Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Pennsylvania Comprehensive Program Integrity Review

Final Report

July 2009

Reviewers:
Doug Colburn, Review Team Leader
Annette Ellis
Primo Joson
Harry Kornblau
Mark Rogers

TABLE OF CONTENTS

INTRODUCTION

The Centers for Medicare and Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Pennsylvania Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Pennsylvania Department of Public Welfare (DPW). The MIG team also visited the office of the Medicaid Fraud Control Unit (MFCU), which in Pennsylvania is referred to as the Medicaid Fraud Control Section (MFCS).

This review focused on the activities of the DPW Bureau of Program Integrity (BPI), which is responsible for Medicaid program integrity. This report describes six effective practices, four regulatory compliance issues, and four vulnerabilities.

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 Pennsylvania improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Pennsylvania's Medicaid Program

The Office of Medical Assistance Programs (OMAP) within DPW administers the Pennsylvania Medicaid Program. As of June 30, 2007, the program served 1,780,870 recipients, approximately 60 percent of whom were enrolled with a managed care organization (MCO) in HealthChoices, Pennsylvania's Medicaid managed care program. The State had enrolled 40,815 managed care providers as of June 30, 2008. The State had 54,763 providers participating in the fee-for-service (FFS) program. Medicaid expenditures in Pennsylvania for the State fiscal year (SFY) ending June 30, 2007 totaled $15,737,016,079. In SFY 2007, the Federal medical assistance percentage varied from 54.39 to 55.05 percent.

Program Integrity Section

The BPI, within OMAP, is the organizational component dedicated to the prevention and detection of provider fraud, abuse and overpayments. At the time of the review, BPI had approximately 80 full-time equivalent staff positions, including the bureau director, 2 division directors, 27 registered nurses, and 33 contracted State agency staff. In addition, BPI has eight part-time medical and dental contracted staff. 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 BPI; global settlements are not included.

Table 1

SFY	Number of Preliminary & Full Investigations	Number of State Administrative Actions or Sanctions (Approximation)	Amount of Overpayments Identified	Amounts Recouped (includes past BPI settlement collections)
2006	4,766	2,274	$ 8,843,040	$ 14,079,749
2007	3,361	1,618	$ 15,823,746	$ 15,172,786
2008	4,108	2,025	$ 9,499,024	$ 17,891,554

Methodology of the Review

In advance of an onsite visit, the review team requested that Pennsylvania 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 August 18, 2008, the MIG review team visited the DPW and MFCS offices. The team conducted interviews with numerous DPW officials, as well as with the MFCS Director. 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 through interviews with representatives of three MCOs.

Scope and Limitations of the Review

This review focused on the activities of the BPI, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, managed care oversight, and provider education. Pennsylvania's Children's Health Insurance Program operates under Title XXI of the Social Security Act and was, therefore, not included in this review. Unless otherwise noted, DPW 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 DPW provided.

RESULTS OF THE REVIEW

Effective Practices

The State highlighted several practices that demonstrate its commitment to program integrity. These practices involve monitoring MCO performance, creating and utilizing a case tracking system, proactive data mining techniques, monitoring of hospital services, and use of a preferred drug list.

Use of teams to monitor MCO performance

The DPW's Bureau of Managed Care Operations (BMCO) uses core teams of staff from separate functional areas, and with varied backgrounds, to monitor physical health MCOs in the HealthChoices program for contract compliance and performance standards, including those for fraud and abuse. To manage this oversight, BMCO uses specific monitoring technology and an Access database which houses all contract monitoring performance standards. The DPW added updated fraud and abuse requirements to the HealthChoices standard contract agreement for 2007. The BPI staff are part of each core team and participate in BMCO meetings. They are responsible for monitoring eight contract compliance and performance standards mostly relating to fraud and abuse and may take part in onsite reviews as needed.

Behavioral health MCOs in the HealthChoices program are monitored every three years by teams from the Office of Mental Health and Substance Abuse Services using a State tool called the Program Evaluation Performance Summary (PEPS). The PEPS review tool consists of questions derived from contract language and Federal Balanced Budget Act standards. The review instrument includes a provider credentialing standard requiring BPI staff to review files for proper licensing, certifications and criminal convictions. The monitoring teams also review MCO policies and procedures for reporting suspected or substantiated fraud and abuse. The MCOs are required to report such cases to BPI.

Effective and accessible case tracking system

The BPI makes use of a case tracking system developed by DPW which enables users to readily access files and determine the status of a case. The system has built-in data safeguards in that only the person responsible for a given case can change the information on that case, while only the Systems Administrator can change overpayment dollar amounts. All entries, updates and edits are tracked by a date/time stamp and can be audited. One useful feature is that if the owner of the case wants an attorney assigned to the case, it can be done within the system. The system will generate an e-mail to the State Office of General Counsel. Once an attorney is assigned, an e-mail automatically comes back confirming the request. The system is proprietary to DPW.

Proactive data mining techniques by specialized medical economists

The BPI completed the implementation of a proactive approach to data mining in SFY 2008. Two medical economists in BPI's Information Technology/Data Support Unit began using algorithms to analyze data on a full-time basis in a sophisticated and iterative way. Utilizing specialized software and the data warehouse profiler, they generated queries to support targeted reviews relating to complaints, referrals, balanced billing and policy enforcement. They also identified the need for additional reviews based on claims processing system limitations and overpayments made without prior medical record review. When an algorithm is proven to be effective, Pennsylvania adds it to the schedule of regularly run reports for ongoing overpayment recovery.

Effective monitoring of hospital compliance with Medical Assistance regulations
In March 2006, DPW hired a contractor to monitor and retrospectively review hospital services and conduct diagnosis related group validation to ensure that payment information agrees with medical record documentation. The contractor utilizes DPW's paid claims database to select claims for data analysis and medical record review by nurses and physicians. Its reviews have found a significant lack of documentation in medical records, incorrect diagnosis and procedure codes, and quality of care concerns. In large part based on the contractor's work, Pennsylvania was able to recover $10,351,109 in the SFY ending on June 30, 2008 and $5,206,989 for the period from July 1 to October 1, 2008.

Development and use of a preferred drug list
In SFY 2005-2006, DPW implemented the Preferred Drug List (PDL) for the FFS Medicaid program. Preferred drugs are those drugs that have been determined to be the best in a particular class based on clinical effectiveness, safety and outcomes. These drugs are placed on the PDL at the recommendation of the Pharmacy & Therapeutics Committee and approval of the Secretary of Public Welfare. The PDL includes approximately 70 drug classes and is reviewed annually. From SFY 2005 to SFY 2008, non-dual eligible per member per month pharmacy spending decreased from $71.51 to $46.32 after accounting for Federal and supplemental rebates.

Additionally, the CMS review team identified a practice that is particularly noteworthy. The CMS recognizes DPW's efforts to educate MCOs about fraud and abuse.

Annual MCO program integrity meeting
The BPI sponsors an annual meeting for its MCOs that provides valuable education regarding fraud and abuse. Fraud and abuse schemes, cooperative relations with stakeholders, and best practices were discussed at the most recent meeting in the spring of 2008. Representatives of the U.S. Department of Health and Human Services - Office of Inspector General (HHS-OIG) discussed fraud, waste and abuse investigations and what makes a good case referral. The meeting also provided training to physicians, designed to make them aware of issues related to fraud and abuse in the Medicaid program and in their practices.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to provider disclosure and notification requirements.

The State's provider enrollment process does not capture all required ownership and control information.
Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5

percent or more. 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.

Pennsylvania's Bureau of Fee for Service enrolls all providers, including MCO network providers, using a common enrollment form. This form does not capture all of the ownership or relationship information specified in the regulation. The State agency relies on a blanket statement in provider agreements requiring the disclosing entity to comply with disclosure requirements specified in 42 CFR Part 455, Subpart B. However, the enrollment form does not have a place to list subcontractors in which the disclosing entity has a 5 percent or greater ownership; therefore, subcontractor relationships with owners of the disclosing entity can not be determined.

Additionally, the State does not collect any disclosure information from providers in its Medical Assistance Transportation Program. These non-emergency medical transportation (NEMT) providers are paid via grants to the 66 Pennsylvania counties and one brokerage provider. The State also does not ensure that the counties or broker collect the required disclosures through oversight, review, or audit.

***Recommendations*:** Review and modify the standard provider enrollment form to collect the information required under 42 CFR § 455.104(a). Do not enroll or pay providers that do not provide all required disclosures. Require NEMT providers to supply the full disclosure information required under 42 CFR § 455.104.

The State does not require NEMT providers to disclose business transactions.
The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractors. Pennsylvania does not require NEMT providers to agree contractually to provide business transaction information upon request. Since these providers are paid via grants to Pennsylvania counties and one broker, they are not enrolled in the State's Medicaid program and do not sign a provider agreement which stipulates that they must provide specific business transaction information when requested.

***Recommendation*:** Modify the Medical Assistance Transportation Program provider agreements to require disclosure upon request of the information identified in 42 CFR § 455.105.

The State's enrollment process does not capture criminal conviction information for NEMT providers.
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 does not enroll NEMT providers. These providers are paid via grants to counties and one broker who are responsible for arranging for the drivers. The MIG review team could find no evidence that disclosure of the information required in 42 CFR § 455.106 is solicited during the NEMT provider enrollment process. If the required criminal conviction information is not available for transmission to DPW, then DPW in turn is unable to meet the regulatory requirement that all criminal conviction disclosures be forwarded to HHS-OIG within 20 working days.

***Recommendations*:** Review and modify provider enrollment packages used in the NEMT program to collect the criminal conviction information required under 42 CFR § 455.106. Refer relevant disclosures to HHS-OIG within the required time frames. Do not enroll providers that do not provide all required disclosures.

The State does not report to HHS-OIG adverse actions it takes on provider applications.
The regulation at 42 CFR §1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. The State is not currently submitting information to the HHS-OIG regarding actions taken on provider applications, including the denial of initial enrollment. BPI management advised that additional procedures for notifying HHS-OIG of provider disclosures made under §455.106(a) are under development for all areas responsible for enrollment. These procedures would address the 42 CFR §1002.3(b)(2) issue identified by this review.

***Recommendations*:** Develop and implement policies and procedures to report to HHS-OIG adverse actions taken against provider enrollment applications and actions taken to limit the ability of providers to participate in the Medicaid program.

Vulnerabilities

The review team identified four areas of vulnerability in Pennsylvania's practices regarding reporting of criminal conviction information, verification of services, compliance with False Claims Act education requirements, and indirect routing of fraud referrals.

Not requiring reporting of certain criminal convictions to DPW.
An interview with Community Care Behavioral Health Organization management revealed that positive responses to criminal conviction questions on the individual provider applications are sent to the affected county. The county then decides whether to report that information to DPW, as the HealthChoices behavioral health contract with DPW does not require the automatic referral of such disclosures.

***Recommendations*:** Amend contracts with MCOs to require them specifically to send all disclosed criminal conviction information to DPW. This information will then enable the State to report such disclosures to HHS-OIG.

Not verifying services billed to MCOs with recipients.
The Federal regulation at 42 § CFR 455.20 requires State Medicaid agencies to verify with recipients that services billed by providers were actually furnished. While Pennsylvania meets this requirement by sending explanations of medical benefits (EOMBs) to 5 percent of FFS recipients, there is no requirement in the HealthChoices managed care contracts to send EOMBs to enrollees. Consequently, the three MCOs interviewed do not routinely interact with recipients. They instead rely on provider audits, general questionnaires, and grievance procedures, which only gives them a general sense of whether provider-billed services were actually furnished.

***Recommendations*:** Modify MCO contacts to require some form of recipient verification of services billed to the Medicaid program. Include this as a compliance standard in the tools used to monitor both the physical and behavioral health programs.

Not ensuring that entities are in compliance with the False Claims Act provision of the Social Security Act.
The review team found that DPW issued a bulletin to providers on the requirement of § 1902(a)(68) of the Social Security Act that any providers or entities receiving $5 million or more in Medicaid payments must provide education on the Federal False Claims Act to their employees. DPW has also required providers to sign and submit an attestation statement that they will comply with these requirements. However, the State acknowledged that it has yet to monitor any entities regarding compliance with these regulations.

***Recommendations*:** Develop and implement policies and procedures to monitor and verify compliance with this DRA requirement.

Indirect routing of BPI fraud referrals to the Pennsylvania MFCS.
The Memorandum of Understanding (MOU) between Pennsylvania's MFCS and DPW states that instances of suspected provider fraud identified by the BPI are only referred to the MFCS after the referral is first approved by both the Department of Public Welfare's Office of General Counsel (DPW-OGC) and the Governor's Office of Counsel. BPI management confirmed this process in interviews with the MIG review team. Whenever BPI identifies an instance of suspected provider fraud, it makes a recommendation to the DPW-OGC that the case be referred to the MFCS using a form entitled "Recommendation for Provider Referral to the Office of Attorney General, Medicaid Fraud Control Section." Once approved by the DPW-OGC, the recommendation is then reviewed by the Governor's Office of Counsel. Only after approval by the Governor's Office of Counsel is the case actually referred to the MFCS.

***Recommendations*:** Modify the MOU between the DPW and the MFCS to require that referrals go directly to the MFCS without being subject to review by the Governor's Office of Counsel.

CONCLUSION

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

- annual meetings with MCOs on program integrity issues,
- proactive data mining by specially trained staff,
- monitoring of hospital compliance by contractors,
- development and use of a PDL,
- use of teams to monitor MCO performance and contract compliance, and
- development of a comprehensive and user-friendly yet secure provider case tracking system.

CMS supports the State's efforts and encourages it 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, four areas of vulnerability were identified. CMS encourages DPW 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 DPW 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 Pennsylvania 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 DPW 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 Pennsylvania on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.