Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Maine 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 Maine Medicaid Program. The MIG conducted the onsite portion of the review at the Office of MaineCare Services (OMS) offices. The MIG review team also visited the office of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Division of Program Integrity (DPI), which is responsible for Medicaid program integrity. This report describes four effective practices, five regulatory compliance issues, and five 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 Maine improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Maine's Medicaid Program

The DPI administers the Maine Medicaid Program. As of June 30, 2008, the program served 300,847 recipients, all of whom were enrolled in fee-for-service. The State had 7,938 providers participating in the Medicaid program; of these, 698 were out-of-state providers. Medicaid expenditures in Maine for State fiscal year (SFY) 2008 totaled $2.2 billion. In SFY 2008, the Federal medical assistance percentage was 63.31 percent.

Program Integrity Section

The DPI is the organizational component dedicated to the prevention and detection of Medicaid provider fraud, abuse and overpayments. At the time of the review, DPI had approximately six full-time equivalent (FTE) positions reporting to the Medicaid Director. The table below presents the total number of investigations, sanctions, identified overpayments, and the average recovery per case review in the past four SFYs as a result of program integrity activities.

Table 1

SFY	Number of Full Investigations	Number of State Administrative Actions or Sanctions (Approximation)	Amount of Overpayments Identified	Average Recovery per Case Review
2005	218	124	$4,300,000	$20,000
2006	144	64	$3,300,000	$23,000
2007	80	47	$5,900,000	$74,000
2008	390	210	$16,800,000	$43,000

Methodology of the Review

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

During the week of November 4, 2008, the MIG review team visited the OMS and MFCU offices. The team conducted interviews with numerous OMS officials and the MFCU. The team also conducted sampling of provider applications, case files, and other primary data to confirm that Maine program integrity practices complied with Federal regulations.

Scope and Limitations of the Review

This review focused not only on the activities of the DPI, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment and provider training. Maine operates an expansion Children's Health Insurance Program (CHIP) under Title XIX of the Social Security Act. The State's CHIP operates under the same billing and provider enrollment policies as Maine's Title XIX program. The same findings, vulnerabilities, and effective practices discussed in relation to the Medicaid program also apply to CHIP.

Unless otherwise noted, DPI 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 DPI provided.

RESULTS OF THE REVIEW

Effective Practices

The State has highlighted several practices that demonstrate its commitment to program integrity. These practices involve the amount of identified overpayments per FTE, increased staffing levels, an effective relationship with the MFCU, and use of permissive exclusion authority.

Average identified overpayments in excess of $1 million per FTE

DPI's average identified overpayments are in excess of $1 million per FTE. Of the identified overpayments, actual recoveries to date have averaged between $500,000 to $650,000 per FTE.

Increased staffing levels

Expansion of the DPI in 2007 resulted in double the number of FTEs. This staffing increase was instrumental in achieving the identification of overpayments discussed above. Current staffing consists of two financial auditors, one nurse, one data analyst,

and nine other programmatic experts with various professional and/or training experiences in health care or administration of the State's Medicaid program.

Effective relationship between DPI and the MFCU
The DPI Director attributes the State's effective relationship with the MFCU, as well as with the State Office of Inspector General and the State Department of Justice, to the fact that each of the agencies focuses on its mission of preventing fraud and abuse, and cooperates and collaborates with one another to reach that goal. The MFCU Director reported that because of the quality of the preliminary case work performed by DPI, the MFCU is able to almost always accept the case.

Use of permissive exclusion authority
Maine uses its permissive exclusion authority to remove aberrant providers. In the past four SFYs, Maine has excluded 167 providers. The State routinely uses Department of Motor Vehicle files, Department of Labor data, and a private software company to locate and deliver notification to the excluded providers.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to provider attestations, verification of receipt of services, and required disclosures of ownership and control information, business transaction information, and criminal conviction information.

Maine does not ensure that providers attest that information provided on claims for dental services is accurate.
The regulation at 42 CFR § 455.18 requires that providers attest to the accuracy of information on all claim forms. The regulation at 42 CFR § 455.19 permits an alternative to attestations on claim forms: the State may print attestation language above the claimant's endorsement on checks or warrants payable to providers. Maine uses the American Dental Association's claim form and it does not contain the required attestation of accuracy of the information on the form.

***Recommendation*:** Utilize a claim form that meets the full requirements of 42 CFR § 455.18 or modify the language on checks payable to include the language specified in 42 CFR § 455.19.

Maine does not verify with recipients whether services billed by providers were received.
Under 42 CFR § 455.20 the State agency must have a method for verifying with recipients whether services billed by providers were received.

The State's Maine Claims Management System, implemented in January 2005, is not able to produce Explanations of Medical Benefits (EOMBs). No other method of verification of service has been implemented. The DPI Director stated that production of EOMBs would resume once the new Medicaid Management Information System (MMIS) is implemented in 2010.

***Recommendation*:** Develop and implement a method for verifying with recipients whether billed services were received. One method would be to devise a questionnaire to be sent to a sample of Medicaid recipients for use until the certified MMIS is functional.

Maine's provider enrollment forms and provider agreement do not capture complete ownership, control and relationship information.

Under 42 CFR § 455.104(a)(1), a provider, or "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. 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 and control information as required by this section.

The MaineCare provider enrollment forms, instructions for completing the forms, and Provider/Supplier Agreement only request information for those who own 5 percent or more of the business. The forms, instructions and agreement do not include language about direct or indirect ownership, and do not ask if anyone named is related to another as a spouse, parent, sibling, or child.

***Recommendation*:** Modify the provider enrollment forms, instructions, and Provider/Supplier Agreement to request all the information required to be disclosed under 42 CFR § 455.104.

Maine's provider enrollment forms and provider agreement do not require providers to disclose certain business transactions.

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. Maine's provider enrollment forms and Provider/Supplier Agreement do not contain such a provision.

***Recommendation*:** Revise the provider enrollment form and the Provider/Supplier Agreement to be consistent with the MaineCare Services' policy for "Requirements of Provider Participation" that requires disclosure upon request of the information identified in 42 CFR § 455.105(b)(2).

Maine's provider enrollment forms and provider agreement do not capture required criminal conviction information.

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 upon 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 disclosure is made.

Maine's Provider/Supplier Agreement and enrollment forms do not capture criminal conviction information for persons with control interest in the provider, and agents and managing employees of the provider. Because Maine is not collecting the information, such disclosures cannot be reported to the HHS-OIG, as required by the regulation.

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

Vulnerabilities

The review team identified five areas of vulnerability in Maine's program integrity practices regarding lack of professional consultants, licensure verification, case referrals to the MFCU, incomplete provider enrollment files, and a Surveillance and Utilization Review Subsystem (SURS).

Not having resources with diverse medical expertise.

While the State agency does have a medical director and a dental consultant, the medical director spends nearly 100 percent of his time in areas other than DPI. Expertise in other medical fields (e.g., additional consultants) will be invaluable when DPI eventually receives a SURS tool and algorithms are developed to identify potential fraud and abuse.

***Recommendation*:** Ensure the availability of health care professional consultants with diverse medical expertise. Encourage the medical director's involvement in Maine's program integrity work.

Not verifying provider licenses.

The State does not verify provider licenses on initial enrollment. The DPI's "Requirements of Provider Participation" policy states that enrolled providers must maintain current licenses and that "the Department verifies licenses when possible and notifies those providers that must submit license renewals".

***Recommendation*:** Modify the policy and practice of the Provider Enrollment Unit to verify provider licenses at the time of enrollment, and any time thereafter.

Not having a formal process for communication with the MFCU regarding the status of case referrals.

The DPI discusses a case informally with the MFCU before sending the case to the MFCU. Although the MFCU accepts virtually all cases referred by DPI, the MFCU evaluates the case

and verbally informs DPI if the case is accepted or not. The MFCU does not issue a written acknowledgement to DPI that they accepted the case. In addition, no formal letter or e-mails are sent to DPI regarding the ongoing status of the cases. If and when the investigation results in a conviction, the MFCU sends DPI copy of the conviction letter.

***Recommendation*:** Develop and implement a policy and procedure for written communication regarding the status of case referrals.

Not maintaining complete files

In 2002, the MaineCare offices had a severe mold infestation which affected the paper provider files. Two years later, a contractor was hired to upload the files into the computer system and the moldy paper files were destroyed. Shortly after completion of the file transfers, DPI staff noted that not all of the required provider enrollment information was uploaded for each file. As a result, in 2004, MaineCare sent providers requests for verification of provider information. Unfortunately, there was no tracking system put into place to identify who responded and who did not. Staff, therefore, are still not confident that they have accurate and complete provider information. The State did begin tracking new provider enrollments in 2006 and in 2010 the State plans to re-enroll all providers when the new MMIS is implemented.

***Recommendation*:** Revise and implement policies regarding required documentation for the MaineCare Provider Enrollment packets to ascertain consistency. Provide training to staff responsible for maintaining the files. Ensure that files are stored appropriately, and that backup systems exist to allow retrieval of all information.

Not having a functioning SURS.

Most program integrity cases are currently opened for a broad review in hopes that a pattern, scheme, or problem area can be identified. Maine does not have a functioning SURS. A SURS would provide information that would assist in targeting providers and focusing reviews on specific codes or issues.

***Recommendation*:** Maintain a SURS with staff trained to utilize all of its reporting capabilities including newly developed data analysis tools, spike reports, and stratified random sampling reports. Attendance at Medicaid Integrity Institute classes offers an opportunity to collaborate with other states in order to enhance the effectiveness of the new certified MMIS and prevent some of the problems that made the current system ineffective.

CONCLUSION

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

- average identified overpayments in excess of $1 million per FTE,
- expansion of the DPI,
- excellent relationship with the State MFCU, OIG, and DOJ, and
- use of permissive exclusion authority

CMS supports the State'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, five areas of vulnerability were identified. CMS encourages OMS 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 OMS 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 Maine 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 Maine 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 Maine on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.