Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Missouri 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 Missouri Medicaid Program. The MIG review team conducted the onsite portion of the review at the Department of Social Services (DSS). The review team also visited the offices of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Program Integrity Unit (PIU) within the MO HealthNet Division (MHD) of DSS, which is primarily responsible for Medicaid program integrity oversight. This report describes two effective practices, seven regulatory compliance issues, and nine 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 Missouri improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Missouri's Medicaid Program

The DSS administers the Missouri Medicaid program. In January 2010, the program served 883,277 beneficiaries. Of that total, 419,987 beneficiaries were enrolled in 6 managed care organizations (MCOs), and the remaining beneficiaries were served on a fee-for-service (FFS) basis. The State had approximately 42,459 FFS participating providers and 67,077 MCO providers. During Federal fiscal year (FFY) 2009, Missouri's Medicaid FFS expenditures totaled approximately $7.5 billion. The Federal medical assistance percentage (FMAP) for Missouri in FFY 2009 was 63.19 percent. However, with adjustments attributable to the American Recovery and Reinvestment Act of 2009, the State's effective FMAP was 71.24 percent for the first two quarters of FFY 2009, 72.26 percent for the third quarter, and 73.27 percent for the fourth quarter.

Program Integrity Section

The PIU, located within MHD's Operations section is the primary organizational component dedicated to Medicaid fraud and abuse activities for FFS providers. The Managed Care Quality Assessment and Improvement Unit located in MHD's Operations Section is responsible for oversight of managed care entity fraud and abuse contract provisions. At the time of the review, PIU had 30 authorized full-time equivalent employees focusing on Medicaid program integrity. The authorized positions include 3 nurses, 12 data analysts, 1 auditor, 2 investigators, 4 unit supervisors and other analysts and specialists. The table below presents the total number of

investigations and overpayment amounts collected for the last four State fiscal years (SFYs) as a result of program integrity (PI) activities within MHD.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Overpayments Identified	Overpayments Collected
2006	203	23	$5,237,400	$6,249,993
2007	241	27	$4,666,810	$6,616,957
2008	178	26	$4,929,379	$4,953,181
2009	188	10	$8,702,466	$8,030,693

* Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation. The State does not have a central tracking system for preliminary investigations.
** 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. Figures represent cases referred to the MFCU.

Methodology of the Review

In advance of the onsite visit, the review team requested that Missouri 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 State provided in advance of the onsite visit.

During the week of July 25, 2010 the MIG review team visited the offices of DSS. The team conducted interviews with numerous officials from PIU, MHD, and DSS staff from the Department of Health and Senior Services as well as the Legal Services Division. Finally, to determine whether the MCOs were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team interviewed staff within MHD's Managed Care Unit. The team also reviewed the managed care contract provisions and gathered information through interviews with representatives of three MCOs. In addition, the team sampled provider enrollment applications, program integrity case files, and other primary data to validate Missouri's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the PIU, but also considered the work of other departments within DSS responsible for a range of program integrity functions, including provider enrollment, managed care and non-emergency medical transportation. The Children's Health Insurance Program (CHIP) in Missouri is a combination program. The Medicaid part of the CHIP program operates under the same FFS billing and provider enrollment policies as Missouri's Title XIX program. The same findings, vulnerabilities, and effective practices discussed in relation to the Medicaid program also apply to the Medicaid CHIP.

Unless otherwise noted, PIU 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 PIU provided.

RESULTS OF THE REVIEW

Effective Practices

As part of its comprehensive review process, the CMS invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Missouri's practices include using provider dashboards to give the State a comprehensive look at certain MHD programs through data mining, and initiating focused audits of certain provider types.

Implementation of provider dashboards

Since SFY 2009, Missouri utilizes what it calls provider dashboards to give them a comprehensive look at certain MHD programs through data mining. The dashboard is an internal tool that comprises a group of algorithms created from current program policy manuals. There are also some general algorithms used in the dashboard, such as services on a holiday, for example. A time period is selected to run the algorithms against all providers within a program area. Each algorithm will note those providers who were two standard deviations above the mean. Analysts can choose to focus on a particular algorithm(s) to conduct a review, issue overpayments, or send self-audit letters. Analysts generally select providers who have the greatest divergence above the mean as a starting point.

Provider Dashboards have been effective at data mining the following provider types:

- Personal Care/Homemaker Chore
- Laboratory/Radiology
- Dental
- Adult Day Healthcare - $14,481 in overpayments identified from 29 self-audit letters, of which $11,521 has been recouped
- Durable Medical Equipment (DME) - sent out 195 self-audit letters which resulted in $227,318 in overpayments being identified, of which $158,706 has been recouped
- Outpatient Hospital
- Many other dashboards which are still active.

Performing focused audits

Missouri has initiated focused audits of certain provider types in recent years. The State's latest finalized focused audit was a project termed "Summer Splash SFY 2009." This project involved opening 53 cases in 7 service areas with a total identified overpayment amount of $445,737. A total of 1,473 hours (the total time from

determining the providers to review, to the onsite provider visits, and the development and completion of the cases for 9 analysts) were involved, which included the review of over 19,500 claims.

The audit breakout is as follows:

Table 2

Provider Type	Cases	Identified Collections
Personal Care/Homemaker Chore	34 cases	$366,000
Physicians	2 cases	$8,000
Optometrists	4 cases	$15,000
Dentists	4 cases	$43,000
Licensed Clinical Social Workers/Counselors	3 cases	$12,000
Clinics	4 cases	$3,000
DME	2 cases	Site visit only

Regulatory Compliance Issues

The State is not in compliance with Federal regulations mandating certain ownership and control disclosures, referrals, and notification activities. In addition, the State is not assuring it will exclude certain entities from doing business for the same reasons that such entities could be subject to a Federal exclusion, and it is not reviewing provider compliance with False Claims Act education requirements.

The DSS does not capture all required ownership, control, and relationship information from FFS providers, the fiscal agent, and MCOs. (Uncorrected Partial Repeat Finding)

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.

This is a partial repeat finding from the previous CMS program integrity review in July 2008. The language in FFS provider enrollment applications does not fully meet the disclosure

requirements of the regulation. For example, non-institutional applications do not request the name and address of subcontractor owners related to the enrolling entity, the relationship of these and entity owners, or the name of other disclosing entities owned by the enrolling entity. Similarly, institutional provider applications do not request the address of the owners, name and address of subcontractor owners related to the enrolling entity, the relationship of these owners, or the name of other disclosing entities owned by the entity. A review of the fiscal agent contract also did not identify the disclosure requirements in the regulation.

The State's contract with each MCO specifies in the body of the contract that the information related to 42 CFR § 455.104(a)(1-3) must be disclosed. The contract further indicates that the information will be reported via a specific attachment (6b) to the contract. However, this attachment does not solicit ownership of a corporation owning the entity, ownership of owned subcontractors, relationship of these owners, or any other disclosing entities of which an owner or person with controlling interest in the MCO also has ownership or controlling interest.

NOTE: The CMS reviewed FFS applications, fiscal agent and managed care contracts and other provider agreements for compliance with 42 CFR § 455.104 as it was effective at the time of this review. That section of the program integrity regulations has been substantially revised and the amendment was effective on March 25, 2011. The amendment adds requirements for provision of Social Security Numbers and dates of birth as well as more complete address information regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any actions the State takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

***Recommendation*:** Modify provider enrollment forms and the MCO and fiscal agent contracts to capture all required ownership, control, and relationship information.

The DSS provider enrollment agreements and NEMT contract do not require providers to disclose certain business transactions. (Uncorrected Partial Repeat Finding)

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

This is a partial repeat finding from the previous CMS program integrity review in July 2008. Both the institutional and non-institutional provider agreements do not contain the language to furnish certain business transaction information upon request. In addition, the State's contract with the NEMT brokers does not require the reporting of business transactions upon request.

***Recommendation*:** Modify provider enrollment agreements and the NEMT contract to meet the requirement at 42 CFR § 455.105(b).

The DSS does not capture the disclosure of criminal conviction information for owners, agents, and managing employees of individual FFS providers, the NEMT broker, and MCOs. (Uncorrected Partial Repeat Finding)

The regulation at 42 CFR § 455.106 states 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 and Human Services-Office of Inspector General (HHS-OIG) whenever such disclosures are made.

This is a partial repeat finding from the previous CMS program integrity review in July 2008. Non-institutional and institutional provider applications ask only if the applying provider has ever been convicted of a crime (excluding minor traffic citations). Criminal conviction disclosures are sent by the Provider Enrollment Unit (PEU) to the DSS Legal Services Division for review and an opinion on whether to enroll the provider. However, the criminal conviction information is not referred to the HHS-OIG. The regulation also requires agents and managing employees to disclose criminal convictions related to their involvement in any program under Medicare, Medicaid, or title XX since the inception of those programs.

Section 2.33.16 (a)(2) of the State's MCO contract requires the disclosure of criminal conviction information described in the regulation. The required information is to be provided in Attachment 6b of the contract. However, the attachment form only asks for the name of any owner or person with controlling interest that has been convicted of a criminal offense related to that individual's involvement with Medicare or Medicaid. Attachment 6b does not have a similar place to disclose the criminal convictions of agents and managing employees. In addition, the form does not reference Title XX-related criminal convictions, nor does it emphasize the time frame "since the inception of the programs" or something similar, such as "ever."

In the NEMT contract, a representative of the broker is required to sign a debarment certification (Section 4.8.4 and Exhibit I) attesting that the offeror is not debarred, suspended or excluded from participation under Federal assistance programs. However, there is no requirement for the broker to disclose criminal convictions related to health care crimes of its owners or persons with controlling interest, agents and managing employees.

***Recommendation*:** Modify provider enrollment applications, and NEMT and MCO contracts to meet the requirements of 42 CFR § 455.106.

The DSS does not report to HHS-OIG adverse actions taken on provider applications or actions to limit the ability of providers to continue participating in the Medicaid program. (Uncorrected Partial Repeat Finding)

The regulation at 42 CFR § 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

This is a partial repeat finding from the previous CMS program integrity review in July 2008. The DSS does not refer information about adverse actions taken on applications to the HHS-OIG as required. While FFS provider termination information is referred, team interviews with a supervisor in the DSS Legal Services Division, MHD Unit and the PEU indicate that denials or limits placed on participation are not reported to the HHS-OIG as required.

***Recommendation*:** Develop and implement policies and procedures for reporting any adverse actions taken on provider applications to HHS-OIG.

The State is not ensuring that it excludes certain managed care entities from participation if these entities could be subject to an HHS-OIG exclusion.

The regulation at 42 CFR § 1002.203 stipulates that the State must provide that it will exclude from participation any health maintenance organization (HMO), or entity furnishing services under a 1915(b)(1) waiver, if such organization or entity could be excluded under 42 CFR § 1001.1001 or § 1001.1051, or has a direct or indirect contractual relationship with an individual or entity that could be excluded under §1001.1001 or § 1001.1051.

The State does not have a statutory provision, language in its Fraud and Abuse Plan, or MCO contractual language that stipulates it will exclude from doing business any HMO or 1915 (b) waiver provider that could be excluded for the reasons listed in 42 CFR § 1001.1001 or 42 CFR § 1001.1051. These regulations require the exclusion of entities owned or controlled by a sanctioned person and the exclusion of individuals with ownership or control interests in sanctioned entities.

***Recommendation*:** Develop and implement a policy to ensure that the State will exclude from participation HMOs or entities providing waiver services under a 1915(b) waiver as specified in the regulation.

The DSS does not provide required notifications about excluded providers.

Under the regulation at 42 CFR § 1002.212, if a State agency initiates exclusion pursuant to the regulation at 42 CFR § 1002.210, it must provide notice to the individual or entity subject to the exclusion, as well as other State agencies; the State medical licensing board, as applicable; the public; beneficiaries; and others as provided in §§ 1001.2005 and 1001.2006.

The DSS does not provide the full range of required notifications when it terminates providers. Interviews with PIU management and review of the copy list for termination letters show that State agency divisions and the MFCU are informed, but not the public as is required.

***Recommendation*:** Develop and implement policies and procedures to ensure that all parties identified by the regulation are notified of a State-initiated exclusion.

The State agency has not complied with the State Plan requirement to review providers' policies and employee handbooks pertaining to the False Claims Act.

Section 1902(a)(68) of the Social Security Act [42 U.S.C. 1396a(a)(68)] requires a State to ensure that providers and contractors receiving or making payments of at least $5 million under a State's Medicaid program have (a) established written policies for all employees (including management) about the Federal False Claims Act, whistleblower protections, administrative remedies, and any pertinent State laws and rules; (b) included as part of these policies detailed provisions regarding detecting and preventing fraud, waste, and abuse; and (c) included in any employee handbook a discussion of the False Claims Act, whistleblower protections, administrative remedies, and pertinent State laws and rules.

Missouri has a State Plan amendment for False Claims Act education in place; however the State has not started conducting compliance reviews with providers receiving or making payments of at least $5 million as the statute requires. A PIU supervisor mentioned that 4 of the 310 providers have voluntarily submitted compliance information; however, the State has not yet requested any compliance information from all providers and contractors related to this Statute and was therefore unable to provide any evidence to determine compliance with the law described in subparagraph (a), (b) or (c) for the remaining providers and contractors. Review of the employee handbook for one of the MCOs interviewed revealed that no information was added to the handbooks regarding False Claims Act education.

***Recommendation*:** Develop and implement a plan to review provider and contractor policies for educating employees about the False Claim Act, whistleblower protections and other compliance requirements, including review of employee handbooks if applicable.

Vulnerabilities

The review team identified nine areas of vulnerability in the State's program integrity practices. These involved the failure to conduct complete exclusion searches, capture managing employee information, and verify with beneficiaries the receipt of managed care services. They also include the absence of written policies or procedures for reporting debarred individuals or entities and for withholding payments due to fraud or willful misrepresentation, the failure to collect required ownership and control, criminal conviction and business transaction disclosures from MCO network providers, and the non-reporting of adverse actions taken against managed care providers.

Not conducting complete searches for individuals and entities excluded from participation in Medicaid.

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 and entities. 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. A new regulation at 42 CFR § 455.436, effective March 25, 2011, now requires States to check enrolled providers, persons with ownership and control interests, and managing employees for

exclusions in both the List of Excluded Individuals/Entities and the Excluded Parties List System (EPLS) on a monthly basis.

Missouri does not have a policy to implement the requirements of these SMDLs. As a result, the provisions of SMDL #08-003 have not been carried out by DSS and provisions of SMDL #09-001 have not been conveyed to providers for implementation. Therefore, such disclosures cannot be checked for possible exclusions on an ongoing basis. For example:

- Monthly searches for excluded FFS providers, as described in SMDL #08-003 have only been performed once in calendar year 2010. The review team was told by a PIU manager that shifts in PIU staff responsibilities resulted in only the May 2010 Medicare Exclusion Database file being checked against MHD providers.
- While personal care services vendor and agency disclosures are checked for exclusion by the PEU at the time of enrollment, personal care attendants are not checked because they are not enrolled by the State. Also, since the requirements of the #09-001 SMDL have not been conveyed to these agencies and vendors, they are not checking staff and subcontractors monthly for exclusions.
- The MHD does not capture in a searchable database information on owners, officers, directors or managing employees who may be disclosed as having affiliations with FFS providers, the fiscal agent, or the transportation broker during the enrollment or contracting process.
- Interviews with MCOs show that providers are searched every month but only on the provider name captured by the MCO, while MCO staff are only searched annually. One MCO indicated during the interview that it searches the EPLS for HHS-OIG exclusions. The EPLS captures individuals and entities debarred from receiving Federal funds, and by referral should include HHS-OIG exclusions. However, that policy is not consistent with the guidance in the SMDLs.

***Recommendation*:** Develop and operationalize policies and capabilities for the State and contractors to capture disclosure information in a searchable database. Implement the SMDLs' guidance on monthly exclusion checking of providers, affiliated parties, contractors and subcontractors.

Not collecting managing employee information on FFS and MCO provider enrollment 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."

The MHD non-institutional FFS provider enrollment forms do not request disclosure of managing employees. In addition, the State's MCOs do not always solicit all managing employee information in their credentialing applications. All three plans use the standardized Universal Credentialing DataSource Form (UCDS form) from the Commission for Affordable Quality Healthcare pursuant to Missouri's Code of State Regulations at 20 CSR 400.7.180. The

UCDS form requests the name and contact information for the Office Manager or Business Office Staff contact. Other staff requested includes the Primary Credentialing Contact person; mid-level practitioners, such as Physician's Assistants and Advanced Registered Nurse Practitioners; partners and associates; covering colleagues; and a Billing Contact person, if this is not the Office Manager. Besides the UCDS form, facility forms were submitted by two MCOs. Managing employee information is not requested on one of the forms. Therefore, the State and MCOs have no way of knowing if excluded individuals are working for enrolled providers in some managing employee capacities.

***Recommendation*:** Develop and implement a procedure to capture information on managing employees in the MMIS or in an alternative repository that would permit ongoing exclusion checks to be performed.

Not requiring MCOs to conduct routine verification of services with beneficiaries.
The State's contract with MCOs requires only that they conduct verification of services with beneficiaries "upon request." Two of the three MCOs interviewed reported that they adhere to the contract and only provide Explanation of Medical Benefits (EOMB) letters upon request by the beneficiary. These could be provided electronically online or mailed to the individual. Both MCOs noted that beneficiaries rarely requested EOMBs; one MCO reported a total of one or two requests; the other reported approximately three per year. The third MCO indicated that it provided EOMBs only to beneficiaries who had some liability for the bill, such as for a service provided out of area or a specialty service not normally covered by the plan. The MCO had sent out approximately 6,700 EOMBs in the previous year.

***Recommendation*:** Modify the MCO contracts to require random or targeted verification of services with beneficiaries.

Not having written policies or procedures to report a debarred individual or entity to the Secretary of HHS.
A Managed Care Unit supervisor acknowledged that MHD currently does not have any written policies or procedures in place for reporting debarments to HHS. If debarments were to occur, the supervisor indicated that this type of information would be reported to the PIU which would do the reporting to the Secretary of HHS. The individual did report that there have been no MCOs found out of compliance with the debarment provisions at 42 CFR § 438.610 since the last review. However, the lack of written guidance leaves the State vulnerable with regard to taking the necessary action if and when a reporting event does occur.

***Recommendation*:** Develop and implement procedures to report debarred individuals and entities to the Secretary of HHS.

Not collecting full ownership and control disclosure information from MCO network providers or NEMT sub-contractors.

The State's contract with the MCOs, at Section 2.18.8 c., requires that the MCOs utilize the standard UCDS form, and all three MCOs interviewed reported utilizing this form. Two MCOs did submit a separate facility application. However, neither the standardized form nor the facility application form addressed all of the disclosure information outlined in § 455.104 that would be captured from FFS providers. The information not requested includes all individuals with 5 percent ownership or control interest; subcontractors; family relationships among the individuals listed; or other disclosing entities in which an individual listed might also have ownership or controlling interest. Although the State and the MCOs indicated that they are following the State's Department of Insurance regulatory guidelines for credentialing, along with the National Committee for Quality Assurance guidelines, there is nothing that precludes them from requiring additional information that would normally be collected from FFS providers.

The State's contract with the NEMT brokers does not speak to obtaining disclosures of ownership and controlling interests from transportation providers, and this information is not being captured. As the lists of disclosed individuals should be run against exclusion and debarment databases, not requiring this information leaves the State vulnerable to having excluded or debarred individuals in the managed care and transportation systems.

NOTE: The CMS reviewed the managed care and NEMT contracts and other provider agreements for compliance with 42 CFR § 455.104 as it was effective at the time of this review. That section of the program integrity regulations has been substantially revised and the amendment was effective on March 25, 2011. The amendment adds requirements for provision of Social Security Numbers and dates of birth as well as more complete address information regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any actions the State takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

***Recommendation*:** Modify the MCO contracts and transportation agreement to require the disclosure of complete ownership, control, and relationship information from all MCO network providers and transportation drivers.

Not requiring disclosure of business transactions from managed care network providers, upon request.

The State's contract with the MCOs and the MCO provider agreements do not require network providers to disclose the business transaction information upon request which Federal regulations at 42 CFR § 455.105 would otherwise require of FFS providers.

***Recommendations*:** Modify the MCO contracts and network provider agreements to require disclosure upon request of the required business transaction information.

Not requiring full disclosure of health care criminal convictions in the managed care networks.
The UCDS form used in the MCOs' credentialing process only captures criminal conviction information on the provider completing the form. No information is obtained about other individuals with ownership or control interests, agents, or managing employees. The facility form submitted by one MCO only asks for criminal information for mental health/substance abuse professionals and only for the past five years. Another MCO facility form outlines the criminal conviction information, but does not provide for its disclosure. These processes do not meet the disclosure standard at 42 CFR § 455.106 which is required in the FFS program. In addition, there is no formal process to report this information to the State.

***Recommendation*:** Develop and implement procedures to collect health care-related criminal conviction information from MCO network providers and to report relevant disclosures submitted by all providers to HHS-OIG as required.

Not withholding payments in cases of fraud or willful misrepresentation.
During an interview, a PIU supervisor stated the State does not have a policy or statute allowing it to withhold payments due to fraud or willful misrepresentation as the Federal regulation at 42 CFR § 455.23(b) allows. This missing program integrity tool prevents the State from exercising its option to withhold provider payments in cases of fraud or willful misrepresentation and providing proper notice of the withholding of payments in accordance with the regulation.

NOTE: The program integrity regulation at 42 CFR § 455.23 has been substantially revised and the amendment was effective March 25, 2011. The regulation as amended requires payment suspension pending investigations of credible allegations of fraud and referral to the MFCU, or other law enforcement agency if there is no certified MFCU in the State.

***Recommendations*:** Develop a State statutory provision, rule, or policy to allow the withholding of payments to providers due to fraud or willful misrepresentation as the regulation allows. Create a suspension of payment notice for such cases that meets the requirements of 42 CFR § 455.23.

Not reporting to HHS-OIG adverse actions taken on managed care provider applications.
The regulation at 42 CFR § 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. Neither the State's contracts nor its policy speaks to the need of the MCO or NEMT broker to report any providers who are denied credentialing due to potential fraud or abuse issues. The State's contracts also do not require the MCO to notify the State if it terminates or de-credentials a provider for cause. The State does require that each MCO submit a quarterly report on fraud and abuse activities which lists terminations; however, the reason for a termination is not indicated (e.g. voluntarily withdrew from the Medicaid program; terminated for cause, etc). One MCO reported that if it terminated a provider for cause, it would include the provider on the termination list, but would add comments at the bottom indicating that the provider's "contract was not renewed," instead of

indicating it was for cause. The MCO's internal notes would have information related to problems with this provider and whether or not the provider had been put on pre-payment reviews or other provisions prior to the non-renewal decision, but the State would have no way of knowing this. The lack of clear direction in the contract as to what needs to be reported, and the limited reporting system prevent the State from obtaining the necessary information on providers that must be reported to HHS-OIG.

***Recommendation*:** Modify the MCO and NEMT broker contracts to require notification to DSS when adverse actions are taken against a provider's participation in the program, including the denial of credentialing for fraud-related concerns. Develop and implement procedures to report to HHS-OIG all adverse actions taken against and limits placed on providers enrolled or applying to participate in the program.

CONCLUSION

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

- implementation of provider dashboards, and
- efforts in performing focused audits.

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

However, the identification of seven areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, nine areas of vulnerability were identified. The CMS encourages MHD to closely monitor 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 MHD 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 Missouri 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 Missouri 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 Missouri on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

Department of Social Services

Missouri Medicaid Audit and Compliance

Medicaid Integrity Program

Corrective Action Plan of Program Integrity Procedures

Draft Report – Missouri

May 2011

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INTRODUCTION

Missouri Medicaid Audit and Compliance (MMAC), Medicaid Integrity Program is responding the review conducted by (CMS) Medicaid Integrity Group (MIG). The MIG review team conducted the onsite portion of the review at the Department of Social Services (DSS). The review team also visited the offices of the Medicaid Fraud Control Unit (MFCU). The MMAC will only be responding to portions of the review that have been identified with provider enrollment or program integrity. MO HealthNet will be responsible for the corrective action plans associated with Managed Care (MCO) and the Non-Emergency Medical Transportation (NEMT). This document is reflective of the cumulating.

The review focused on the activities of the Program Integrity Unit (PIU) within the MO HealthNet Division (MHD) of DSS, which was primarily responsible for Medicaid program integrity oversight until the development of the MMAC, January 2011. The report describes seven regulatory compliance issues, and nine vulnerabilities in the State's program integrity operations. MMAC is responding to seven regulatory compliance issues and nine areas of vulnerabilities in the State's program integrity operations. Furthermore, if a timeline has not been discussed in our response for the areas of program integrity, we feel these issues can be resolved within 90 days.

Cognizant Acknowledgment

Many of the repeat finding associated with the Provider Enrollment processes were in a holding pattern in hopes of the pilot program UPEP (PECOS) being developed for Missouri's utilization. UPEP was to improve efficiency, access to external data sources for validation purposes, better management controls, decreased errors, linkage to Medicare claims and a significant financial savings. Therefore, changes to Missouri's Provider Enrollment system were dependent upon this great product. Then suddenly, the project was placed on-hold and canceled January 2010. Although, we are not using this as an excuse for the findings in this report, we are still very interested in UPEP and would welcome an opportunity to assist in getting this product made available to the Medicaid programs.

MO HealthNet Managed Care states as a general response, the 2009 Request for Proposal (RFP) number B3Z09135, the State of Missouri Division of Purchasing and Material Management Terms and Conditions state:

- The contract shall be construed according to the laws of the State of Missouri. The contractor shall comply with all local, state, and federal laws and regulations related to the performance of the contract to the extent that the same may be applicable.

The contracts related to RFP B3Z09135 were approved by the Centers for Medicare and Medicaid Services (CMS) on September 14, 2009.

Official Response from Missouri
May 2011

The State of Missouri is currently in the process of releasing a new RFP with contracts effective July 1, 2012. The following additional language will be added to the RFP in response to the areas of non-compliance and vulnerabilities identified in the review.

MO HealthNet Non Emergency Medical Transportation (NEMT) states as a general response, the 2009 Request for Proposal (RFP) number B3Z10097, the State of Missouri Division of Purchasing and Material Management Terms and Conditions state:

- The contract shall be construed according to the laws of the State of Missouri. The contractor shall comply with all local, state, and federal laws and regulations related to the performance of the contract to the extent that the same may be applicable.

The contracts related to RFP B3Z10097 were submitted to the Centers for Medicare and Medicaid Services (CMS) on September 14, 2009.

The State of Missouri is currently in the process of renewing the NEMT contract effective July 1, 2011. The following additional language will be added to the RFP in response to the areas of non-compliance and vulnerabilities identified in this review.

The DSS does not capture all required ownership, control, and relationship information from FFS providers, the fiscal agent, non-emergency medical transportation broker and MCOs. (Uncorrected Partial Repeat Finding)

Recommendation: Modify provider enrollment forms, and the MCO, NEMT and fiscal agent contracts to capture all required ownership, control, and relationship information.

- Regulations are being promulgated for submission requiring ownership down to 5%, family relationship information and the disclosure any person with ownership of another entity. Anticipated filing date entered = Wed, Jun 15 2011, Register filing deadline = Wed, Jun 15 2011 - Register publication date = Fri, Jul 15 2011 - Register volume = 36 - Register number = 14 - Register link = current/2011/v36n14/v36n14.asp – Last day of comments = Sun, Aug 14 2011 - First day to file order with JCAR = Mon, Aug 15 2011 - Last day to file order with JCAR (59th day) = Wed, Oct 12 2011 - 90 Days = Mon, Nov 14 2011.
- MMAC is currently verbally requesting this information when enrolling providers as it is not clear on the online application. As a short term solution MMAC will create a supplemental form on the Department's website that requires the additional information for the application. The form will request the information required under 42 CFR 455.104.
- Managed Care responded; please refer to new sections of the contract 2.18.8.c, 2.33.5 and 3.9.5 in Attachment A

THE DSS PROVIDER ENROLLMENT AGREEMENTS AND NEMT CONTRACT DO NOT REQUIRE PROVIDERS TO DISCLOSE CERTAIN BUSINESS TRANSACTIONS. (UNCORRECTED PARTIAL REPEAT FINDING)

RECOMMENDATION: MODIFY PROVIDER ENROLLMENT AGREEMENTS AND THE NEMT CONTRACT TO MEET THE REQUIREMENT AT 42 CFR § 455.105(B).

- MMAC will include in a supplemental form, to its application to, requiring providers to, upon request, furnish documentation of significant business transactions between provider and wholly owned supplier or with subcontractor in the last 5 years to address the requirements established in 42 CFR 455.105.
- Regulations are being promulgated requiring providers to submit this information upon request. Anticipated filing date entered = Wed, Jun 15 2011, Register filing deadline = Wed, Jun 15 2011 - Register publication date = Fri, Jul 15 2011 - Register volume = 36 - Register number = 14 - Register link = current/2011/v36n14/v36n14.asp – Last day of comments = Sun, Aug 14 2011 - First day to file order with JCAR = Mon, Aug 15 2011 -

Last day to file order with JCAR (59th day) = Wed, Oct 12 2011 - 90 Days = Mon, Nov 14 2011.

- Managed Care responded; please refer to new section 2.33.5 and 3.9.5 on Attachment A.
- The NEMT contract will be amended to include the provisions outlined in 42 CFR 455.105(b)

THE DSS DOES NOT CAPTURE THE DISCLOSURE OF CRIMINAL CONVICTION INFORMATION FOR OWNERS, AGENTS, AND MANAGING EMPLOYEES OF INDIVIDUAL FFS PROVIDERS, THE NEMT BROKER, AND MCOS. (UNCORRECTED PARTIAL REPEAT FINDING)

RECOMMENDATION: MODIFY PROVIDER ENROLLMENT APPLICATIONS, AND NEMT AND MCO CONTRACTS TO MEET THE REQUIREMENTS OF 42 CFR § 455.106.

- MMAC will include in a supplemental form, to its application, to require providers to report all criminal convictions of those owners, managing employees and agents to MMAC as required by 42 CFR 455.106.
- Managed Care responded; please refer to new section 2.18.8.c, 2.33.5, 2.33.6 and 3.9.5 on Attachment A.
- The NEMT contract will be amended to include the requirement for the broker to disclose criminal convictions related to health care crimes of its owners or persons with controlling interest, agents and managing employees as outlined in 42 CFR 455.

THE DSS DOES NOT REPORT TO HHS-OIG ADVERSE ACTIONS TAKEN ON PROVIDER APPLICATIONS OR ACTIONS TO LIMIT THE ABILITY OF PROVIDERS TO CONTINUE PARTICIPATING IN THE MEDICAID PROGRAM. (UNCORRECTED PARTIAL REPEAT FINDING)

RECOMMENDATION: DEVELOP AND IMPLEMENT POLICIES AND PROCEDURES FOR REPORTING ANY ADVERSE ACTIONS TAKEN ON PROVIDER APPLICATIONS TO HHS-OIG.

- MMAC will develop policies to refer all provider enrollment denials and closed end agreements to the HHS-OIG. These policies will be developed within the next 30 days and implemented after development.
- MMAC will establish and implement process to ensure application denials and other adverse actions are reported to the OIG. This process will be developed within the next 30 days and implemented after development.
- Managed Care responded; please refer to new section 2.18.8.c, 2.33.6, 2.33.7, 2.33.8, 2.33.9 and 3.9.5 on Attachment A.

THE STATE IS NOT ENSURING THAT IT EXCLUDES CERTAIN MANAGED CARE ENTITIES FROM PARTICIPATION IF THESE ENTITIES COULD BE SUBJECT TO HHS-OIG EXCLUSION.

RECOMMENDATION: DEVELOP AND IMPLEMENT A POLICY TO ENSURE THAT THE STATE WILL EXCLUDE FROM PARTICIPATION HMOS OR ENTITIES PROVIDING WAIVER SERVICES UNDER A 1915(B) WAIVER AS SPECIFIED IN THE REGULATION.

- Managed Care responded; please refer to new section 2.33.7, 2.33.8, and 2.33.9 on Attachment A.

THE DSS DOES NOT PROVIDE REQUIRED NOTIFICATIONS ABOUT EXCLUDED PROVIDERS.

RECOMMENDATION: DEVELOP AND IMPLEMENT POLICIES AND PROCEDURES TO ENSURE THAT ALL PARTIES IDENTIFIED BY THE REGULATION ARE NOTIFIED OF A STATE-INITIATED EXCLUSION.

- Policy will be established to determine the difference between provider termination and provider exclusion. Regulation will be enacted stating who will be placed on the exclusion list.
- MMAC is a new unit within DSS and is currently developing the unit's website, policies, procedures, and regulations. MMAC will develop a procedure by which excluded individuals are reported as required in 42 CFR 1002.210 and 212. The listing of excluded individuals will be posted on MMAC's website and available to the public.
- Managed Care responded; please refer to new section 2.33.9 and 3.9.5 on Attachment A.

THE STATE AGENCY HAS NOT COMPLIED WITH THE STATE PLAN REQUIREMENT TO REVIEW PROVIDERS' POLICIES AND EMPLOYEE HANDBOOKS PERTAINING TO THE FALSE CLAIMS ACT.

RECOMMENDATION: DEVELOP AND IMPLEMENT A PLAN TO REVIEW PROVIDER AND CONTRACTOR POLICIES FOR EDUCATING EMPLOYEES ABOUT THE FALSE CLAIM ACT, WHISTLEBLOWER PROTECTIONS AND OTHER COMPLIANCE REQUIREMENTS, INCLUDING REVIEW OF EMPLOYEE HANDBOOKS IF APPLICABLE.

- Formulate reports from our Missouri Medicaid Information System (MMIS) to identify providers with $5 Million or more in payments for Fiscal Year.
- Send notification letter to $5 Million + providers regarding MMAC's compliance with DRA.
- Providers have 30 days to respond once they receive letter.
- Provide samples of attestation format upon request.
- Sanctions may be imposed if provider does not comply with the request (including termination).
- **MMAC steps to maintain compliance with state plan:**
  1. Update and track provider responses, including return to sender.
  2. Maintain contact information from provider's compliance unit.
  3. Follow-up on no-responses with sanction letter per regulations.
  4. Maintain substantiation and compliance information received from provider.

Vulnerabilities

NOT CONDUCTING COMPLETE SEARCHES FOR INDIVIDUALS AND ENTITIES EXCLUDED FROM PARTICIPATION IN MEDICAID.

RECOMMENDATION: DEVELOP AND OPERATIONALIZE POLICIES AND CAPABILITIES FOR THE STATE AND CONTRACTORS TO CAPTURE DISCLOSURE INFORMATION IN A SEARCHABLE DATABASE. IMPLEMENT THE SMDLS' GUIDANCE ON MONTHLY EXCLUSION CHECKING OF PROVIDERS, AFFILIATED PARTIES, CONTRACTORS AND SUBCONTRACTORS.

- Missouri Regulation will be enacted to mirror the federal language of 42 CFR 455.436. Anticipated filing date entered = Wed, Jun 15 2011, Register filing deadline = Wed, Jun 15 2011 - Register publication date = Fri, Jul 15 2011 - Register volume = 36 - Register number = 14 - Register link = current/2011/v36n14/v36n14.asp – Last day of comments = Sun, Aug 14 2011 - First day to file order with JCAR = Mon, Aug 15 2011 - Last day to file order with JCAR (59th day) = Wed, Oct 12 2011 - 90 Days = Mon, Nov 14 2011. After regulation is effective, providers will be advised accordingly and reviews will be conducted to ensure that provider employees are not excluded.
- MMAC is working to create a new provider enrollment system that will include the ability to perform ongoing searches of providers and owners against the federal exclusions database. Funding has tentatively been released for the development of a Provider Enrollment system which will help with the new re-enrollment regulation as well. We feel this will take a year to implement due to the creation of a request for bid from a contractor, setup time and training. This is all contingent upon actual receivership of the funding.
- Managed Care responded; please refer to new section 2.18.8.c and 2.33.8 on Attachment A.

NOT COLLECTING MANAGING EMPLOYEE INFORMATION ON FFS AND MCO PROVIDER ENROLLMENT FORMS.

RECOMMENDATION: DEVELOP AND IMPLEMENT A PROCEDURE TO CAPTURE INFORMATION ON MANAGING EMPLOYEES IN THE MMIS OR IN AN ALTERNATIVE REPOSITORY THAT WOULD PERMIT ONGOING EXCLUSION CHECKS TO BE PERFORMED.

- Provider applications/enrollment forms will be modified accordingly to capture owners, officers, directors or managing employees in a searchable database. This modification will occur within 365 days.
- Managed Care responded; please refer to new section 2.18.8.c, 2.33.3, 2.33.4, 2.33.5, 2.33.6 and 3.9.5 on Attachment A.

NOT REQUIRING MCOS TO CONDUCT ROUTINE VERIFICATION OF SERVICES WITH BENEFICIARIES.

RECOMMENDATION: MODIFY THE MCO CONTRACTS TO REQUIRE RANDOM OR TARGETED VERIFICATION OF SERVICES WITH BENEFICIARIES.

- Managed Care responded; please refer to new section 2.34 on Attachment A.

NOT HAVING WRITTEN POLICIES OR PROCEDURES TO REPORT A DEBARRED INDIVIDUAL OR ENTITY TO THE SECRETARY OF HHS.

RECOMMENDATION: DEVELOP AND IMPLEMENT PROCEDURES TO REPORT DEBARRED INDIVIDUALS AND ENTITIES TO THE SECRETARY OF HHS.

- Managed Care responded; please refer to new section 2.18.8.c, 2.33.4, and 3.12.2 on Attachment A.

NOT COLLECTING FULL OWNERSHIP AND CONTROL DISCLOSURE INFORMATION FROM MCO NETWORK PROVIDERS OR NEMT SUB-CONTRACTORS.

RECOMMENDATION: MODIFY THE MCO CONTRACTS AND TRANSPORTATION AGREEMENT TO REQUIRE THE DISCLOSURE OF COMPLETE OWNERSHIP, CONTROL, AND RELATIONSHIP INFORMATION FROM ALL MCO NETWORK PROVIDERS AND TRANSPORTATION DRIVERS.

- Managed Care responded; please refer to new section 2.18.8.c, 2.33.5, and 3.9.5 on Attachment A.

- 42 CFR 455.104 addresses information that must be disclosed by a "disclosing entity". A disclosing entity is defined in 42 CFR 455.101 as a Medicaid provider or fiscal agent. The Medicaid provider for NEMT is the NEMT broker. Subcontractors are not addressed in 42 CFR 455.104. The DSS believes the provisions of 42 CFR 455.104 have been met in RFP B3Z10097, Section 4.5.5 which states "The offeror must provide full and complete information by disclosing the following related to the identity of each person, partnership, limited liability, corporation, or any other organization or entity with an ownership or control interest in the offeror, or any NEMT subcontractor in which the offeror has a 5% or more ownership interest for the prior 12-month period. The offeror may satisfy this requirement by providing a completed Form CMS-855 (Medicare and Other Federal Health Care Programs Provider/Supplier Enrollment Application).

- The name and address of each person with an ownership or controlling interest of 5% or more in the offeror or in any subcontractor in which the offeror has direct or indirect ownership of 5% or more;

- A statement as to whether any such person with ownership or controlling interest is related to any other of the persons named with ownership or controlling interest; as spouse, parent, child, or sibling, and

- The name of any other organization in which the person also has ownership or controlling interest. This is required to the extent that the offeror can obtain this information by requesting it in writing. The offeror must keep copies of all of these requests and responses to them, make them available upon request, and advise the State of Missouri when there is no response to a request.

- For purposes of providing the above information, the offeror shall understand that a "person with an ownership or control interest" shall mean a person or corporation that (1) owns directly or indirectly, 5% or more of the offeror's capital or stock or received 5% or more of its profits; or (2) has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the offeror or by its property or assets, and that interest is equal to or exceeds 5% of the total property and assets of the offeror, or (3) is an officer or director of the offeror (if it is organized as a corporation) or is a partner in the offeror (if it is organized as a partnership).
- The percentage of direct ownership or control is calculated by multiplying the percent of interest which a person owns by the percent of the offeror's assets used to secure the obligation (e.g., if a person owns 10 percent of a note secured by 60 percent of the offeror's assets, the person owns 6% of the offeror).
- The percentage of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization (e.g., if a person owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the offeror, the person owns 8% of the offeror)."

- In addition, Section 1902(a) (70) of the Social Security Act outlines the prohibitions and conflict of interest related to self referrals of the NEMT broker. This prohibition is outlined in the NEMT RFP B3Z10097, Section 2.11.1.

NOT REQUIRING DISCLOSURE OF BUSINESS TRANSACTIONS FROM MANAGED CARE NETWORK PROVIDERS, UPON REQUEST.

RECOMMENDATIONS: MODIFY THE MCO CONTRACTS AND NETWORK PROVIDER AGREEMENTS TO REQUIRE DISCLOSURE UPON REQUEST OF THE REQUIRED BUSINESS TRANSACTION INFORMATION.

- Managed Care responded; please refer to new section 2.33.5 and 3.9.5 on Attachment A.

NOT REQUIRING FULL DISCLOSURE OF HEALTH CARE CRIMINAL CONVICTIONS IN THE MANAGED CARE NETWORKS.

RECOMMENDATION: DEVELOP AND IMPLEMENT PROCEDURES TO COLLECT HEALTH CARE-RELATED CRIMINAL CONVICTION INFORMATION FROM MCO NETWORK PROVIDERS AND TO REPORT RELEVANT DISCLOSURES SUBMITTED BY ALL PROVIDERS TO HHS-OIG AS REQUIRED.

- Managed Care responded; please refer to new section 2.18.8.c, 2.33.6, 2.33.7, 2.33.8, 2.33.9 and 3.9.5 on Attachment A.

NOT WITHHOLDING OF PAYMENTS IN CASES OF FRAUD OR WILLFUL MISREPRESENTATION.

RECOMMENDATIONS: DEVELOP A STATE STATUTORY PROVISION, RULE, OR POLICY TO ALLOW THE WITHHOLDING OF PAYMENTS TO PROVIDERS DUE TO FRAUD OR WILLFUL MISREPRESENTATION AS THE REGULATION ALLOWS. CREATE A SUSPENSION OF PAYMENT NOTICE FOR SUCH CASES THAT MEETS THE REQUIREMENTS OF 42 CFR § 455.23.

- Regulation will be enacted allowing the suspension of payments to providers upon suspicion of Fraud waste and abuse. Anticipated filing date entered = Wed, Jun 15 2011, Register filing deadline = Wed, Jun 15 2011 - Register publication date = Fri, Jul 15 2011 - Register volume = 36 - Register number = 14 - Register link = current/2011/v36n14/v36n14.asp – Last day of comments = Sun, Aug 14 2011 - First day to file order with JCAR = Mon, Aug 15 2011 - Last day to file order with JCAR (59th day) = Wed, Oct 12 2011 - 90 Days = Mon, Nov 14 2011. Provider applications/enrollment forms will be modified accordingly.
- Managed Care responded; please refer to new section 2.33.2.a on Attachment A.

NOT REPORTING TO HHS-OIG ADVERSE ACTIONS TAKEN ON MANAGED CARE PROVIDER APPLICATIONS.

RECOMMENDATION: MODIFY THE MCO AND NEMT BROKER CONTRACTS TO REQUIRE NOTIFICATION TO DSS WHEN ADVERSE ACTIONS ARE TAKEN AGAINST A PROVIDER'S PARTICIPATION IN THE PROGRAM, INCLUDING THE DENIAL OF CREDENTIALING FOR FRAUD-RELATED CONCERNS. DEVELOP AND IMPLEMENT PROCEDURES TO REPORT TO HHS-OIG ALL ADVERSE ACTIONS TAKEN AGAINST AND LIMITS PLACED ON PROVIDERS ENROLLED OR APPLYING TO PARTICIPATE IN THE PROGRAM.

- Managed Care responded; please refer to new section 2.18.8.c, 2.33.6, 2.33.7, 2.33.8, 2.33.9 and 3.9.5 on Attachment A.

In addition to the specific areas addressed above, the following provisions were added to the RFP to address program integrity and fraud and abuse concerns:

- 2.12.16.c.6 Member Handbook/MO HealthNet ID Card
- 2.12.16.c.22 Fraud and Abuse Hotline
- 2.16.4.c.2 and 17 Provider Manual/MO HealthNet ID Card/Hotline

- The NEMT RFP B3Z10097, Section 2.11.7, states "The broker shall develop and implement policies and procedures to exclude individuals and transportation providers from the broker's network that have been identified as having Office of Inspector General (OIG) sanctions, having failed to renew their license or certification registration, having a revoked professional license or certification, having been excluded from participation in federal health care programs under either section 1128 of the Social Security Act, or having been terminated by the state agency. The broker can access debarred and OIG sanction information on the Internet at http://exclusions.oig.hhs.gov/. The broker shall maintain documentation of verification of the OIG sanctions. The state agency or its authorized agent shall conduct a periodic review to determine if appropriate exclusions and corrective action have occurred. The broker shall terminate contracts with transportation providers who have been determined to have been convicted of fraud or abuse." The NEMT contract will be amended to add the requirement to notify DSS when adverse actions are taken against a subcontracted provider's participation in the NEMT program, including the denial of credentialing for fraud-related concerns.