Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Utah Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare and Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Utah Medicaid Program. The onsite portion of the review was conducted at the offices of the Utah Department of Health (UDOH). The MIG review team also met with staff from the Medicaid Fraud Control Unit (MFCU) at the UDOH office.

This review focused on the activities of the UDOH Division of Health Care Financing (DHCF) Bureau of Program Integrity (BPI), which is responsible for Medicaid program integrity. This report describes four effective practices, five regulatory compliance issues, and two vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Utah improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Utah's Medicaid Program

The DHCF within UDOH administers the Utah Medicaid Program. As of June 30, 2007, the program served 195,938 recipients, approximately 93 to 96 percent of whom were enrolled with a managed care plan. The State reported 17,964 providers participating in the fee-for-service (FFS) program. The total number of providers participating in the managed care plans was not available. Medicaid expenditures in Utah during the State fiscal year (SFY) ending June 30, 2007 totaled $1,486,152,235. In Federal fiscal year 2007, the Federal medical assistance percentage was 70.14 percent.

Program Integrity Section

The BPI is the organizational component dedicated to the prevention and detection of provider fraud, abuse and overpayments. Utah recently elevated its program integrity function to a bureau level within the State Medicaid Agency. At the time of the review, BPI had 35 positions, one of which was vacant. BPI staff included four administrative, program and technical support positions, eight staff devoted to medical review (audit), and eight staff devoted to fraud investigations and recovery (including work on the Surveillance and Utilization Review Subsystem (SURS), data warehouse and payment error rate measurement). BPI also had 14 staff devoted to utilization review (prior authorizations and medical review) and one staff member who manages and oversees hearings and appeals. Provider enrollment is performed internally through the State Agency's Provider Enrollment Unit located in the Bureau of Medicaid Operations. Utah does not employ a fiscal agent or an independent SURS contractor.

The table below presents the number of preliminary and full investigations of providers, State administrative actions or sanctions, and overpayments identified and recovered.

Table 1

SFY	Number of Preliminary & Full Investigations	Number of State Administrative Actions or Sanctions (Approximation)	Amount of Overpayments Identified	Amounts Recouped (includes past settlement collections)
2005	Not available	Not available	$ 755,652.51	$ 1,236,837.73
2006	Not available	Not available	$ 2,522,326.44	$ 2,526,926.44
2007	674	255	$ 1,694,748.99	$ 1,771,293.29

Methodology of the Review

In advance of the onsite visit, the review team requested that Utah 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, SURS, and the MFCU. A four-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of June 2, 2008, the MIG review team visited the UDOH office. The team conducted interviews with numerous UDOH officials, as well as with staff from the State's transportation broker and the MFCU. To determine whether managed care contractors were complying with contract provisions and other Federal regulations related to program integrity, the MIG team reviewed the contract provisions and gathered information from managed care organizations (MCOs) through interviews with representatives of four MCOs.

Scope and Limitations of the Review

This review focused on the activities of BPI, 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. Utah operates a stand-alone State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act. Therefore, Utah's SCHIP was not included in this review.

Unless otherwise noted, UDOH provided 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 so provided.

RESULTS OF THE REVIEW

Effective Practices

The State has highlighted several practices that demonstrate its commitment to program integrity. These include practices of open communication and cooperation with internal

components and external partners, development of written policies and procedures, and enhanced program integrity monitoring of managed care contractors.

Open and inclusive communications
BPI involves all internal components involved in program integrity in its meetings and communications. Utah's contracted MCOs also take part in monthly BPI meetings.

Relationship with the MFCU
BPI has worked to develop a cooperative and collaborative relationship with the MFCU in Utah. Although the State Medicaid Agency has not made large numbers of referrals in the past, the groundwork for improvement in this area has been laid by the establishment of more frequent meetings and consultations with the MFCU, as well as mutual training of staff.

Development of written policies and procedures
Immediately following its reorganization, BPI placed major emphasis on the development of policies and procedures to promote programmatic continuity and consistency. The team observed that a detailed manual with written policies and procedures is already in place.

Enhanced program integrity monitoring standards
The UDOH made a conscious effort to include program integrity and provider enrollment standards as components in the managed care compliance standards expected of Medicaid MCOs in the State. The Quality Assessment and Performance Improvement Plan compliance standards, which are monitored by the State's External Quality Review Organization (EQRO), include both of these elements within the managed care entities' contract language. This is not a common practice in the EQRO monitoring process.

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

The State's FFS enrollment and MCO credentialing processes do 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.

The Utah FFS Provider Application packet includes a checklist of documents and several forms (e.g., Direct Deposit, W-9, Authorized Provider Services, Provider Agreement). There is no form for reporting ownership disclosure information. Of the four application packets reviewed, three entities responded to ownership disclosure information by providing a written statement that limited the reporting to the identification of the owners of the entity. Upon receipt of an application packet, Utah does not review the application packet for completeness.

The MIG review team reviewed Utah's application packets and determined that the State does not use any forms or other method to solicit information about persons with ownership and control or related parties (other than through the obligation stated in the provider application and agreement). The State's contracts with MCOs require information about persons with ownership and control interests but do not request relationship information. In addition, MCOs do not request a complete set of disclosures in contracting with their providers.

***Recommendations*:** Collect the required disclosures for all FFS providers and check for missing information before enrolling providers. Insert full disclosure requirements into all contracts with MCOs and require the MCOs to modify their provider credentialing applications and enrollment procedures to request and ensure receipt of all appropriate ownership and control disclosure information.

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

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractors. Utah obligates its FFS providers to meet this requirement in its standard provider agreement. However, the provider agreements between MCOs and their providers do not require disclosure of the specified business transactions.

***Recommendation*:** Require MCOs to modify their credentialing applications and provider agreements or contracts to incorporate the appropriate business transaction language.

The State's FFS enrollment process and managed care credentialing application forms do not capture criminal conviction information.

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made.

Although Utah requires that providers, managing employees and agents make such disclosures, the FFS provider enrollment application and agreement does not require providers to submit criminal conviction information for persons with ownership or control interest. In addition, MCO credentialing applications only require such disclosures for providers and do not require

submission of criminal conviction information for persons having ownership or control interest or persons who are agents or managing employees of providers. The omission to collect required criminal conviction information prevents Utah from forwarding information on owners, persons with control interest, agents and managing employees to HHS-OIG within 20 working days, as is required by the regulation.

***Recommendations*:** Collect the required disclosures for all FFS providers and refer information to HHS-OIG as required. Require MCOs to modify their credentialing procedures and applications to request information required to be disclosed under 42 CFR § 455.106. Refer that information to HHS-OIG as required.

The State does not notify all required parties when there is a State-initiated exclusion.
The regulation at 42 CFR § 1002.212 stipulates that when a State initiates an exclusion, it must provide notification to the other State agencies, the State medical licensing board, the public, beneficiaries, and others as provided in Sections 1001.2005 and 1001.2006.

Interviews with State staff and review of supplementary information provided after the review revealed that Utah does not fully comply with 42 CFR § 1002.212 because the scope of its notifications is limited. While Utah does notify the MFCU and relevant State agencies when certain types of providers are excluded for fraud, State staff indicated that as a rule they do not notify the State licensing board of exclusions. Nor does the State notify the general public of exclusions, except in the case of institutional providers which fail to meet Medicare or Medicaid standards. The State also reported that it does not notify entities "in which [an] excluded individual is known to be serving as an employee, hospitals, skilled nursing facilities, home health agencies, HMOs, medical societies, state area agencies on aging, or the National Practitioner Data Bank."

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

The State does not report to HHS-OIG adverse actions it takes on provider applications and MCOs do not always inform the State of adverse actions in MCO provider credentialing.
The regulation at 42 CFR §1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. During onsite interviews, BPI staff indicated that the State does not report all adverse actions taken to HHS-OIG. In addition, FFS Provider Enrollment Unit staff reported that only providers who appear on OIG exclusion lists or exclusions taken by the State's Division of Occupational and Professional Licensure (DOPL) are reported to BPI.

In addition, BPI staff were uncertain whether MCOs reported all adverse actions to the DHCF Bureau of Managed Care (BMC) or directly to HHS-OIG. MCOs do notify BMC of aberrant provider behavior. However, there is no consistent definition across health plans and entities of what information should be reported. None of the representatives of the four MCOs with whom

the review team met indicated they notified the State when they denied credentialing or terminated a provider's credentials for reasons other than suspension of licensure by DOPL.

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

Vulnerabilities

The review team identified two areas of vulnerability in Utah's practices regarding the oversight of recipient fraud and abuse cases and capture of managing employee information.

Not providing oversight regarding investigation of recipient abuse cases and referral of recipient fraud cases.

Under 42 CFR § 455.15(b) and (c), if the State Medicaid agency's preliminary investigation leads to a suspicion that a recipient has defrauded the Medicaid program, the case must be referred to an appropriate law enforcement agency; if the agency believes that a recipient has abused the program, the State Medicaid agency must conduct a full investigation.

DHCF has delegated responsibility for recipient fraud and abuse and recovery of funds to a sister agency, the Department of Workforce Services (DWS), through an interagency agreement. DWS determines recipient eligibility and manages all recipient fraud and abuse issues reported to any State agency. However, DHCF does not contractually require, nor does it receive, any reports on the status of fraud and abuse-related cases referred to DWS or the Medicaid dollars recovered as a result of DWS actions. Because DWS does not provide DHCF with any information on investigations of recipient fraud or abuse or Medicaid recoveries, DHCF cannot know whether it is fulfilling its responsibilities under Federal regulations.

***Recommendation*:** Amend the interagency agreement with DWS to require regular reporting on the status of recipient fraud and abuse cases and on the recoupment of Medicaid dollars through DWS actions.

Not capturing managing employee information on FFS provider enrollment and managed care credentialing forms.

Under 42 CFR § 455.101, a managing employee is defined as "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency." Neither the State nor its MCOs solicit managing employee information in all provider enrollment and credentialing forms. Thus, the State would have no way of knowing if excluded individuals are working for providers or health care entities in such positions as billing managers and department heads.

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

database where it can be used to search for exclusions at the point of initial enrollment and periodically thereafter.

CONCLUSION

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

- the inclusion of relevant internal components and MCO contractors in BPI communications and meetings,
- BPI's increasingly cooperative working relationship with the MFCU,
- the development of comprehensive written policies and procedures, and
- the inclusion of provider enrollment and program integrity standards in the managed care monitoring tool used by the State agency.

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

However, the identification of five areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, two vulnerabilities were identified. CMS encourages UDOH 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 UDOH to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request that the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Utah will ensure that the deficiencies will not recur. The corrective action plan should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If UDOH 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 Utah on building upon effective practices, correcting its regulatory compliance issues, and eliminating its vulnerabilities.