Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

West Virginia Comprehensive Program Integrity Review

Final Report

January 2013

Reviewers:
Tonya Fullen, Review Team Leader
Steve Gatzemeier
Mark Rogers
Eddie Sottong
Joel Truman, Review Manager

Table of Contents

Introduction

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the West Virginia Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Bureau for Medical Services (BMS), which is the State Medicaid agency. The review team also visited the provider enrollment contractor and conducted a phone interview with the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of BMS' Office of Quality and Program Integrity (OQPI), which is responsible for Medicaid program integrity in West Virginia. This report describes one effective practice, eight regulatory compliance issues, and seven vulnerabilities in the State's program integrity operations.

The CMS is concerned that the review identified two uncorrected repeat or partial repeat findings and four uncorrected repeat or partial repeat vulnerabilities from its 2009 review of West Virginia. The CMS will work closely with the State to ensure that all issues, particularly those that remain from the previous review, are resolved as soon as possible.

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

Overview of West Virginia's Medicaid Program

The BMS administers the West Virginia Medicaid program. As of January 1, 2012, the program served 327,882 beneficiaries. Of this total, 163,053 beneficiaries were enrolled in 3 full service managed care organizations (MCOs). Another 7,781 were enrolled in the Physicians Assured Access System, which is a primary care case management program.

The State had 23,108 participating fee-for-service (FFS) providers, while the various health plans each had between 267 and 8,556 affiliated providers. According to CMS financial data, total computable Medicaid expenditures for the State fiscal year (SFY) ending June 30, 2011 were just over $2.8 billion.

Medicaid Program Integrity Division

The OQPI is part of the Division of Finance and Administration within BMS. At the time of the MIG review, OQPI had five full-time equivalent employees (FTEs) focusing on Medicaid program integrity, including four auditors and one data analyst. This represents the same number

of program integrity FTEs reported during West Virginia's 2009 review when five auditors were reported. The table below presents the number of preliminary and full investigations and overpayment amounts identified and collected for BMS in the last four SFYs as a result of program integrity activities. The investigations and collections data do not include global settlements or dollars collected by other components within the Medicaid agency, such as the Financial Compliance Unit.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Overpayments Identified Through Program Integrity Activities	Overpayments Collected Through Program Integrity Activities
2008	7	7	$2,393,347	$1,949,694
2009	10	10	$2,549,721	$1,317,337
2010	17	17	$2,549,253	$1,500,302
2011	7	7	$2,591,830	$1,363,736

* Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
** 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. At the time of the review, the State indicated that it was unable to distinguish between preliminary and full investigations but was in the process of developing a future method of identifying each type of case.

Methodology of the Review

In advance of the onsite visit, the review team requested that West Virginia complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosures, and managed care. A four-person team reviewed the responses and materials that the State provided in advance of the onsite visit. Telephone interviews were also conducted with three MCOs and the MFCU prior to the team going onsite.

During the week of May 14, 2012, the MIG review team visited the BMS and fiscal agent offices. The team conducted interviews with numerous BMS officials as well as with provider enrollment contractor staff. To determine whether MCOs were complying with the contract provisions and other Federal regulations relating to program integrity, the MIG team reviewed the State's managed care contracts. The team met separately with BMS staff to discuss managed care oversight and monitoring. In addition, the team conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate West Virginia's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the OQPI, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, contract management, and provider training. West Virginia operates a stand-alone Children's Health Insurance Program (CHIP). The stand-alone CHIP operates under Title XXI of the Social Security Act and was, therefore, not included in this review.

Unless otherwise noted, BMS 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 BMS 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. West Virginia reported that a mutually supportive relationship with the MFCU served as an effective program integrity tool.

Relationship with the MFCU

The 2009 CMS program integrity review identified significant problems with the interaction and the cooperation between the State Medicaid agency and the MFCU. Both units are under new leadership, which has created an opportunity to build a better working relationship.

The 2012 team found that both units meet monthly to discuss new issues and potential cases from OQPI and to receive updates from the MFCU on ongoing investigations. According to the MFCU director, one result of the more collaborative working relationship is that the number of referrals received from the State agency increased from 6 in SFY 2009 to 22 in SFY 2010 and 23 in SFY 2011.

Additionally, the State has developed a Medicaid Fraud Referral Form which incorporates all the criteria in CMS' September 2008 guidance document "Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit." This guidance was adopted in Federal regulations at 42 CFR 455.436 effective March 25, 2011. Besides meeting the original referral criteria, the form also solicits information on whether the State agency recommends a payment suspension and the date suspensions were taken. The form also requests staff to list all current OQPI reviews and reviews conducted on providers of interest in the last five years as well as final disallowance amount(s).

The State and the MFCU have also established a bi-annual joint training session for the staff of both units. The initial training was conducted in SFY 2008. Another session was held in 2010, and the most recent session took place on April 17, 2012. The agenda of the last meeting included time for staff to provide input on "hot issues." There was also an opportunity for investigators to pose questions on policy, legal issues, documentation, and the newly created referral form. Each director was able to question the other unit's personnel and provide insight into their respective units. The training strengthened each group's ability to understand the needs and concerns of the other. The meeting also served as a catalyst for making improvements in the coming year.

While the State agency and the MFCU have made progress in developing a cooperative and collaborative working relationship, the team identified concerns about some aspects of the fraud referral process and the issuance of suspension notices. These are discussed more fully in the regulatory compliance section below.

Regulatory Compliance Issues

The CMS review team found eight regulatory non-compliance issues related to program integrity in West Virginia. These issues are significant and represent risk to the West Virginia Medicaid program. Ranked in order of risk to the program, these compliance issues include: not complying with Federal regulations regarding suspension of payments in cases involving credible allegations of fraud, not having administrative procedures to initiate permissive exclusions against providers, making payments to an excluded provider, failing to conduct complete exclusion searches, failing to collect complete ownership and control, business transaction, and criminal conviction disclosures, and not complying with Medicaid State Plan requirements regarding False Claims Act education monitoring.

The State does not suspend payments in cases of credible allegations of fraud.

The Federal regulation at 42 CFR 455.23(a) requires that upon the State Medicaid agency determining that an allegation of fraud is credible, the State Medicaid agency must suspend all Medicaid payments to a provider, unless the agency has good cause to not suspend payments or to suspend payment only in part. Under 42 CFR 455.23(d) the State Medicaid agency must make a fraud referral to either a MFCU or to an appropriate law enforcement agency in States with no certified MFCU. The referral to the MFCU must be made in writing and conform to the fraud referral performance standards issued by the Secretary.

From March 25, 2011 to the date of the onsite visit, West Virginia referred eight cases to the MFCU without making a timely suspension of payments or providing a written justification for non-suspension based on exception criteria in the regulation. The team identified two cases in which the State failed to suspend payments or cite exception criteria in writing upon referral to the MFCU. In one case, a pay hold was placed on the provider only after the MFCU obtained a successful conviction. In other cases where payments were appropriately suspended, the State failed to meet a provision of the regulation requiring that notice of the suspension be sent to the provider within 5 days unless the MFCU requests a delay of up to 30 days in writing, which can be renewed twice.

In addition the State's official "Notice of Suspension" is not in accord with another section of the regulation, which requires that the basis of any suspension be clearly stated. The notice refers solely to a provider's indictment as the grounds for any payment cutoff. However, indictments are not the only circumstances under which payments must be suspended. Lastly, the team observed that OQPI does not calculate the Medicaid dollars paid in cases where timely payment suspensions should have been imposed and therefore cannot estimate the total losses to the Medicaid program which such cases represent.

Recommendations: Develop and implement policies and procedures to suspend payments to providers immediately upon referral to the MFCU when an investigation determines that a

credible allegation of fraud exists, or provide written documentation of a good cause exception not to suspend. Ensure that such policies and procedures comply with all provider notice requirements in 42 CFR 455.23.

The State does not have administrative procedures to initiate exclusions for any reason for which the HHS-OIG could exclude a provider.

The regulation at 42 CFR 1002.210 requires that the State institute administrative procedures to exclude a provider for any reason for which the HHS-OIG could exclude a provider under 42 CFR Parts 1001 and 1003.

The BMS management indicated that that the State does not have administrative procedures to initiate permissive exclusions against providers. State officials said the Medicaid agency was developing a permissive exclusion policy and working with its fiscal agent to develop procedures for making appropriate notifications.

Recommendation: Develop and implement policies and procedures for undertaking State-initiated provider exclusions when warranted and consistent with the regulation at 42 CFR 1002.210.

The State made payment to an excluded provider for an item or service ordered or referred by an excluded provider.

Under the Federal regulation at 42 CFR 1002.211, no payment may be made by the State agency for any item or service furnished on or after the effective date specified in the notice by an excluded individual or entity, or at the medical direction or on the prescription of a physician who is excluded when a person furnishing such item or service knew, or had reason to know, of the exclusion.

The State disclosed, and the review team verified through case sampling, that one excluded provider billed West Virginia Medicaid for $37,125. The provider was excluded by HHS-OIG in 1998 and had not been reinstated when he was enrolled in the West Virginia program in 2004. The State did not detect the excluded provider until March 2010 when BMS began routinely searching the MED file and terminating providers who showed up on it. Internal correspondence dated June 2012, which BMS provided after the onsite review, indicated that pharmacy payments associated with the provider had been stopped, but other Medicaid payments were still being made. According to the State, all payments were subsequently stopped, and agency officials were determining if the Federal share of the overpayment had been returned.

Recommendation: Develop and implement policies and procedures to ensure that all parties identified by the regulation are checked against the LEIE/MED and EPLS upon enrollment, reenrollment, and at least monthly thereafter to ensure that the State does not pay Federal funds to excluded persons or entities. Promptly return to CMS the Federal share of any overpayments improperly issued to providers for services billed during any period of exclusion.

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid.

The Federal regulation at 42 CFR 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System (EPLS)[1] no less frequently than monthly.

The State's fiscal agent collects and stores in a searchable database information related to FFS providers, managing employees, agents, and persons with ownership or control interests in FFS providers. The information is searched against the LEIE and EPLS for exclusions and debarments during the initial enrollment process or upon reenrollment of a provider. However, while the LEIE is also searched on a monthly basis after enrollment, no monthly EPLS searches are performed.

Recommendation: Develop and implement policies and procedures for appropriate collection and maintenance of disclosure information about the provider, any person with an ownership or control interest, or who is an agent or managing employee of the provider. Search the LEIE (or the Medicare Exclusion Database [MED]) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

The State does not capture all required ownership and control disclosures from disclosing entities. (Uncorrected Partial Repeat Finding)

Under 42 CFR 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or managed care entity, must disclose to the State Medicaid agency the name, address, date of birth (DOB), and Social Security Number (SSN) of each person or entity 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. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under 455.104(b)(2), a disclosing entity, fiscal agent, or managed care entity must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or managed care entity as spouse, parent, child, or sibling. Moreover, under 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or managed care entity in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or managed care entity has an ownership or controlling interest. In addition, under 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or managed care entity. As set forth under 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and managed care entities prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or managed care entity.

[1] On July 30, 2012, the EPLS was migrated into the new System for Award Management (SAM). State Medicaid agencies should begin using the SAM database. See the guidance at http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-01-12.pdf for assistance in accessing the database at its new location.

The 2009 CMS review found that FFS provider enrollment forms and the fiscal agent contract were not soliciting the addresses of persons with ownership and control interests in the enrolling entity or its subcontractors. In addition, no evidence was provided that MCOs were providing full ownership and control disclosures about their own organizations or subcontractors in which the MCO had ownership or control interests. The State had taken steps to correct these compliance issues prior to the 2012 review. It created a form entitled "Supplemental Provider Enrollment Pages" which went into use in March 2011 for all FFS provider types. However, the form does not solicit information on persons with 5 percent or more ownership or control interest in the disclosing entity and subcontractors, or family relationships among such persons. The form also does not capture the name of other disclosing entities in which persons with an ownership or control interest in the enrolling entity also have ownership or control interests. In addition, the form does not solicit all of the disclosure information required by the regulation in its amended form that went into effect on March 25, 2011. For example, it does not request expanded address information for corporate entities with an ownership or control interest in the provider.

West Virginia's fiscal agent contract was not available for the team to review. However, the State's review guide responses indicated that 455.104-related disclosures were not required in the State's contract with the fiscal agent. State officials mentioned that such disclosure requirements will be added in 2012 for the next fiscal agent procurement.

The State's model contract with MCOs is partially compliant. Article II, Section 7.6 of the contract solicits the name and address of persons with ownership or control interests in the MCO and subcontractors, and requests information on the relationship of such persons as well as the name of other related disclosing entities. However, the form does not ask for the DOB and SSN of persons with ownership or control interests, expanded address requirements for corporate entities with ownership or control interests, or other tax identification numbers of subcontractors in which the MCO has an ownership or control interest. The form also does not solicit the name, address, DOB and SSN of any managing employees.

Recommendations: Develop and implement policies and procedures for the appropriate collection of disclosures from disclosing entities, fiscal agents, and MCOs regarding persons with an ownership or control interest, or who are managing employees of the disclosing entities, fiscal agents, and MCOs. Modify disclosure forms as necessary to capture all disclosures required under the regulation. The MIG made the same recommendation regarding the solicitation of 455.104-related disclosures from MCOs in the 2009 review report.

The State does not adequately address business transaction disclosure requirements in MCO contracts.

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

Although Article II, Section 7.6 of the model MCO contract references the disclosure of information related to business transactions from MCO network providers, the contract does not require contracting MCOs to submit entity-level business transaction information upon request.

Recommendation: Revise the MCO model contract to require disclosure upon request of the information identified in 42 CFR 455.105(b).

The State does not capture criminal conviction disclosures from providers or contractors. (Uncorrected Repeat Finding)

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 the U.S. Department of Health & Human Services-Office of Inspector General (HHS-OIG) whenever such disclosures are made. In addition, pursuant to 42 CFR 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

The 2009 CMS report found that health care-related criminal conviction disclosures by FFS providers were not being reported to the HHS-OIG as required by the regulation. During the 2012 review, the team found that criminal conviction disclosures are being solicited, but the fiscal agent that performs provider enrollment tasks does not have policies or procedures to report such disclosures convictions to HHS-OIG on behalf of the State agency.

The current model MCO contract does not require persons with ownership or control interests in the MCO or agents and managing employees to disclose criminal convictions related to their involvement in Medicare, Medicaid or Title XX since the inception of those programs. The review team was told by supervisory staff in the managed care program that this language will be added to the SFY 2013 contracts with an effective date of July 7, 2012.

The 2009 review team also found that West Virginia's MCOs did not routinely report health care-related criminal convictions to the State agency or to HHS-OIG when disclosed. The 2012 review team was unable to find language in the MCO contract requiring such reporting; and the MCOs stated during interviews that they have received no instructions on this from the State.

Recommendations: Develop and implement policies and procedures and modify contracts as needed for the appropriate collection and timely reporting to HHS-OIG of disclosures from providers and MCOs regarding persons with an ownership or control interest, or persons who are agents or managing employees of the providers, who have been convicted of a criminal offense related to Medicare, Medicaid, or Title XX since the inception of the programs. Modify disclosure forms as necessary to capture all disclosures required under the regulation. The 2009 review report also recommended that the State agency develop and implement a policy and procedure for reporting criminal conviction information to HHS-OIG within 20 working days.

The State does not comply with its State plan amendment regarding False Claims education monitoring.

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

annually 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.

West Virginia identifies appropriate entities and requires them to submit a signed annual attestation of compliance with the False Claims Act education requirements. In accordance with its State plan, a sample of covered entity certifications, along with written policies and compliance documentation, are to be reviewed each year. However, the current program integrity director stated that the State failed to request attestations and other documentation during SFYs 2009, 2010, and 2011. This left the State unable to confirm compliance for the most recently completed fiscal years in which spot checking was required. At the time of the review, the Medicaid agency indicated that it had just sent out 104 attestations and documentation requests for SFY 2011.

Recommendation: Develop and implement policies and procedures to ensure that the State agency monitors provider and contractor compliance with the False Claims Act education requirements in accordance with the Medicaid State Plan.

Vulnerabilities

The West Virginia Medicaid program is at risk because it has a number of vulnerabilities in its program integrity activities. They include: inadequate resources to accomplish core program integrity functions, general weaknesses in the oversight of managed care and waiver programs, failure to conduct complete exclusion searches on network providers, not verifying out-of-state provider licenses, and not capturing full ownership and control, business transaction, and criminal conviction disclosures from managed care network providers.

Inadequate resources to accomplish core program integrity functions. (Uncorrected Partial Repeat Vulnerability)

The 2009 review team found that limited staff was a hindrance to the effective performance of program integrity functions in West Virginia. This remains an issue in 2012. Currently there are five employees assigned to program integrity duties. During Federal fiscal year 2011, 16 States and the District of Columbia had smaller Medicaid programs than West Virginia in terms of annual program expenditures. Of these, only two States had a smaller number of program integrity staff at the time of their last MIG review.

The need for FTEs severely limits OQPI's ability to pursue investigations and other core functions. While West Virginia's track record on audits is fairly strong (the number of audits increased each year from SFY 2008 to 2010 and averaged 386 per year), the State reported an average of only 10 preliminary and full investigations over SFY 2008-2011. In contrast, Maine and Nebraska, both smaller Medicaid programs, reported conducting an average of 484 and 145 investigations, respectively over the same time period. The extremely low figures reported by West Virginia may be partially due to problems the State has experienced in defining and

tracking case investigations. Nevertheless, the lack of resources assigned to case investigations has contributed to the State's relatively low annual fraud and abuse recoupment totals. During interviews, agency officials indicated that they expected the Recovery Audit Contractor to supplement OQPI operations and boost the identification and collection of overpayments.

The impact of insufficient resources was apparent in other areas as well, such as provider outreach. The review team observed, for example, that the Medicaid policy manual, which was currently under revision, does not adequately address program integrity functions. The State acknowledged that the guidance it offered to providers on billings was sufficiently unclear or vague on key points as to allow unscrupulous providers to take advantage of the program. Agency officials did say that they were trying to address this concern and all provider manuals were being reviewed and rewritten in order to furnish providers with more concrete guidance and direction.

In addition, the agency makes use of a manual tracking system for provider audits which is relatively cumbersome and inefficient. Investigators must manually enter notations on a spreadsheet to indicate new developments in cases. The spreadsheet is attached to a file folder and is reviewed when case information is updated. No electronic version of the case file is available. If the tracking sheets or case files were lost or destroyed, the information they contained could not be retrieved. The State agency depends on this system to document cases identified for recovery and collections.

Recommendation: Develop and implement policies and procedures for organizing program integrity operations commensurate with the size of West Virginia's Medicaid program, including the investigation and auditing of provider types where Medicaid dollars are most at risk, the development of an improved tracking system, and the dissemination of clear program guidelines to providers.

Limited program integrity oversight of the State's managed care and waiver programs. (Uncorrected Partial Repeat Vulnerability)

The 2009 CMS review found inadequate oversight of managed care program integrity activities. This was partly due to the failure of MCOs to keep the State informed about ongoing investigations and new cases.

The 2012 review team found a similar situation. The OQPI indicated that none of its key program integrity functions, such as data analysis and review, post-payment review, and the development of fraud referrals and policy recommendations, directly involved the State's managed care or home and community based waiver programs, although these programs are run within BMS. In the FFS program, OQPI staff regularly reviews policy manuals and makes recommendations designed to address perceived structural weaknesses and loopholes. Such recommendations may be on service limits, billing codes, and edits to reduce improper payments from occurring, and they are given due consideration by senior staff within the agency.

In contrast, program integrity policies in the managed care program are reviewed by a program supervisor who does not report to OQPI and has little or no communication with it. The Managed Care unit contracts with an External Quality Review Organization (EQRO) to conduct

annual onsite Systems Performance Reviews to assess MCO compliance with structural and operational standards. However, the EQRO reviews do not include a review of compliance with program integrity standards nor do they include a sample review of claims or encounter data validation.

While the MCOs are required to submit internal fraud and abuse plans annually, and these are reviewed for compliance with Federal regulations and the MCO contract, the review team noted that there was no proactive oversight of program integrity operations in the managed care program and no substantive input from OQPI on program integrity issues. Although OQPI has greater communication with the unit that oversees home and community based waiver programs, it also has no influence the setting of program integrity standards or policies in these programs.

Recommendations: Develop and implement policies and procedures to enhance reciprocal communications between the OQPI's program integrity staff and the units overseeing West Virginia's managed care and home and community based waiver programs. Ensure that OQPI input is considered in the design of program integrity-related policies, procedures, contract requirements and reviews of these programs by State agency personnel and contractors.

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

The regulations at 42 CFR 455.104 through 455.106 require States to solicit disclosure information from disclosing entities, including providers, and require that provider agreements contain language by which the provider agrees to supply disclosures upon request. If the State neither collects nor maintains complete information on owners, officers, and managing employees in the Medicaid Management Information System, then the State cannot conduct adequate searches of the LEIE or MED.

The CMS issued a State Medicaid Director Letter (SMDL) #08-003 dated June 16, 2008 providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the MED upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties, including owners, agents, and managing employees. 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 LEIE and the EPLS[2] on a monthly basis.

During the onsite visit, BMS management told the review team that providers are not being required to check their own employees and subcontractors for exclusions. With the implementation of a web-based enrollment process which the State agency hoped to institute in

[2] On July 30, 2012, the EPLS was migrated into the new System for Award Management (SAM). State Medicaid agencies should begin using the SAM database. See the guidance at http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-01-12.pdf for assistance in accessing the database at its new location.

SFY 2012, FFS providers will be required to attest that it is their responsibility to check the exclusion and debarment lists for staff and contractors.

Although Article III, Section 2.1 of the model contract obligates MCOs to ensure that they contract with no debarred persons (in accordance with 42 CFR 438.610), the contract only requires the MCO to search the LEIE and the MED, not the EPLS. The team found that none of the MCOs in practice checked the status of network providers and affiliated parties in the EPLS on a monthly basis. One of the MCOs interviewed also did not run any checks on agents listed on its entity and individual application forms. Another MCO did not capture information on persons with ownership and control interests in or agents and managing employees of network providers and thus was not in a position to do complete exclusion searches in the LEIE or EPLS.

Recommendations: Amend the contract to require the appropriate collection and maintenance of disclosure information about disclosing entities, and about any person with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity. Require the contractor to search the LEIE and the EPLS upon enrollment, reenrollment, credentialing or recredentialing of network providers, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

Not verifying all out-of-state provider licenses during the enrollment process.
West Virginia does not routinely verify the validity of all provider licenses during the enrollment process. Although each professional provider is required to send in a copy of a current license as part of the enrollment process, the license is only verified if the issuing State has an on-line verification process. Since all States do not have on-line licensure verification capabilities, copies of licenses from those States would be accepted without further scrutiny. This leaves the Medicaid agency vulnerable to enrolling providers having invalid licenses or licenses with significant practice limitations.

Recommendation: Implement policies and procedures to verify all provider licenses at the time of enrollment, including checks for possible restrictions or limitations.

Not capturing ownership and control disclosures from network providers.
Under 42 CFR 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or managed care entity, must disclose to the State Medicaid agency the name, address, DOB, and SSN of each person or entity 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. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under 455.104(b)(2), a disclosing entity, fiscal agent, or managed care entity must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or managed care entity as spouse, parent, child, or sibling. Moreover, under 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or managed care entity in which a person with an

ownership or controlling interest in the disclosing entity, fiscal agent, or managed care entity has an ownership or controlling interest. In addition, under 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or managed care entity. As set forth under 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and managed care entities prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or managed care entity.

The review team found that MCO network provider applications do not request the DOB and SSN of persons with an ownership or control interest, the tax identification numbers of subcontractors in which the MCO has an ownership or control interest, or the name, address, DOB and SSN of managing employees.

Recommendations: Modify the managed care contract to require, or ensure that managed care provider enrollment forms require, the disclosure of complete ownership, control, and relationship information from all MCO network providers. Include contract language requiring MCOs to notify the State of such disclosures on a timely basis.

Not adequately addressing business transaction disclosures in network provider contracts. (Uncorrected Repeat Vulnerability)

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.

West Virginia's MCO network provider agreements did not contain language, also found in 42 CFR 455.105, specifying that any requested business transaction information must be submitted within 35 days. Two of the MCOs interviewed indicated they were not previously aware of this requirement but would take immediate action to comply with it.

Recommendation: Modify the managed care model contract and/or network provider agreements to require timely disclosure upon request of the information identified in 42 CFR 455.105(b). The MIG made the same recommendation regarding business transactions for MCO provider agreements in 2009.

Not capturing criminal conviction disclosures from network providers. (Uncorrected Partial Repeat Vulnerability)

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 the HHS-OIG whenever such disclosures are made. In addition, pursuant to 42 CFR 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

The review team found that two of the MCOs interviewed do not require the disclosure of health care-related criminal convictions from their network providers, while one MCO did solicit criminal conviction information going back to the inception of the Medicare, Medicaid, or Title XX programs. The team also found no contractual requirement that MCOs report appropriate network provider convictions, when disclosed, to the State agency or to HHS-OIG. The failure to require that information of this type be passed on deprives the State agency and HHS-OIG of a potential opportunity to remove problem providers from the managed care program. Similar problems with the collection and reporting of health care-related criminal convictions were found during the 2009 review.

Recommendations: Modify the managed care contract to require, or ensure that managed care provider enrollment forms require, the disclosure of health care-related criminal convictions on the part of persons with an ownership or control interest, or persons who are agents or managing employees of network providers. Include contract language requiring MCOs to notify the State of such disclosures on a timely basis. The CMS made the same recommendation following the 2009 review.

Conclusion

The State of West Virginia applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of eight areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, seven areas of vulnerability were identified. The CMS is particularly concerned over the six uncorrected repeat or partial repeat findings and vulnerabilities. The CMS expects the State to correct them as soon as possible.

To that end, we will require West Virginia 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 West Virginia 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 West Virginia has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The MIG looks forward to working with the State of West Virginia on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
350 Capitol Street, Room 251
Charleston, West Virginia 25301-7307
Telephone: (304) 558-1700 Fax: (304) 558-1451

Earl Ray Tomblin
Governor

Rocco S. Fucillo
Cabinet Secretary

February 22, 2013

Elizabeth Lindner,
Centers for Medicare & Medicaid Services
Center for Program Integrity
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Dear Ms. Lindner:

The West Virginia Department of Health and Human Resources and the Bureau for Medical Services (Bureau), the single state agency, offers the following Corrective Action Plan to the: "Medicaid Integrity Program, Review of Program Integrity Procedures, Final Report - West Virginia, dated January, 2013".

Regulatory Compliance Issues:

1. The State does not suspend payments in cases of credible allegations of fraud.

Effective March 1, 2013, BMS has fully instituted a new fraud suspension process which will be utilized in all cases of credible allegations of fraud. Copies of the new Fraud Suspension Process (attachment #1), "Credible Allegations of Fraud" form (attachment #2), Notice of Suspension (attachment #3), and Notice of Suspension Discontinuation (attachment # 4) forms to be utilized are included with this Corrective Action Plan. BMS and MFCU will collaborate with and initiate written "good cause exceptions not to suspend" for all active fraud referrals as required by 42 CFR 455.23.

With each referral OQPI issued to MFCU, the state will first determine whether a provider should be suspended. MFCU will then review and determine whether a good cause

exception not to suspend should be issued. If so, MFCU will send written confirmation via email to OQPI requesting not to suspend a provider with reasons allowed by 42 CFR 455.23. This emailed request will be included within each case file along with any subsequent renewals (if needed).

OQPI and MFCU maintain their monthly progress meetings where all prior fraud referrals will be included in agendas to discuss any case progress or updates. All fraud referrals will be contained in a log at OQPI within an Excel spreadsheet and maintained by OQPI secretarial staff until we have transitioned to the new I-Sight case tracking tool which is targeted for implementation by 7/1/2013.

A quarterly review of the fraud suspension process (beginning April 1, 2013) will be conducted by OQPI staff to ensure that it is being implemented correctly. Case notes of these meetings, along with any improvements in the process, will be placed in the PI 2012 Corrective Action Plan file by OQPI staff.

2. The State does not have administrative procedures to initiate exclusions for any reason for which the HHS-OIG could exclude a provider.

BMS is working on development of policies and procedures for undertaking State-initiated provider exclusions when warranted and consistent with the regulation at 42 CFR 1002.210. BMS has held internal meetings to review the federal regulations regarding permissive exclusions; to review the HHS-OIG 2010 guidance for implementation of permissive exclusions; and to discuss/develop related policy and procedures. In addition, BMS is currently contacting other State Medicaid agencies regarding their process. BMS plans to have policy and procedures written by the end of April that will be submitted to the Policy Review Committee in early summer.

3. The State made payment to an excluded provider for an item or service ordered or referred by an excluded provider.

This provider was terminated by BMS with an effective date of 4/11/2011 once it was discovered by our payments contractor Molina that his license had been terminated by an OIG decision. BMS calculated the payments made in error however, the Federal share of the overpayment had not been returned to CMS at the time of the PI review. The federal share of this overpayment has been returned to CMS at the end of 1st fiscal quarter 2013. Actions have been taken to ensure this specific provider is unable to reenroll in WV Medicaid unless and until he is reinstated by the disqualifying party.

BMS is working with its Fiscal Agent to revise the current provider enrollment policies and procedures to ensure that all parties identified by the regulation are checked against the

LEIE/MED and EPLS upon enrollment, reenrollment, and at least monthly thereafter.

To date, BMS and its Fiscal Agent have developed and implemented policy and procedures for checking LEIE/MED on enrollment, re-enrollment and monthly and for checking EPLS on enrollment and re-enrollment. While the current procedures noted in italics below do not specify all of the parties that are checked against the LEIE/MED and EPLS, in practice the Fiscal Agent is checking each person listed on the enrollment application who has an ownership or controlling interest of five percent or more, or who is an agent or managing employee in the provider entity. The current application further defines ownership interest as equity in the capital, the stock or the profits of the provider. Person with an ownership or controlling interest means a person, partnership, corporation or other entity that:

(a) has an ownership interest totaling 5% or more;

(b) has an indirect ownership interest equal to 5% or more;

(c) has a combination of direct and indirect ownership interests equal to 5% or more;

(d) owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the provider if that interest equals at least 5% of the value of the property or assets of the provider;

(e) is an officer or director of a provider that is organized as a corporative; or

(f) is a general or limited partner of a provider that is organized as a partnership or limited partnership.

The Provider Enrollment Specialist verifies that the applicant and owner(s) listed on page 5 of the Provider Enrollment Application have not been excluded from participation with Medicare, Medicaid or any other Federal Health Care program.

The list of entities to be searched includes, but is not limited to:

State or federal exclusions

Social Security Death Match

OIG/LEIE

NPPES (to validate NPI)

License

EPLS (Excluded Parties List)

BMS has worked with its FA to develop a manual process to check SAM (formerly EPLS) on a monthly basis. The provider file will be compared to SAM electronically and a report (WV PROV082) generated for providers whose name matches one in the SAM file. The report, currently in testing, will then be manually reviewed based on a workflow that will narrow the number of providers for whom correspondence will be generated. The report is tentatively scheduled to "go live" by the end of April.

4. The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid.

BMS has developed a draft Disclosure Form (attachment #5) to collect information about the provider, any person with ownership or control interest, or who is an agent or managing employee of the provider. In addition the elements from the disclosure form have been incorporated into the web-based provider enrollment tool under development. As noted above, BMS has implemented a process to search the LEIE/MED on enrollment, re-enrollment and monthly for excluded parties or entities. BMS has implemented a process to search the EPLS on enrollment and re-enrollment and has worked with its FA to develop a manual process to check SAM (formerly EPLS) on a monthly basis. The provider file will be compared to SAM electronically and a report (WV PROV082) generated for providers whose name matches one in the SAM file. The report, currently in testing, will then be manually reviewed based on a workflow that will narrow the number of providers for whom a letter will be generated. The report is tentatively scheduled to "go live" by the end of April. In addition, at the beginning of February, an individual on the BMS staff was given provider sanction/exclusion monitoring duties which should help to ensure that the Fiscal Agent conducts complete searches for individuals and entities excluded from participating in Medicaid.

5. The State does not capture all required ownership and control disclosures from disclosing entities. (Uncorrected Partial Repeat Finding)

Re: FFS

BMS is working on a web-based provider enrollment tool that will collect more comprehensive disclosure information (see screenshots attachment #6) than the current paper enrollment application/supplemental pages. A phased-in re-enrollment of providers via the web-based tool is targeted to begin in the summer of 2013. The current paper enrollment application with supplemental pages will be revised to match the web-based tool. In addition, BMS is working with its Fiscal Agent to revise the current draft Disclosure Form to capture all disclosure

information required by Federal Regulation and to develop and implement the policies and procedures for its use.

Re: MCOs

BMS implemented a corrective action by amending the MCO contract. As amended, the MCO contract complies with 42 CFR 455.104. Specifically, Article II , Section 7.6 of the SFY 2014 contract addresses these requirements as follows:

Article II, Section 7.6, Disclosure of Ownership

The MCO, as a "disclosing entity," must supply BMS with full and complete information of each person (individual or corporation) with an ownership or control interest in the MCO or the MCO's subcontractor in which the MCO has direct or indirect ownership of five percent or more, in accordance with 42 CFR 455. 104. This disclosure shall include for each person:

- *The name and address of the person, including the primary business address, every business location, and P. O. Box address, as applicable;*
- *Date of birth and Social Security Number (in the case of an individual);*
- *Tax identification number for a corporation with an ownership or control interest in the MCO or in subcontractor in which the MCO has a 5 percent or more interest;*
- *Whether the person (individual or corporation) with ownership or control interest in the disclosing entity and/or subcontractor is related to any other person with ownership or control interest such as a spouse, parent, child, or sibling;*
- *The name of any other organization in which a person with ownership or control interest in the MCO also has an ownership or control interest; and*
- *The name, address, date of birth, and Social Security Number of an agent or a managing employee of the disclosing entity.*

The disclosures must be submitted at the time of contract execution, contract renewal, or contract extension, within 35 days after any change in ownership of the MCO, and within 35 days of BMS request. The MCO must also submit to BMS a copy of any information it submits

to the Department of Insurance regarding disclosure of ownership or control interest.

BMS amended the disclosure form to solicit the items that MIG identified as missing: the DOB and SSN of persons with ownership or control interests, expanded address requirements for corporate entities with ownership or control interests, or other tax identification numbers of subcontractors in which the MCO has an ownership or control interest as well as the name, address, D08 and SSN of any managing employees. This form has been used by the MCOs since February, 2012. The form and instructions are attached-please see the attachments titled "WV Disclosure of Ownership Reporting Memo" and ""WV Disclosure of Ownership Reporting Template." (attachment #7 and #8)

6. **The State does not adequately address business transaction disclosure requirements in MCO contracts.**

BMS implemented a corrective action by amending the MCO contract. Article II, Section 7.6 of the SFY 2014 MCO contract complies with 42 CFR 455.105(b) requiring disclosure upon request of the information identified. The requirement specifies that MCOs must disclose business transactions within 35 days of request. See below:

Article II, Section 7.6, Business Transactions of Medicaid Providers

"Federal regulations contained in 42 CFR 455.105 require the MCO to disclose the following information related to business transactions within 35 days of request of the Secretary of DHHS or BMS: full and complete information about (1) the ownership of any subcontractor with whom the MCO has had business transactions totaling more than $25,000 during the previous 12-month period and (2) any significant business transactions between the MCO and any wholly owned supplier, or between the MCO and any subcontractor, during the previous five years"

7. **The State does not capture criminal conviction disclosures from providers or contractors. (Uncorrected Repeat Finding)**

RE: FFS

As noted above, the current policies and procedures for provider enrollment includes collection of criminal conviction disclosures from providers regarding persons with an ownership or control interest, or persons who are agents or managing employees of the providers. The web-based provider enrollment tool, noted above, will collect more comprehensive disclosure information to include criminal convictions (see screenshots attachment #9). A phased-in reenrollment of providers via the web-based tool is targeted to begin in the summer of 2013. The current paper enrollment application with supplemental pages will be revised to match the

web-based tool. In addition, BMS is working with its Fiscal Agent to revise the current draft Disclosure Form (attachment #10) to capture all disclosure information required by Federal Regulation and to develop and implement the policies and procedures for its use.

Re: MCOs

BMS implemented a corrective action by amending the MCO contract. As amended, Article II, Section 7.6 of the MCO contract complies with 42 CFR 455.106 requiring disclosure any criminal convictions related to Medicare, Medicaid, or Title XX programs by MCOs. According to Article II, Section 7.6 of the MCO contract:

Prohibited Affiliations with Individuals Debarred by Federal Agencies

"The MCO may not have a director, officer, principal, partner, agent, managing employee or other person with ownership or control interest of five percent or more in the MCO and who:

- *Has been convicted of a criminal offense as described in sections 1128(a) and 1128(b) (1), (2), or (3) of the Social Security Act;*

- *Has had civil money penalties or assessments imposed under section 1128A of the Social Security Act;*

- *Has been excluded, suspended or debarred from participation in Medicare or any of the state health care programs*

The MCO must submit information as described above, for any person who was formerly described as a director, officer, principal, partner, agent, managing employee or other person with ownership or control interest of five percent or more in the MCO, but is no longer so described because of a transfer of ownership or control interest to an immediate family member or a member of the person's household, in anticipation of or following a conviction, assessment of a civil monetary penalty, or imposition of an exclusion.

The MCO is prohibited from having a *consulting or any other agreement with an excluded, debarred or suspended person for the provision of items or* services *that are significant and material to the MCO's contractual obligation with the State.*

The MCO must immediately inform BMS of any circumstances that are grounds for its exclusion, or the exclusion of its contracted providers, from participation in the Medicaid program, in accordance with 42 CFR 1001 .1001 and 42 CFR 1001.1051.

At the time of contract and contract renewal or upon written request by BMS, the MCO must submit information on any person who is a director, officer, principal, partner, agent, managing employee or other person with ownership or control interest of five percent or more in the MCO and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs, as required in 42 CFR 455.106."

8. The State does comply with its State plan amendment regarding False Claims education monitoring.

Re: FFS

OQPI has completed the monitoring for SFY 2011. Further, OQPI has begun its yearly requests to affected providers for SFY 2012. Providers meeting the criteria have been issued for SFY2012, and are currently being reviewed for adherence. Yearly False Claims attestations requests and review will continue to go out each year as required.

Re: MCOs

BMS implemented a corrective action by amending the MCO contract. Article Ill, Section 2.6 of the SFY 2014 MCO contract requires the MCO *"to educate providers in regards to the MCO's written policies on the False Claims Act, including policies and procedures for detecting and preventing waste, fraud, and abuse pursuant to the Deficit Reduction Act of 2005, Section 6032."*

Article Ill, Section 8.1, Fraud and Abuse Guidelines of the MCO contract contains a subsection entitled False Claims Act, which requires the MCOs to *"establish written or electronic policies and procedures for the education of employees of affected entities regarding false claims recoveries."* As noted in BMS' informal comments to MIG's draft report from November 2012, the State's External Quality Review Organization, Delmarva, assesses compliance with this requirement as part of the annual compliance review. Delmarva added a set of Fraud and Abuse (FA) compliance standards to the annual compliance review in 2010, which assessed MCO performance for 2009. Standard FA.8 (copied below) specifically assesses compliance with the False Claims Act requirement. This standard states, "Pursuant to Section 6032 of the Deficit Reduction Act of 2005, any entity who receives or makes Title XIX (Medicaid) payments of at least $5,000,000 annually must establish written or electronic policies and procedures for the education of employees of affected entities regarding false claims recoveries."

Beginning 2010, on-site compliance reviews by Delmarva assessed MCO compliance with the entire set of Fraud and Abuse (FA) standards and provided BMS with baseline performance rates. The 2012 review, which assessed 2011 performance, was the third annual assessment of MCO compliance with this standard. In the most recent on-site compliance review, all three MCOs fully met the requirements in FA.8 for the performance year 2011.

Excerpt from annual compliance review standards:

Table 2

Contract/CFR Reference	Standard	Element	Component	Element/Component Description
Fraud and Abuse				
Article III. Section 8.1 Section 1902(a)(68) of the Social Security Act	FA	8		Pursuant to Section 6032 of the Deficit Reduction Act of 2005, any entity who receives or makes Title XIX {Medicaid) payments of at least $5,000,000 annually must establish written or electronic policies and procedures for the education of employees of affected entities regarding false claims recoveries.

In addition, amended SFY 2014 MCO contract Article Ill, 2.1 requires the MCO to include a provision about False Claims Act education in the MCO's provider contract:

The MCO's provider contracts or addenda to provider contracts must abide by all federal regulations and must be consistent with the requirements of this statement of work and at a *minimum must include the following provisions:*

...12. Requirement to comply with Section 6032 of the Deficit Reduction Act of 2005, if the network provider receives annual Medicaid payments of at least $5 million (cumulative, from all sources). A provider must: 1. Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A). 2. Include as part of such written policies detailed provisions regarding the network provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse. 3. Include in any employee handbook a *specific discussion of the Jaws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and the provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.*

Vulnerabilities

1. Inadequate resources to accomplish core program integrity functions. (Uncorrected Partial Repeat Vulnerability)

The State of West Virginia, like many other state agencies across the country, are revisiting the most efficient methods to comply with all federal regulations. The requirement to contract with one or more Recovery Audit Contractors (RAC) is being implemented in WV and in fact a contract was awarded effective 10/1/2012. BMS is working to implement this contract and are hopeful we can effectively supplement the existing resources of OQPI.

Further, WV is working to collaborate with the Medicaid Integrity Group (MIG) within CMS to engage in audits that have had successes in other states. WV BMS is currently working in collaboration with the MIG to identify an appropriate scenario based upon those experiences.

At the time of the PI Review in May of 2012 OQPI did not log all preliminary investigations in an electronic database. Since the PI review this has been fully implemented and therefore OQPI and CMS representatives will have a complete record of all preliminary investigations conducted by OQPI staff and their outcome with appropriate documentation similar to that of a fully investigated fraud referral.

BMS continues to review existing resources and will supplement existing staff when/if additional resource allocations become available.

BMS has awarded a contract for a new Data Warehouse/Decision Support System (DW/DSS) which in addition to the warehouse/data mining tools available to OQPI includes a new electronic case tracking system complete with workflow to be utilized by OQPI. Beginning in early 2013 OQPI will have implemented this new case tracking tool (I-Sight) in order to better track all case work and fraud referrals. This tool will also enable OQPI to properly report all case activity requirements for future CMS PI reviews as well as regulatory reporting requirements including but not limited to RAC reporting and suspensions of payments..

The OQPI chapter of the WV Medicaid manual has been completely re-written since the PI review and in accordance with the suggestions offered in May, 2012. This manual has gone through the policy approval committee, has been approved and has been publicly posted with an effective date of December 1, 2012.

http://www.dhhr.wv.gov/bms/Documents/Chapter_800B_QPI.pdf

2. Limited program integrity oversight of the State's managed care and waiver programs. (Uncorrected Partial Repeat Vulnerability)

MCO
As noted in BMS' informal comments to MIG's draft report from November 2012, BMS implemented a corrective action by requiring the State's EQRO, Delmarva, to assess MCO compliance with Fraud and Abuse standards as part of the annual 2009 compliance review beginning year 2010. BMS and Delmarva's assessment of program integrity standards surpasses the requirements of this external quality review activity, which are detailed in federal regulations at 42 CR 438 Subpart E.

BMS is working to improve coordination between OQPI and the Office of Managed Care and Procurement Services. For example, the Office of Managed Care and Procurement Services is developing a policy manual on program integrity procedures, which detail MCO and State responsibilities and outlines processes for coordination. The director of the Office of Managed Care and Procurement Services shared this manual with the OQPI staff, who reviewed and provided input. In addition, the Director of the Office of Quality and Program Integrity and the Director of the Medicaid Fraud Control Unit participated in a quarterly Task Force meeting with the MCOs and other program vendors in January 2013.

In its informal comments to MIG's draft report, BMS requested that MIG clarify its criteria of what constitutes "proactive oversight of program integrity operations in the managed care program." However, MIG has not provided its response to the State's request.

BMS: A member of the OQPI team continues to meet regularly as a member of the committee that oversees the waiver contracts and specific audits. Further, OQPI continues to collect recoveries based on the findings as a result of their audits once demand letters are issued by implementing pay holds, liens, disenrollment, etc. based upon audit findings. We are working to ensure additional audits can be undertaken based upon data mining as needed either by our RAC contractor and/or OQPI staff.

Lastly, relating to MCO oversight, OQPI is working collaboratively with the State MFCU and MCOs to implement coordination of fraud referrals, In February, 2013, an OQPI staff member is attending a class at the Medicaid integrity Institute (MII) relating to oversight of MCOs in an effort to identify best practices for incorporation in WV.

3. Not conducting searches for individuals and entities excluded from participating in Medicaid.

Re: FFS

As noted previously, BMS is working with its Fiscal Agent to revise the current provider enrollment documents, policies and procedures to ensure the appropriate collection and maintenance of disclosure information about disclosing entities, and about any person with

a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity. An upcoming BMS provider newsletter will include a reminder to providers regarding their responsibility to check the exclusion and debarment lists for staff and contractors. In addition, at the annual provider workshop in April, providers will be reminded of this responsibility.

Re: MCOs

BMS implemented a corrective action by amending the MCO contract. As amended, the MCO contract requires the MCO to screen providers and persons with ownership and control interests of in-network providers and managing employees against LEIE/MED and EPLS upon enrollment, re -enrollment, and at least monthly thereafter. Per Article Ill, Section 2.1 of the SFY14 MCO contract: *"The MCO must perform federal databases checks as required by 42 455.436. The MCO must examine exclusion and debarment status for all providers, entities, persons with ownership and control interest, agents, principals, partners, directors and managing employees using the HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS). All providers must be matched against the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), and other appropriate databases to confirm provider identity upon contracting. The MCO must check the LEIE and EPLS no less frequently than monthly."*

As stated in BMS' informal comments to MIG's draft report, the State's EQRO, Delmarva, reviews each MCO's credentialing and recredentialing policies and procedures as part of the annual compliance review. In addition, during the on-site portion of the compliance review, a sample of provider credentialing and recredentialing records is reviewed, using the NCQA methodology, to ensure that the MCOs are complying with their policies and procedures as well as state and federal requirements.

The credentialing and recredentialing requirements of the annual compliance review are found in the Quality Assessment and Performance Improvement (QAPI) standards (see excerpts below). QAPI standard 15.d requires that "The MCO must comply with any additional requirements established by the State." The "additional requirements established by the state" include the requirement to conduct exclusion searches using the HHS-OIG's list of Excluded Individuals/Entities (LEIE) and Excluded Parties List System (EPLS) during the credentialing and recredentialing process.

The results of the review for calendar year 2011 (conducted in 2012) provided evidence that all three MCOs query the LEIE database and two query the EPLS database as part of their routine credentialing and recredentialing procedures. Evidence of these queries was

found in the provider credentialing and recredentialing records reviewed on-site for the 2011 period of performance. For the 2011 review, two MCOs (Carelink and UniCare) received a finding of "met," as they query both databases. The Health Plan of the Upper Ohio Valley received a finding of "partially met" as they did not query the EPLS database.

In July 2012, the EPLS database was migrated into the System for Award Management (SAM). The credentialing and recredentialing standard has been updated to reflect this change and to require the MCOs to query the LEIE and the SAM databases for the next annual compliance review.

Excerpt from annual compliance review standards:

Table 3

Contract/ CFR Reference	Standard	Element	Component	Element/Component Description
Quality Assessment and Performance				
42 CFR 438.214(C) Article III section 2.1 Provider Network-General Requirements	QA	15		The MCO's provider selection policies and procedures must not discriminate against particular practitioners that serve high-risk populations or specialize in conditions that require costly treatment.
42 CFR 438.214 (e) Article III section 2.1 Provider Network-General Requirements	QA	15	*d*	The MCO must comply with any additional requirements established by the State. (Note: any state requirements re credentialing will be included here and will be found in the reviewer guidelines.) The MCO must conduct exclusion searches using the HHS-OIG's List of Excluded Individuals/Entities (LEIE) and Excluded Parties List System (EPLS) on a monthly basis. On a routine basis, the MCO must also conduct checks of the following

Contract/ CFR Reference	Standard	Element	Component	Element/Component Description
				Federal databases: Social Security Administration's Death Master File, the National Plan and Provider Enumeration System. *For the 2012 review, EPLS will be changed to System for Award Management (SAM) as EPLS was migrated to SAM in July 2012.

4. Not verifying all out-of-state provider licenses during the enrollment process.

BMS and its Fiscal Agent are revising the provider enrollment policies and procedures to ensure that all provider licenses are verified at the time of enrollment, to include checks for possible restrictions or limitations. In addition, the website with contact information for all state medical boards will be provided to the Fiscal Agent for use in calling to obtain license verification and possible license restrictions or limitations when an on-line verification tool is not available.

5. Not capturing ownership and control disclosures from network providers.

BMS implemented a corrective action by amending the MCO contract. As amended, the MCO contract requires all provider contracts to comply with 42 CFR § 455.104. Article Ill, Section 2.1 of the SFY 14 MCO contract states:

> *The MCO's provider contracts or addenda to provider contracts must abide by all federal regulations and must be consistent with the requirements of this statement of work and must include the following provisions:*
>
> *... 5. Requirements for provider disclosure of ownership and control, in accordance with 42 CFR 455.104. The MCO provider contracts must include language defining ownership per 42 CFR 455.101. The MCO provider contracts or disclosure forms must request the provider to disclose information on ownership and control and information on interlocking relationships per 42 CFR 104 b (3). A provider that is a business entity, corporation or a partnership must disclose the name, DOB, SSN and address of each person who is provider's director, officer, principal, partner, agent, managing employee*

or other person with ownership or control interest of five percent or more in the provider or in provider's subcontractor. The address for corporate entities must include as applicable: primary business address, every business location, and P.O. Box address and tax ID. Contracts or disclosures forms must solicit information on interrelationships of persons disclosed per 42 CFR 455.104 (b). MCO contracts or disclosure forms must request tax ID of any provider's subcontractor in which the provider (if entity) has a 5 percent or more interest. The MCO provider contracts must request the name of each entity in which provider's persons with ownership and control interest have an ownership or control interest. The provider must agree to keep information current at all times by informing MCO in writing within 35 days of any ownership and control changes to the information contained in its application

6. Not adequately addressing business transaction disclosures in network provider contracts. (Uncorrected Repeat Vulnerability)

BMS implemented a corrective action by amending the MCO contract. As amended, the SFY 14 MCO contract Article Ill, Section 2.1, item 6 requires providers *"to disclose significant business transactions in accordance with 42 CFR 455.105"; further specifying that "a provider contract must include language requiring a provider to disclose the following information related to business transactions within 35 days of request of the Secretary of DHHS or BMS: full and complete information about (1) the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the previous 12-month period and (2) any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the previous five years. "*

7. Not capturing criminal conviction disclosures from network providers. (Uncorrected Partial Repeat Vulnerability)

BMS implemented a corrective action by amending the MCO contract. As amended, the SY 14 MCO contract Article Ill, Section 2.1, item 7 requires all provider contracts to comply with § 455.106: *"The MCO's provider contracts or addenda to provider contracts must abide by all federal regulations and must be consistent with the requirements of this statement of work and must include the following provisions ... 7. The provider contracts or disclosure forms must request the provider, provider's director, officer, principal, partner, agent, managing employee or other person with ownership or control interest of five percent or more in the provider to disclose information on 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 contracts must require a provider to notify the MCO immediately of the time provider receives notice of such conviction. The MCO must include the definition of "Convicted" per 42 CFR 1001.2 in the contract or disclosure form"*

Article Ill, Section 2.1 of the MCO contract requires MCOs to report health care-related criminal convictions to the Department:

"The MCO must submit a report to the Department by the 15th of each month with the names and addresses of any health care professional, institutional provider, or supplier that is denied credentialing, suspended, or terminated because of concerns about provider fraud, integrity, or quality deficiencies during the prior calendar month. The report must also state the action taken by the MCO (e.g., denied credentialing). The MCO must also report any health care-related criminal convictions, when disclosed, to the Department. The MCO must also notify appropriate licensing and/or disciplinary bodies and other appropriate authorities. If the MCO does not have any individuals to report from the prior period, the MCO must submit the report stating that it did not have any providers who were denied credentialing, suspended, or terminated for that period."

Please see the attached instructions and template for completing this report ("MCO Guidance - Providers Denied Credentialing, Suspended, or Terminated Memo" and "MHT Monthly Report - Providers Denied Credentialing, Suspended, or Terminated.") (attachment #11 and #12)

The MCO must also report any health care-related criminal convictions, when disclosed, to the State. Per Article II, Section 7.6 of the MCO contract, "the MCO *must immediately inform BMS of any circumstances that are grounds for its exclusion, or the exclusion of its contracted providers, from participation in the Medicaid program, in accordance with 42 CFR 1001.1001 and 42 CFR 1001.1051."*

Thank you for the opportunity to respond to the report findings and vulnerabilities.

Sincerely,

Nancy V. Atkins, RN, MSN, NP-BC
Commissioner
Bureau for Medical Services