Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Minnesota Comprehensive Program Integrity Review

Final Report

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Reviewers:
Michael Tripp, Review Team Leader
Randal Brasky
Bonnie Harris
Marysol Mateo
Claudia Simonson

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INTRODUCTION

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

This review focused on the activities of the DHS Surveillance and Integrity Review Section (SIRS), which is responsible for Medicaid program integrity. This report describes seven effective practices, four regulatory compliance issues, and two 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 Minnesota improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Minnesota's Medicaid Program

The Health Care Unit within DHS administers the Minnesota Medicaid Program. As of June 30, 2007, the program served 744,839 recipients, approximately 80 percent of whom were enrolled with a managed care plan. The State had enrolled 91,208 managed care providers as of June 30, 2007. The State had 78,966 providers participating in the fee-for-service (FFS) program. Medicaid expenditures in Minnesota for State fiscal year (SFY) 2007 totaled $6,048,350,646. In SFY 2007, the Federal medical assistance percentage was 50 percent.

Program Integrity Section

The SIRS is the organizational component dedicated to the prevention and detection of provider fraud, abuse and overpayments. SIRS is a smaller component of the Performance Measurement and Quality Improvement section. At the time of the review, SIRS had approximately 16 full-time equivalent staff and one supervisor reporting to the section manager. Three additional non-supervisory positions in the section were vacant. The table below presents the total number of investigations, sanctions, identified overpayments, and amounts recouped in the past three SFYs as a result of program integrity activities. These numbers only reflect the activities of SIRS; no managed care information is provided.

Table 1

SFY	Number of Preliminary & Full Investigations	Number of State Administrative Actions or Sanctions (Approximation)	Amount of Overpayments Identified	Amounts Recouped (includes past settlement collections)
2005	924	100	$ 5,286,305.27	$ 2,619,010.45
2006	662	85	$ 2,936,803.17	$ 2,908,584.84
2007	762	200	$ 5,199,778.14	$ 3,682,630.85

Methodology of the Review

In advance of an onsite visit, the review team requested that Minnesota 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 review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of March 17, 2008, the MIG review team visited the DHS and MFCU offices. The team conducted interviews with numerous DHS officials, as well as with staff from the State's transportation broker and the MFCU. 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 managed care organizations (MCOs) through interviews with representatives of four MCOs.

Scope and Limitations of the Review

This review focused on the activities of the SIRS, but also considered the work of other components and contractors responsible for a range of program integrity functions including provider enrollment, contract management, and provider training. Minnesota operates an expansion State Children's Health Insurance Program (SCHIP) under Title XIX of the Social Security Act. The State's SCHIP operates under the same managed care model and FFS billing and provider enrollment policies as Minnesota's Title XIX program. The same findings, vulnerabilities, and effective practices discussed in relation to the Medicaid program also apply to the Medicaid portion of SCHIP.

Unless otherwise noted, DHS 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 DHS provided.

RESULTS OF THE REVIEW

Effective Practices

The State has highlighted several practices that demonstrate its commitment to program integrity. These practices involve the effective and open communication within the agency and with the MFCU, as well as specific claims payment practices and efforts to prevent payment for medically unnecessary treatment.

SIRS integration with the agency's health care administration

DHS' philosophy is that program integrity is not the responsibility of one unit, but rather the responsibility of the entire agency. The State also believes that program integrity is part of the bigger picture of being able to serve clients and of providing quality care. Program integrity should not hinder delivery of or access to care; rather it should enhance the delivery and quality by ensuring appropriate services are provided and paid for. The State has built program integrity into everything from strong policy on benefits and eligibility to rules and statutes that allow for enforcement.

Prepayment edit and claims payment processes

The State highlighted its prepayment edit process which is constantly being refined. Prepayment reviews (as well as numerous other reviews) are conducted through a mechanized edit system, which denies claims that fail to meet standards. These prepayment reviews are done within a 30 day time frame. Minnesota law requires all clean claims to be paid within 30 days or be penalized 18% interest.

Recipient lock-in program

Minnesota Restricted Recipient Program (MRRP) staff has worked closely with MCOs to bring about Universal Restriction. Universal Restriction means that regardless of which entity restricts a recipient, managed care or FFS, the restriction will follow the recipients if they change plans, move from FFS to managed care, or vice versa. MRRP staff enter the restrictions into Medicaid Management Information System so that edits can be created. These edits automatically prevent payment to all providers who are not the recipients' designated providers.

Cooperation with the MFCU

The State emphasized the high level of cooperation between DHS and the MFCU. A focus on mutual goals and respect for each other's roles has allowed atypical approaches to fraud cases. For example, when a case is referred to the MFCU, DHS may impose a payment withhold against the provider. Commonly, prosecutors do not want the payer to alert the provider through such an action that the provider is the target of an investigation. However, the Minnesota MFCU understands the importance of preventing the continued outlay of public funds for billings that appear to be fraudulent. DHS has had to defend a number of these withholding actions in court and the MFCU has assisted DHS in the defense of its actions. For each referred case, SIRS and MFCU staff assess the effect of

possible action on the other party, and accommodate each other's concerns when possible.

Open communication between SIRS and MCO investigative staff
Contracts between DHS and MCOs require MCOs to report to DHS "any suspected Fraud and/or Abuse by Providers within twenty-four (24) hours after the MCO knows or has reason to believe of such suspected Fraud and/or Abuse." Reporting of suspected fraud and/or patterns of abuse by recipients is also required by the contract. In addition, SIRS staff periodically visit the MCOs onsite to interview compliance and investigative staff. Communication also includes frequent phone conversations, e-mails, in-person meetings, and fraud and abuse task force meetings.

Additionally, the CMS review team identified two practices that are particularly noteworthy. CMS recognizes the State's Personal Care Assistant (PCA) provider enrollment requirements and Personal Care Provider Organizations (PCPOs) training program as further evidence of the State's program strengths. The State plans to augment these two already implemented noteworthy practices with implementation of date-specific claim submission requirements for PCA claims instead of span-dating claims, which will allow the State to better track claims activity for PCA providers and will provide better claims integrity for this provider type.

PCAs required to have individual provider numbers
Minnesota Medicaid requires each PCA that works for a PCPO to be enrolled as an individual provider, allowing the State to track the activities of PCAs from one organization to another. In addition, PCA activity can be tracked for services provided to recipients across multiple managed care plans.

PCPO provider training
Minnesota Medicaid offers extensive training to PCPOs prior to their enrollment. The training covers such areas as Minnesota Health Care Programs coverage and billing policy; participant centered planning and options available; covered and non-covered services; locating resources available to the provider; provider accountability and responsibilities; and reconciling claim activity (remittance advice).

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to required disclosure and notification activities.

The State's FFS enrollment process and managed care credentialing application forms do not always capture ownership and control disclosures.
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 five

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.

Minnesota's provider enrollment forms do request the names of individuals who own or have controlling interests in disclosing entities or providers or related subcontractors, their relationships, and the identity of other disclosing entities in which these individuals have an ownership or controlling interest. However, the State provided the review team with an example of an institutional provider enrollment application in which the provider did not supply required disclosures. Despite the absence of the disclosures, the State enrolled the provider. In addition, MCO credentialing applications do not require submission of the disclosure information concerning ownership for group providers.

***Recommendations*:** Collect the required disclosures for all FFS providers. Do not enroll providers that do not provide all required disclosures. Require MCOs to modify their credentialing applications to request information required to be disclosed under 42 CFR § 455.104.

The State's managed care provider credentialing applications and contracts do not require disclosure of business transactions.

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers must furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractor. Neither Minnesota's managed care provider credentialing forms, nor the contracts between the MCOs and their providers, require disclosure of the specified business transactions.

***Recommendation*:** Require MCOs to modify credentialing applications or provider contracts to require disclosure upon request of the information identified in 42 CFR § 455.105.

The State's FFS enrollment process and managed care credentialing application forms do not always capture 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 on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made.

The State's FFS provider enrollment forms do request required criminal conviction information. However, the State provided the review team with an example of an institutional provider enrollment application in which the provider did not supply required criminal conviction

information. Despite the absence of the disclosures, the State enrolled the provider. In addition, MCO credentialing applications do not require submission of criminal conviction information regarding persons with ownership or control or agents or managing employees of providers. The omission to collect required criminal conviction information prevents Minnesota from forwarding information on providers, owners, agents and managing employees to HHS-OIG within 20 working days, as is required by the regulation.

***Recommendations*:** Collect the required disclosures for all FFS providers. Do not enroll providers that do not provide all required disclosures. Require MCOs to modify their credentialing applications to request information required to be disclosed under 42 CFR § 455.106. Refer that information to HHS-OIG as required.

The State does not report to HHS-OIG adverse actions it takes on provider applications and MCOs do not always inform the State of adverse actions in MCO provider credentialing.
The regulation at 42 CFR §1002.3(b)(2) and (b)(3) requires reporting to HHS-OIG of any action a State takes on provider applications for participation in the program. Enrollment staff indicated that they do not report to HHS-OIG adverse actions against a provider's participation including the denial of initial enrollment. Enrollment staff was not aware whether MCOs reported such adverse actions directly to HHS-OIG. None of the representatives of the four MCOs with whom the review team met indicated they notified the State when they denied credentialing or terminated a provider's credentials, only notifying the State when they terminated a provider's contract. Without being notified of adverse actions in MCO credentialing, the State cannot report appropriate adverse actions to HHS-OIG.

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

Vulnerabilities

The review team identified two areas of vulnerability in Minnesota's practices regarding contract monitoring and capturing disclosure information.

Not capturing managing employee information on FFS provider enrollment and managed care credentialing 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." Neither the State nor its MCOs solicit managing employee information in all provider enrollment and credentialing forms. 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.

***Recommendation*:** Modify FFS provider enrollment and managed care credentialing packages to require disclosure of managing employee information.

Not adequately monitoring contractors.
The State does not demonstrate effective oversight or have regular procedures in place to receive communication from MCOs or from the transportation broker concerning fraud and abuse investigation results immediately after such actions occur; provider disenrollment and decredentialing, disciplinary action and termination; and collection of disclosure information from providers. For example, the State's MCO contract only requires an annual fraud and abuse report, with no additional formal written contact during the year. Although SIRS and managed care staff stated that the relationship with MCOs was good and the parties had regular oral communication, SIRS and managed care staff may not be aware of MCO fraud and abuse issues until many months have passed. In addition, several MCOs have memoranda of understanding with the MFCU, and the State is not always included in communications between the MCO and the MFCU.

***Recommendations*:** Develop procedures to improve communication with its contracted entities to protect the overall integrity of the State's program.

CONCLUSION

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

- the integration of program integrity operations with the agency's health care administration,
- the prepayment edit and claims payment processes,
- the universal recipient restriction program,
- the agency's cooperative working relationship with the MFCU,
- open communication between SIRS and MCO investigative staff
- State requirements for PCAs to be enrolled providers with the Medicaid program, and
- the PCPO training program.

CMS supports the State's efforts and encourages the State to implement requirements for PCA date-specific claims submission. CMS also encourages the State to look for additional opportunities to improve overall program integrity.

However, the identification of four areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, two vulnerabilities were identified. CMS encourages DHS 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 DHS 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 that 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 Minnesota will ensure that the deficiencies will not recur. The corrective action plan 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 DHS 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 Minnesota on building upon effective practices, correcting its regulatory compliance issues, and eliminating its vulnerabilities.