Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Missouri Comprehensive Program Integrity Review

Final Report

July 2008

Reviewers:
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INTRODUCTION

CMS' Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Missouri Medicaid Program. The onsite portion of the review was largely conducted at the MO HealthNet Division (MHD) offices within the Department of Social Services. The MIG review team also visited the State's Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the MHD Provider Enrollment (PEU), Program Integrity (PIU), and Program Operations (PO) Units which are responsible for enrolling providers, program integrity, and managed care contractual oversight, respectively. The report addresses regulatory compliance issues and vulnerabilities. The review team identified four areas of non-compliance with Federal regulations during its review.

- 42 CFR § 455.104(a) provides that State Medicaid agencies must require providers to disclose specific ownership and control information relating directly to the provider and concerning any subcontractors in which the provider has direct or indirect ownership of five percent or more.
- 42 CFR § 455.105(b) provides that State Medicaid agencies must require providers to disclose information on the ownership of subcontractors with whom the provider has significant business transactions. Such information must be reported to the State or to the Secretary of the U.S. Department of Health and Human Services (HHS) upon request.
- 42 CFR § 455.106(b)(1) provides that State Medicaid agencies must require providers to disclose the identity of any owner, agent, or managing employee convicted of a health-care related criminal offense. When apprised of such information, the Medicaid agency must report it to the HHS-Office of the Inspector General (HHS-OIG) within 20 working days.
- 42 CFR § 1002.3(b)(2) and (3) provide that the Medicaid agency must notify HHS-OIG of action taken on a provider's application for participation in the program.

In its response to the draft report, the MHD indicated that it did not agree with several of the MIG's findings. The State cited, as an example, its belief that MHD's provider enrollment applications capture ownership and controlling interests and partnership interests in a manner that complies with Federal requirements. The MHD's PIU, PEU, and POU indicated that they would nonetheless recommend that the Division undertake a three phase implementation to fully respond to the issues identified in the report. The MHD also requested a technical clarification in the second paragraph of the Introduction, which CMS has inserted. The State's response to the draft report is included in its entirety as Attachment A to this final report.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;

2. Identify program vulnerabilities and noteworthy 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 MHD administers the Missouri Medicaid Program. As of the State Fiscal Year (SFY) ending June 30, 2007, the program served 825,899 recipients and Medicaid expenditures totaled $5,063,028,951. The Federal medical assistance percentage for Missouri for SFY 2007 was 62 percent. MHD processed an average of 79.6 million claims annually for the past three SFYs.

At the time of the review, MHD had 37,868 enrolled providers. Missouri's six Medicaid managed care organizations (MCO) contracted with 11,809 providers. Approximately 38 percent of Missouri Medicaid recipients are enrolled in managed care plans. Although the State tracks expenditures by recipient eligibility category and not by delivery system, cost data provided by the State suggest that managed care enrollees account for between 16 and 18 percent of total Medicaid expenditures. Approximately 73 percent of Missouri's Medicaid expenditures were for recipients with fee-for-service (FFS) coverage, and between nine and 11 percent of expenditures were for FFS recipients in eight small State waiver programs.

Program Integrity Section

In Missouri, the organizational component dedicated to fraud and abuse detection activities is the Office of Finance & Operations; primary program oversight is conducted by the PIU. At the time of the review, the PIU had approximately 25 full-time employees dedicated to identifying provider fraud, abuse and inappropriate payments. The table below presents the total number of audits and overpayment amounts collected for the last three SFYs as a result of program integrity activities.

Table 1

SFY	Overpayment Recoveries	# of Case Reviews Conducted	Average Recovery per Case Review
2005	$2,856,442	436	$6,551
2006	$5,372,703	433	$12,408
2007	$4,665,069	428	$10,899

Methodology of the Review

In advance of an onsite visit, the review team requested that Missouri complete a comprehensive review guide and supply documentation to support 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 program integrity review questionnaire supplied to the State was sent out to each of Missouri's six MCOs. A three-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of September 25, 2007, the MIG review team visited the MHD offices and the MFCU. The team conducted interviews with numerous MHD officials as well as the MFCU

Director. To determine whether managed care plans were complying with the contract provisions and other Federal regulations relating to program integrity, the CMS team reviewed the State's MCO contracts and MCO questionnaire responses. The team conducted in-depth interviews with representatives from two of the six MCOs and met separately with MHD's Program Management Unit to discuss managed care oversight and monitoring effects.

Scope and Limitations of the Review

This review focused on the activities of the PIU. Missouri's State Children's Health Insurance Program (SCHIP) operates as an expansion program under Title XIX of the Social Security Act and was, therefore, included in this review. However, because Missouri's SCHIP operates under the same FFS billing and provider enrollment policies as Missouri's Title XIX program, the same findings and vulnerabilities discussed in relation to the Medicaid program apply to SCHIP. Unless otherwise noted, MHD 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, financial, or collections information that MHD provided.

RESULTS OF THE REVIEW

REGULATORY COMPLIANCE ISSUES

The State is not in compliance with Federal regulations related to required provider disclosures of ownership and control information, business transaction information, and criminal conviction information; and the required notification to HHS-OIG regarding exclusions.

MHD provider enrollment applications do not capture 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 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.

MHD enrollment applications do not capture all of the required disclosures. Therefore, the inter-relationships of entities, related organizations, and subcontractors cannot be easily established, and MHD cannot always determine when a provider seeking to enroll in Medicaid has an ownership or control interest in excluded related organizations or subcontractors. Similarly, MCO credentialing application forms do not capture all the disclosures required under this regulation. The State's MCO contract does not mandate that MCOs require these disclosures from their contracted providers.

***Recommendation*:** Modify FFS provider enrollment applications to capture appropriate ownership and control information. Require MCOs to modify credentialing application forms to capture required disclosures.

MHD FFS provider enrollment and managed care credentialing applications do not require providers to disclose certain business transactions.

The regulation at 42 CFR § 455.105(b) requires that, upon request, providers furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractors. Missouri's FFS provider enrollment agreement and applications do not require provision of this information. MCO credentialing application forms do not require submission of the disclosures under this section.

***Recommendation*:** Modify the FFS provider agreement to require providers to supply business transaction information identified in 42 CFR § 455.105. Require MCOs to modify credentialing application forms to require disclosure of the information identified in 42 CFR § 455.105.

MHD's FFS provider enrollment and managed care credentialing applications do not capture required criminal conviction information for managing employees.

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 HHS-OIG whenever such disclosures are made.

While the MHD FFS provider applications ask for some relevant criminal conviction information, the forms do not explicitly ask whether a managing employee or anyone with a controlling interest has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX. While two MCOs reported they conduct criminal background checks on all provider employees, the MCO credentialing applications do not solicit criminal conviction information about anyone besides the provider applicant. MHD does not report health care-related criminal conviction disclosures to HHS-OIG as required in 42 CFR § 455.106(b).

***Recommendation*:** Modify FFS provider applications to meet the full criminal conviction disclosure requirements of the regulation. Require that managed care credentialing applications solicit the required criminal conviction disclosures. Develop and implement procedures to report to HHS-OIG within 20 working days any criminal conviction disclosure made during the FFS enrollment, re-enrollment or MCO credentialing process.

MHD does not report to the HHS-OIG adverse actions it takes on provider applications.

The regulation at 42 CFR § 1002.3(b)(2) and (3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. These adverse

actions include the denial or termination of participation in the program, including when an owner or managing employee has been convicted of a criminal offense related to Medicare, Medicaid, or Title XX programs.

MHD does not promptly report all such adverse actions or actions taken to limit participation to HHS-OIG. MHD does not require its MCOs to report adverse credentialing decisions. Therefore, MHD cannot report such adverse actions in its managed care program to HHS-OIG.

***Recommendation*:** Develop and implement procedures to report to HHS-OIG all adverse actions taken against and limits placed on Federal financial participation and managed care providers' participation in the program. Require MCOs to notify MHD of all adverse actions MCOs take on provider credentialing.

AREAS OF VULNERABILITY

The review team identified two areas of vulnerability in Missouri's program integrity practices.

Not capturing the identities of all managing employees during the enrollment process
States must solicit providers' disclosures of the identities of managing employees who have been convicted of health care-related offenses. Capturing the identities of all managing employees would assist the State in ensuring that no FFP was spent on providers or entities with managing employees who are convicted of such offenses and thereafter excluded. MHD does not capture the identities of managing employees in either the FFS or managed care enrollment processes. As a result, the MHD cannot conduct searches of data bases in order to ensure that providers or entities billing Medicaid do not employ managing employees who have been excluded from the program.

***Recommendation*:** Require disclosure of all managing employees on all FFS enrollment and managed care credentialing forms.

Not capturing disclosures regarding MCO ownership or management or searching changes in MCO management for exclusion
MHD enrolls MCOs as Medicaid providers. The State has no policy directing its staff to ask MCOs to provide required disclosures or disclosures of managing employees when there are personnel changes in MCO management during the contract term. Without these disclosures, the State cannot conduct an exclusion search of the new management staff.

***Recommendation*:** Develop policies and procedures to solicit MCO management staff disclosures and to require disclosures of changes in MCO management staff during the contract term.

CONCLUSION

The State of Missouri has some effective program integrity practices, and CMS encourages MHD to look for 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 areas of vulnerability were identified. CMS encourages MHD to closely examine the areas of vulnerability that were identified in the review.

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 they 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 areas of non-compliance or vulnerability will take more than 90 calendar days from the date of the letter. If MHD 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 and eliminating its vulnerabilities.

Attachment A

MATT BLUNT
GOVERNOR

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June 11, 2008

Robb Miller, Director
Division of Field Operations
Medicaid Integrity Group
233 North Michigan Avenue, Ste. 600
Chicago, IL 60601

Dear Robb Miller:

This letter is in response to the draft report on the review of Medicaid Program Integrity. While the MO HealthNet Division (MHD) appreciates your review and believes it will be helpful in improving MHD's operations, MHD nonetheless disagrees with several of the Medicaid Integrity Group's findings. For example, the report states that, "MHD provider enrollment applications do not capture ownership control and relationship information." MHD's provider enrollment application does capture ownership information by requiring enrolling providers "to submit a list showing the names and addresses of individuals having direct or indirect ownership, controlling interest, or partnership interest…." Thus, MHD believes that it is in compliance with the federal requirements on this point. But in order to improve its operations, MHD offers the following response.

Correction:

On page 1 of the report under the INTRODUCTION section, paragraph two, MHD would like for the text of the first sentence after the word "MHD" to be replaced with "Provider Enrollment (PEU), Program Integrity (PIU), and Program Operations (PO) Units, which are responsible for enrolling providers, program integrity, and managed care contractual oversight, respectively."

Response:

The MO HealthNet Division/Program Integrity, Provider Enrollment, and Program Operations Units will recommend that MHD undertake three phases of implementation in order to fully respond to the issues identified in the report and improve MHD operations.

<u>Phase I</u> – Altering Provider Enrollment Applications and amending Managed Care Organizations' contracts.

The Program Integrity and Provider Enrollment Units will recommend changing the language in Provider Enrollment applications, forms, and instructions (both paper and on-line applications) to more clearly require the following:

1. MHD providers/applicants to disclose the name and address of each person and/or any subcontractor with an ownership or controlling interest either directly or indirectly of 5 percent or more. 42 CFR § 455.104(a)(1) and 42 CFR § 455.104(b).

2. Disclosure of whether any of the named individuals are related to each other as spouse, parent, child, or sibling, etc. 42 CFR § 455.104(a)(2).

3. MHD providers/applicants to disclose the name of any other entity and/or subcontractor in which any named individual also has an ownership or controlling interest, noting the applicant may have to obtain this information by requesting it in writing. The applicant must keep copies of all such requests and responses, make them available to MHD upon request, and must also advise MHD when there is no response to their request. 42 CFR § 455.104(a)(3).

4. MHD providers/applicants to furnish, upon request, full and complete information related to business transactions within 30 days of the request. This would include the ownership of any subcontractor and any significant business transactions between the provider and any wholly owned supplier. 42 CFR § 455.105(a)(b).

5. MHD providers/applicants to disclose the identity of any person who has an ownership or control interest in the applicant or provider (entity), or is an agent or managing employee. MHD providers/applicants will also identify if any of these individuals have been convicted of a criminal offense related to that person's involvement with any healthcare program. 42 CFR § 455.106.

Managed Care Organizations (MCOs) are required by contract to use the Missouri Standardized Credentialing Form pursuant to RSMo § 354.442.1(15) and 20 CSR 400-7.180. While the MHD cannot modify this standardized form, Program Operations will recommend that MHD amend MCO contracts to require the following:

1. MCOs to capture disclosure information identified in 42 CFR § 455.104(a)(1-3) and 42 CFR § 455.105 from their contracted providers.

2. MCOs to report to MHD whether the provider, a managing employee, or anyone with a controlling interest has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX. MHD will also develop procedures to report to HHS-OIG within 20 working days any criminal conviction disclosure made during the MCO credentialing process.

3. MCOs to notify MHD of all adverse actions the MCOs take on provider credentialing. The adverse actions include the denial or termination of participation in the program, including when an owner or managing employee has been convicted of a criminal offense related to Medicare, Medicaid, or the Title XX programs.

MHD will draft procedures and/or rules to report the following: any disclosures of criminal convictions referenced above to the Inspector General within

20 working days from either the date the information is received, or the date MHD takes action on a provider's application when such disclosures of criminal conviction are made. 42 CFR § 455.106. MHD will also develop policies and procedures to solicit MCO management staff disclosures and to require disclosures of changes in MCO management staff during the contract term.

Phase II – Propose language changes to the Code of State Regulations (13 CSR 70-3.020 and 13 CSR 70-3.030).

In order to fully implement the proposed changes identified in Phase I, and clearly articulate that an applicant's/provider's violation of the Phase I requirements is cause for sanction, the Program Integrity Unit will propose that MHD amend two of its rules: 13 CSR 70-3.020, governing the MO HealthNet Division's provider application process; and 13 CSR 70-3.030, which identifies the grounds for sanction for violating Title XIX (Medicaid) program rules.

Phase III – Propose changes to the MMIS system to capture additional information.

To facilitate the organization of additional information obtained through implementing Phase I, the Provider Enrollment Unit will examine changes to the MMIS information system to make the information more readily searchable.

If you have any questions regarding the MO HealthNet Division's response to the Medicaid Integrity Group's review, please contact David Hart of my staff at 573-751-3399.

Sincerely,

Ian McCaslin, M.D., M.P.H.
Director

IM:sb