review, DHW had 22,524 participating FFS providers. Approximately 1,248 providers are participating in Idaho's three managed care organizations (MCOs). Over the past three State fiscal years (SFYs), DHW processed an average of 8.9 million claims per year. In SFY 2007, 89 percent of all claims were submitted electronically. Medicaid expenditures in Idaho for the SFY ending June 30, 2007, totaled $1,225,297,064. The Federal medical assistance percentage for Idaho for Federal fiscal year 2007 was 68.7 percent.

Bureau of Audits and Investigations

The Bureau of Audits and Investigations, within the Division of Management Services, is the organizational component dedicated to fraud and abuse activities. At the time of our review, the Bureau of Audits and Investigations had approximately 32 full-time equivalent employees (FTEs), with 7 FTEs focusing on Medicaid program integrity. During SFY 2005 through SFY 2007, Bureau staff conducted an annual average of 228 preliminary investigations and 138 full

investigations. The table below presents the total number of audits and overpayment amounts collected for the last three SFYs as a result of program integrity activities.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations	Number of State Administrative Actions	Amount of Overpayments Identified	Amount of Overpayments Collected
2005	245	122	77	$1,042,525	$ 584,870
2006	216	136	85	$ 794,568	$ 435,678
2007	224	156	117	$1,944,959	$1,149,524

* 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.

Methodology of the Review

In advance of the onsite visit, CMS requested that Idaho complete a comprehensive review guide and supply documentation in support of its answers to the review guide. The review guide included such areas as provider enrollment, claims payment and post-payment review, managed care, surveillance and utilization review subsystem, and the MFCU. A five-person team reviewed the answers and documents that the State provided in advance of the onsite visit.

During the week of September 22, 2008, the MIG review team visited the DHW offices and also met with the MFCU Director. The team conducted interviews with numerous officials from DHW and the MFCU, as well as with staff from the provider enrollment contractor and a dental contractor. To determine whether managed care contractors were complying with the contract provisions and other Federal regulations relating to program integrity, the MIG team reviewed the contract provisions and gathered information from the MCOs through interviews with representatives of two MCOs, and met with staff from the DHW divisions that oversee the managed care programs.

Scope and Limitations of the Review

This review focused on the activities of the Division of Medicaid and the Division of Management Services. Idaho operates a combination Children's Health Insurance Program (CHIP), which is part Medicaid expansion and part stand alone under Title XXI of the Social Security Act. The stand alone portion of the program was not included in this review. However, the Medicaid expansion portion of the CHIP program operates under the same FFS billing and provider enrollment policies as Idaho's Title XIX program. The same findings and vulnerabilities discussed in relation to the Medicaid program apply to this part of the CHIP program as well. Unless otherwise noted, DHW 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 DHW provided.

RESULTS OF THE REVIEW

Effective Practices

The State has highlighted a practice that demonstrates its commitment to program integrity.

Thorough preliminary investigations

Idaho's program integrity staff conduct very thorough preliminary investigations and refer cases to the MFCU whenever there is reliable evidence of provider fraud. The program integrity area has experienced investigators; it was the investigatory unit for criminal investigations before the MFCU came into existence in July 2007.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to disclosures of certain business transactions and criminal conviction information, and reporting requirements.

The State does not require disclosure of business transactions in its FFS operations.

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractors.

The State agency's provider enrollment contractor uses the CMS 855 form to enroll institutional providers. In addition, the State does not have a signed provider agreement for every institutional provider. Those providers, both institutional and non-institutional, that signed a DHW Medicaid Provider Agreement meet the regulatory requirement.

***Recommendation*:** Modify the institutional enrollment process to require signed provider agreements from all institutional providers to meet the requirement in 42 CFR § 455.105.

Idaho does not capture required criminal conviction information in its FFS operations.

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 U.S. Department of Health & Human Services Office of Inspector General (HHS-OIG) whenever such disclosures are made.

Provider enrollment applications used by the State's enrollment contractor do not ask for disclosure of criminal conviction information from individual providers.

***Recommendation*:** Modify provider enrollment applications to meet the full criminal conviction disclosure requirements of the regulation.

DHW does not report to HHS-OIG adverse actions taken on PAHP provider applications.
The regulation at 42 CFR §1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. The State Medicaid agency does not require its PAHPs to report adverse credentialing decisions. Staff from the two PAHPs interviewed stated that they do not report to the State agency when they deny enrollment of a provider. Therefore, Idaho's DHW can not promptly report to HHS-OIG all adverse actions taken by the PAHPs against a provider's application for participation.

***Recommendations*:** Require PAHPs to notify the State when taking adverse action against a provider's participation in the program, including when it denies credentials for fraud-related concerns. Develop and implement procedures to report to HHS-OIG all adverse actions taken against and limits placed on providers applying to participate in the program.

Areas of Vulnerability

The review team identified six areas of vulnerability in Idaho's practices regarding verification of services for PAHP recipients, verification of provider licenses, capture and reporting of disclosure information, and communication among the State agencies and external partners.

Not verifying with recipients whether PAHP services billed by providers were received.
Under 42 CFR § 455.20, the agency must have some method for verifying receipt of services with recipients. That obligation still applies when the State agency contracts with a PAHP. Idaho's PAHP contract states that the "Contractor must have methods and procedures to verify that services are actually provided as billed." However, based on interviews with two PAHPs and written responses to the MIG review guide, Idaho's PAHPs do not take any action to verify with recipients that billed services were actually received.

***Recommendation*:** Monitor and enforce PAHP contracts to ensure that PAHPs are undertaking some form of verification of services.

Not verifying provider licenses.
Idaho does not routinely verify provider licenses during the enrollment process. Although each professional provider is required to send in a copy of his current license as part of the enrollment process, the license would only be verified if the enrollment application was missing some information.

***Recommendation*:** Develop and implement a procedure to routinely verify provider licenses during enrollment or re-enrollment processes.

Not capturing ownership, control, and relationship information in the PAHP credentialing process.
Two of the State's contracted PAHPs do not ask for disclosure information concerning ownership, control and relationship information from individual providers in the credentialing and re-credentialing process.

***Recommendation*:** Modify all provider credentialing and re-credentialing forms to capture the required ownership, control, and relationship information.

Not requiring disclosure of business transaction information upon request in the PAHP credentialing process.
Credentialing forms used by two of the State's contracted PAHPs do not require the disclosure of certain business transactions with wholly owned suppliers or any subcontractors upon request.

***Recommendation*:** Require the PAHPs to modify credentialing forms to require disclosure of the required business transaction information.

Not requiring PAHPs to report criminal conviction information to the State.
The State's contracted PAHPs do require disclosure of criminal conviction information from individual providers in the credentialing and re-credentialing process; however, the State does not have a procedure for the PAHPs to notify the State if there is a self-disclosure. During interviews with two PAHPs, both said that if they did have a criminal disclosure the information would only be forwarded to their credentialing committee for a decision. Because PAHPs are not reporting criminal conviction information to the State, the State is not able to pass on the unreported information to the HHS-OIG.

***Recommendations*:** Develop and implement a procedure for PAHPs to notify the State of criminal conviction disclosures. Develop and implement a procedure to report criminal conviction information to HHS-OIG within 20 working days.

Lack of effective communication among State agencies, PAHPs and the MFCU and lack of oversight of PAHPs.
Fraud referrals received by DHW are not always forwarded to the program integrity area for preliminary investigation. DHW may forward the referral directly to the MFCU or resolve the issue internally, without involving the program integrity area. In addition, some referrals are forwarded to the MFCU with no resource information on the referral.

The Memorandum of Understanding between the Idaho Office of Attorney General and the DHW states "DHW will incorporate, to whatever extent practical, fraud screens in the development of the Medicaid Management Information System (MMIS), and will consult with the MFCU on their design." However, the MFCU has not been consulted in the development of the new MMIS system so that new fraud screens may be developed.

The State Medicaid agency lacks oversight of PAHPs. During interviews, the MIG team was told that the State knew that Federal regulations were being met by the PAHPs because of contractual requirements to do so. Yet no one from the State was able to articulate how the State agency verifies that the PAHPs have operationalized the State contract requirements.

***Recommendations*:** Develop and implement a procedure to forward all fraud referrals to the program integrity area for investigation. Consult with the MFCU in the development of the new MMIS system so that new fraud screens may be developed. Develop and implement policies and procedures for providing oversight of PAHPs to ensure that State contract requirements and Federal regulations are being followed.

CONCLUSION

The State of Idaho applies an effective practice, thorough preliminary investigations of suspected fraud or abuse, that demonstrates program strengths and the State's commitment to program integrity. 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, six areas of vulnerability were identified. The CMS encourages DHW to closely examine each area of vulnerability that was identified in this review.

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