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 & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Utah Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Department of Health (DOH). The review team also conducted an interview with the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Office of Internal Audit and Program Integrity (OIA-PI) which is responsible for Medicaid program integrity. This report describes 2 effective practices, 5 regulatory compliance issues, and 12 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 DOH administers the Utah Medicaid program through a combination of fee-for-service (FFS) and managed care services. As of January 1, 2010, the program served 207,781 beneficiaries. Utah contracts with 15 managed care entities (MCEs). These include three MCEs which provide physical health services (one on a risk, one on a non-risk and one on an FFS basis), nine prepaid mental health plans (PMHPs) which offer behavioral health services, one MCE which provides risk-based non-emergency medical transportation (NEMT), one MCE providing a hemophilia program and one MCE called the Utah Healthy Outcomes Medical Excellence program. Approximately 60 percent of the State's Medicaid population is enrolled in some form of managed care. Program integrity oversight functions for MCEs are delegated to the Bureau of Managed Health Care (BMHC). Likewise, contract and program integrity oversight functions for home and community based services (HCBS) waiver programs are delegated to the Bureau of Long Term Care (BLTC), which is in Utah's DOH.

As of January 1, 2010, the Utah Medicaid program had 22,343 providers participating in the FFS program and 11,233 participating managed care providers. Medicaid expenditures for the State fiscal year (SFY) ending June 30, 2010 totaled $1,723,295,258. The Federal medical assistance percentage (FMAP) for Utah for Federal fiscal year (FFY) 2010 was 71.68 percent. However, with FFY 2010 adjustments attributable to the American Recovery and Reinvestment Act of 2009, the State's effective FMAP was 80.78 percent.

Office of Internal Audit and Program Integrity

The OIA-PI within DOH is the primary organizational component dedicated to the prevention, detection, and investigation of provider fraud and abuse. At the time of the review, the OIA-PI had 10 full-time equivalent employees. The table below presents the number of preliminary and full investigations and the amount of overpayments identified and collected for the last four SFYs as a result of program integrity activities.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Overpayments Identified	Overpayments Collected
2007	54	not available	$537,756	$533,940
2008	119	3	$1,106,722	$1,098,990
2009	134	5	$3,595,583	$3,327951
2010	89	2	$5,078,030	$4,406,472

* 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.

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 and disclosures, program integrity, managed care, and the MFCU. A five-person review team reviewed the responses and documents that the State provided in advance of the onsite visit.

During the week of October 18, 2010, the MIG review team visited the Utah DOH. The team conducted interviews with numerous DOH officials, as well as the MFCU director. To determine whether HCBS waiver programs were complying with the contract provisions and other Federal regulations relating to program integrity, the MIG review team interviewed State staff from BLTC and DOH. The review team also interviewed staff from BMHC, reviewed the managed care contract provisions, and gathered information through interviews with representatives from the two capitated physical health plans (which are also referred to in this report as managed care organizations or MCOs) and two of the PMHPs. In addition, the team conducted sampling of provider enrollment applications, selected claims, case files, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of OIA-PI, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, managed care and NEMT. Utah operates its Children's Health Insurance Program as a stand alone program. The stand alone program operates under the authority of Title XXI and is beyond the scope of the review.

Unless otherwise noted, OIA-PI 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 OIA-PI provided.

Results of the Review

Effective Practices

As part of its comprehensive review process, 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. Utah reported the State's ability to capture, maintain and monitor an expanded number of disclosures in its database and its relationship with the MFCU.

Expanded database capacity for capturing disclosure information

Utah's provider file database allows the provider enrollment section in the Medicaid agency to capture and maintain all disclosure information on FFS and managed care providers, corporate owners, Board of Director members, office managers and business entities. The database, which became available in 2002, has a built-in capacity to accommodate entries for as many individuals as necessary. Furthermore, all names are cross-checked against the Medicare Exclusion Database (MED) on a monthly basis, and a sanctioned provider report can be generated rapidly for scrutinizing and comparing data on managing employees and corporate owners. This expanded provider file capacity provides the State the opportunity to monitor excluded individuals at all levels of a business entity.

In SFY 2010, the exclusion checking process enabled the State to identify 12 providers on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals/Entities (LEIE) that had been enrolled previously by the State of Utah. The State was able to confirm that no payments had been made to these providers during the period of exclusion from Federal health programs.

This database provides the State with the ability to more effectively screen its providers. However, CMS has concerns that the State's effort in collecting disclosures is inadequate as discussed in the Regulatory Compliance section of this report. In addition, the State's NEMT broker does not adequately check for exclusions as described in the Vulnerabilities section of this report.

Frequent and productive communication between the State's program integrity unit and MFCU

The OIA-PI and MFCU relationship is one of mutual cooperation that works well for both parties. The State and MFCU meet formally on a monthly basis, with additional contacts, either in-person or via e-mail, taking place between these meetings to

discuss cases and other relevant issues. In addition, both parties have made efforts to include the MCOs in these meetings on at least a quarterly basis. Further, both units engage in mutual ongoing training, although the MFCU acknowledged that OIA-PI has provided its staff with more training than vice versa. The instruction offered to MFCU staff has included training on pharmaceutical issues and the Medicaid Management Information System (MMIS), among other things.

In addition, the current referral form used by OIA-PI was developed in collaboration with the MFCU approximately two years before the onsite review. This referral form contains all of the elements required to meet the guidelines in CMS' September 2008 publication, "*CMS-MIG Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit*." The MFCU reported to the team that the two components work closely in deciding which cases should be referred.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to the collection of required disclosure information, a provision for exclusion of managed care plans, and reporting of adverse actions to HHS-OIG. Although Utah has a provider file database (as discussed in the Effective Practices section) that stores disclosure information and allows for exclusion checking, the MIG review team identified several problems regarding collection of disclosure information.

Utah does not collect all ownership and control disclosures from FFS providers, the NEMT broker, and MCEs. (Uncorrected Partial Repeat Finding)

Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

The MIG's 2008 program integrity review found that Utah was not collecting all of the required ownership and control disclosure information required at 42 CFR § 455.104. While the Medicaid agency has developed a new FFS provider form (called the Medicaid Provider Application Ownership Disclosure Information form) which collects most of the required

information, it still does not ask for disclosure of the name and family relationship (where applicable) of each person with an ownership or control interest in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. It also does not request the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity likewise has an ownership or control interest.

The NEMT broker contract does not request relationship information for persons with a 5 percent or more ownership or control interest in the disclosing entity. It also does not request any subcontractor disclosure information or relationship information regarding persons with ownership interest in subcontractors, or the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity likewise has an ownership or control interest.

The State requires its MCEs to use a common disclosure form which instructs the applicant to list the name and address of each person with the appropriate level of ownership and control interest. However, the form does not have a space to record the address. The disclosure form template for PMHPs does have the space to record the address, but one completed form reviewed by the team listed the address of the facility location, not a differentiated list of addresses, for the identified PMHP Board of Directors.

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

Recommendation: Modify the FFS provider enrollment applications, NEMT contracts, and MCE disclosure forms to capture all required ownership, control, and relationship information.

Utah's NEMT broker contract and certain MCE contracts do not require disclosure of business transaction information upon request. (Uncorrected Repeat Finding)

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

The State's contracts with the NEMT broker and its two MCOs, the capitated physical health plans, do not meet the regulatory requirements. The NEMT broker contract is silent on the disclosure of business transactions. The contract between the State and the MCOs requires that "the contractor will follow all Federal and State laws and regulations, including the applicable requirements under 42 CFR § 431, subpart F and 42 CFR §§ 160 and 164."

However, there is no specific reference to 42 CFR § 455 subpart B or the specific language of 42 CFR § 455.105(b)(2).

Recommendation: Modify contracts with the NEMT broker and MCOs to meet the requirements of 42 CFR § 455.105(b).

The State does not require the disclosure of health care-related criminal conviction information from the NEMT broker and one of the MCOs.

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

The DOH contracts with the NEMT broker and the non-risk physical health plan do not require the broker and the MCO to disclose health care-related criminal convictions pertaining to owners, agents, and managing employees as stipulated in the regulation.

Recommendation: Modify the contracts with the NEMT broker and the non-risk MCO to meet the requirements of 42 CFR § 455.106.

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

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

The OIA-PI staff reported that the provider enrollment section had not been reporting all actions taken on FFS provider applications or actions taken to otherwise limit a provider's ability to participate in the Utah Medicaid program for program integrity reasons. This precludes OIA-PI from reporting such information to HHS-OIG as required by the regulation. This was also a finding in the MIG's 2008 program integrity review. In response to the 2008 finding, Utah submitted a policy document entitled "Sanctioned Providers Adverse Actions Disclosure" (revised version dated 2/24/09) as part of its post-review corrective action plan (CAP). The new policy established procedures for the provider enrollment section to notify the Bureau of Program Integrity (now called OIA-PI) when DOH imposed sanctions against providers. However, during the 2010 review, the team could find no indication that the Medicaid agency had implemented the reporting procedures.

Recommendations: Develop and implement a policy and procedure to ensure that OIA-PI is notified of all negative actions taken on provider applications or against enrolled providers for program integrity reasons. Ensure that adverse actions are reported to HHS-OIG as required by the regulation.

The State's MCE contracts contain no provision for excluding managed care plans.
The regulation at 42 CFR § 1002.203 stipulates that the State must provide that it will exclude from participation any health maintenance organization, or entity furnishing services under a 1915(b)(1) waiver, if such organization or entity could be excluded under 42 CFR § 1001.1001 or § 1001.1051, or has a direct or indirect contractual relationship with an individual or entity that could be excluded under § 1001.1001 or § 1001.1051.

The DOH does not have a policy or any language in its contracts with the physical health plans and PMHPs stipulating that the entity will be excluded if it has a direct or indirect contractual relationship with an individual or entity that could be excluded under 42 CFR § 1001.1001 or § 1001.1051.

Recommendation: Insert appropriate language in the MCE contracts to meet the requirements of 42 CFR § 1002.203.

Vulnerabilities

The review team identified 12 areas of vulnerability in Utah's program integrity practices. These included inadequate oversight of beneficiary fraud and abuse case referrals for investigation, lack of program integrity oversight across State Medicaid agency components and MCEs and failure to utilize the State's permissive exclusion authority. Other issues include the failure to collect appropriate disclosures from managed care and transportation network providers or report adverse actions taken against network applicants and providers for program integrity reasons, as well as the failure to consistently collect all disclosure information from provider applicants. In addition, the State did not require its MCOs, PMHPs and HCBS waiver programs to verify beneficiary receipt of services by providers, failed to conduct complete exclusion searches, and did not monitor compliance by all managed care contractors with the provisions of the False Claims Act.

Inadequate oversight regarding the handling and referral of beneficiary fraud and abuse cases. (Uncorrected Repeat Vulnerability)
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.

Utah's DOH delegates the responsibility for investigating beneficiary fraud and abuse cases to a sister agency, the Department of Workforce Services (DWS), through an interagency agreement. The DWS determines beneficiary eligibility and manages all beneficiary fraud and abuse issues reported to any State agency. However, OIA-PI does not contractually require, nor does it receive, any reports on the status of fraud and abuse-related cases referred to DWS. Because DWS does not provide OIA-PI with any information on

investigations of beneficiary fraud or abuse, OIA-PI cannot know whether it is fulfilling its responsibilities under the Federal regulation.

In response to the MIG's 2008 program integrity review, Utah submitted a CAP which contained one element indicating that the Medicaid agency would amend its interagency agreement with DWS to require regular reporting on the status of beneficiary fraud and abuse cases and on the recoupment of Medicaid dollars through DWS actions. Although the CAP stated that the agreement would be amended and made effective on July 1, 2009, during onsite interviews, OIA-PI staff reported that the amendment has not yet been signed by DWS.

Recommendations: Ensure that the amended agreement is signed by both parties as soon as possible. Develop and implement guidelines regarding the reporting format and frequency of reporting and expected response times for both components when dealing with inquiries and follow-up issues.

Lack of program integrity oversight, tracking, and coordination across State Medicaid agency components.

In November 2009, Utah's Bureau of Program Integrity was reorganized, with the program integrity function being relocated to OIA-PI. As a result of the reorganization, the component responsible for program integrity activities lost its organizational status as a bureau and much of its staff. Currently there are no formalized communication processes among the OIA-PI and other bureau level components, such as Medicaid Operations, BMHC, and BLTC. Without formalized communication processes, such as those established by a Memorandum of Agreement, OIA-PI is unable to address fraud, waste and abuse issues in the Utah Medicaid program as effectively and expeditiously as it might otherwise be able to do. The team found several examples of the lack of communication between the Medicaid agency and OIA-PI. They include:

- Waiver programs administered in DOH do not communicate with program integrity in a systematic manner. The DOH reports potential fraud and abuse issues to the Bureau of Internal Review and Audits (BIRA) which reports to the MFCU directly without OIA-PI being notified. This was evidenced in the sampling of program integrity cases conducted by the team. During follow-up interviews, OIA-PI had no knowledge of or involvement in actions taken against providers in waiver programs. This was confirmed when the team asked DOH for the list of providers who were mandatorily removed from the program. When shown this list, OIA-PI staff was unaware of a group of providers under DOH jurisdiction which had been forced out of the program.

- A lack of communication and coordination was also evident in the reporting of State-initiated provider exclusions. Prior to the team's onsite visit, OIA-PI believed that when exclusion actions were taken, the provider enrollment section was responsible for the notification of the required parties as specified in the regulation at 42 CFR §1002.212. The OIA-PI's role was limited to ensuring that the notifications were made. During the onsite review, the provider enrollment section indicated that it was changing prior policy and assigning OIA-PI future responsibility for notifying the required parties in the

event of future exclusions. However, an interview with OIA-PI revealed that its staff was not aware of this new responsibility. Moreover, when informed of the new policy, OIA-PI reported that it would inform the HHS-OIG, State licensing boards, and the State Division of Occupational and Professional Licensing (DOPL) of the exclusions. It was unaware that it needed to notify other state agencies, the public, beneficiaries, and other providers, as is stipulated in 42 CFR §1002.212.

- The review team also found no evidence of regularly scheduled meetings among bureaus, departments, and agencies that have delegated responsibilities for program integrity. As described earlier, OIA-PI is located outside the reporting structure for the other key Medicaid components, such as Medicaid Operations, where provider enrollment and the MMIS are housed, BMHC, and BLTC. At the time of the review, OIA-PI had no regularly scheduled meetings with the provider enrollment section or BMHC within DOH or with BLTC and BIRA within DOH, although such meetings would help improve communications significantly and provide opportunities for early detection of fraud, waste, and abuse trends in the Medicaid program.

- The OIA-PI could provide useful recommendations to the State Medicaid agency regarding MMIS edits and sanctions. However, the program integrity unit sees its opportunities to provide effective input as limited. For example, OIA-PI reported that its recommendations regarding edits to the MMIS could take an average of three years to be implemented. This assertion could not be corroborated during interviews with MMIS staff who indicated that edits typically take about six months to implement. The OIA-PI also reported increasingly reduced access to Medicaid data. The establishment of regular reciprocal communications would help clarify expectations for turnaround time on data requests, and increase OIA-PI's ability to be proactive and responsive to program integrity concerns in a timely manner.

Recommendations: Establish procedures for improving communication on program integrity issues among all components of the State agency and relevant sister agency components. These should include timelines for responses to inquiries from OIA-PI and other Medicaid components. Develop and implement policies and procedures for disseminating information on the handling and disposition of fraud and abuse cases. Arrange for increased OIA-PI participation on committees addressing program integrity efforts throughout DOH and consider assigning OIA-PI a greater role in coordinating agency-wide program integrity efforts.

Not utilizing permissive exclusion authority.
Utah has a statute and policies which support the implementation of permissive exclusions. These are exclusion actions which the State could undertake at its discretion for any reason that HHS-OIG could exclude a provider under 42 CFR Parts 1001 and 1003. Despite having this statutory authority, the State reported that in practice, it had thus far only excluded entities that were previously excluded by HHS-OIG or DOPL. The failure to make use of permissive exclusions can result in the retention of providers with questionable program integrity records in the Utah Medicaid program. This was also cited as a concern in an

August 2009 report by the State's Office of the Legislative Auditor General entitled "*A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program."*

Recommendation: Implement existing statutory authority and policies for initiating the discretionary exclusion of problem providers when warranted and with consideration for appropriate due process.

Inadequate oversight of program integrity activities in the managed care program.
Utah uses an external quality review organization to monitor managed care plan contract compliance in general. However, this review is limited in scope to the requirements found in 42 CFR Part 438 and has not been supplemented by proactive State oversight of program integrity and provider enrollment practices. The team observed, for example, that there are no internal written policies and procedures which address:

- Monitoring the program integrity activities of physical health plans and PMHPs, such as investigations and fraud referrals;
- Analyzing utilization and referral patterns to detect fraud and abuse in the managed care programs;
- Ensuring that MCEs check for prohibited affiliations with individuals debarred by Federal agencies and report any identified debarments; and
- Verifying disclosures received of persons with ownership and control interests in Utah's contracted MCOs and PMHPs.

Written policies and procedures ensure the State conducts its program integrity activities in the most effective and efficient manner. The absence/shortage of written policies and procedures leaves the State vulnerable to inconsistent operations and ineffective functioning in the event the State loses experienced managed care staff.

Recommendations: Develop and implement policies and procedures within the managed care division that provide for active oversight of program integrity and provider enrollment activities during managed care compliance reviews. Evaluate managed care plan compliance with all applicable program integrity and provider enrollment regulations, including the requirement to check for prohibited affiliations under 42 CFR § 438.610.

Not collecting all ownership and control disclosure information from transportation and MCE network providers.
The DOH contract does not require the NEMT broker or other MCEs (PMHPs and physical health plans) to collect the full range of ownership and control disclosures from NEMT subcontracted companies and drivers and MCE network providers that Federal regulations at 42 CFR § 455.104 would otherwise require from FFS providers.

The State's NEMT broker contract does not require the drivers or subcontracted companies

to disclose any ownership information that would otherwise be required from FFS providers.

The State's MCEs use varying credentialing applications which do not ask for information on persons with ownership and control interests in the provider, family relationships among such persons, and interlocking relationships of ownership and control with subcontractors. Consequently, these individuals cannot be searched for HHS-OIG exclusions. This leaves the State vulnerable to having excluded parties in ownership and control positions of providers or subcontractors which serve Medicaid managed care enrollees.

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

Recommendations: Modify the NEMT provider application and the MCE credentialing applications to capture all required ownership, control, and relationship 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.

Not requiring MCO and PMHP network providers and NEMT subcontracted companies and drivers to disclose business transaction information upon request.
The physical health plans' provider agreements do not require network providers or subcontractors to disclose the business transaction information on request which Federal regulations at 42 CFR § 455.105 would otherwise require of FFS providers. Additionally, even though it is required by the PMHP contract, one PMHP subcontract likewise does not contain language that would require network providers or subcontractors to disclose specified business transaction information on request.

The NEMT broker's contract with subcontracted companies and driver applications also does not require the disclosure of any business transaction information upon request.

Recommendation: Modify the MCE and NEMT provider agreements to meet the requirements of 42 CFR § 455.105(b).

Not capturing the full range of criminal conviction information from managed care providers.
The credentialing agreements used by the PMHPs and physical health plans during the provider credentialing process do not ask for health care-related criminal conviction disclosures by agents and managing employees. Therefore, the State is unable to report such disclosures to the HHS-OIG.

Recommendation: Develop and implement policies and procedures to collect health care-related criminal conviction information from agents and managing employees of MCE providers and to report relevant disclosures to HHS-OIG.

Not consistently collecting all required disclosure information from provider applicants.

The review team observed, and provider enrollment staff confirmed, that providers have found the FFS disclosure form to contain confusing instructions which have led some applicants to omit required information. All FFS providers, agents or managing employees are expected to complete all questions on the form. However, the first direction on the form is: "If ownership does not apply check 'No', if answered 'Yes', fill out the information below." In a sample of provider enrollment forms reviewed by the team, when "No" was checked on the form, the middle part of the form related to criminal convictions was not completed in 4 of the 25 files examined.

Recommendations: Revise the FFS provider disclosure form in order to obtain disclosures from all parties to meet the requirements of 42 CFR § 455.104-106. Develop and implement policies and procedures to ensure that all required information is obtained on provider applicants.

Not requiring the reporting of adverse actions taken against NEMT subcontracted companies and driver applications and providers applying for participation in MCE networks.

The DOH contracts for the NEMT broker, PMHPs, and the risk-based physical health plan do not specifically require the reporting of all program integrity-related adverse actions taken on provider and driver applications or network provider terminations.

There is no contractual requirement with the NEMT broker to report any actions taken on subcontracted company and driver applications.

The language in the PMHP contract only requires the contractor to report adverse actions with regards to "denying admission to or removing a licensed mental health therapist." There is no requirement to report adverse actions taken against other provider types that may provide subcontracted services. The contract with the risk-based health plan does not require any reporting of adverse actions taken against plan providers.

The absence of such reporting requirements may make it easier for problem providers to find a way into the MCOs, PMHPs, and the FFS Medicaid program undetected. In addition, the failure of the NEMT broker, PMHPs and the risk-based MCO to notify the Medicaid agency of adverse actions taken for program integrity reasons also precludes the Medicaid agency from reporting such actions to the HHS-OIG, as the regulation at 42 CFR § 1002.3(b)(3) would require in the FFS program.

Recommendations: Modify the contracts with the NEMT broker, PMHPs, and physical

health plans to require the entities to notify the State when taking adverse action against a driver's or provider's participation in the program, including when it denies credentialing for fraud-related concerns. Implement policies and procedures to report all such adverse actions to HHS-OIG.

Not requiring beneficiary verification of receipt of services in the managed care and HCBS waiver programs.

The State's contracts with the PMHPs and physical health plans do not require that they conduct direct verification of provider-furnished services with beneficiaries. None of the five MCEs that were interviewed indicated that they were performing routine verification of services with beneficiaries with regard to subcontracted services. One MCE did state that service verification may be performed in conjunction with investigations of plan providers.

The Utah HCBS waiver programs do issue annual statements to beneficiaries regarding services billed, but these are insufficient as an alternate form of service verification in that they do not include dates of service or servicing providers.

Recommendations: Revise the MCO and PMHP contracts to require the development and implementation of a method for verifying with beneficiaries whether billed services were received. Revise the annual statements used by the HCBS waiver program to include all language to meet the verification requirement of 42 CFR § 455.20 or develop a different method of verifying with beneficiaries whether services billed by providers were received.

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. 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 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. These SMDLs, and others that MIG has issued, can be found in section 17010 of the Medicaid Program Integrity Manual which can be found at: http://www.cms.gov/Manuals/IOM/ .

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 Excluded Parties List System (EPLS) on a monthly basis. While the State is collecting the required disclosures, the State is not conducting monthly searches of the LEIE or the MED for NEMT.

As mentioned in the Effective Practices section, Utah's MMIS houses extensive disclosure information in its provider subsystem. This enables the State agency to perform monthly exclusion checks using the MED on providers and affiliated parties in both the FFS and managed care delivery systems. The team found that Utah's transportation broker is an exception. It does not check HHS-OIG's LEIE on a monthly basis for excluded parties. The owner was unaware of the LEIE as an available resource and indicated that the only check performed on drivers applying to work for the broker was done with the State's Bureau of Criminal Investigation. This practice runs counter to the guidance provided in the above referenced SMDLs and leaves the State vulnerable to allowing Medicaid payments to excluded parties.

Recommendation: Search the LEIE (or the 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 person or entities.

Not monitoring provider compliance with the False Claims Act.
Section 1902(a)(68) of the Social Security Act [42 U.S.C. 1396a(a)(68)] requires a State to ensure that providers and contractors receiving or making payments of at least $5 million under a State's Medicaid program have: (a) established written policies for all employees (including management) about the Federal False Claims Act, whistleblower protections, administrative remedies, and any pertinent State laws and rules; (b) included as part of these policies detailed provisions regarding the detection and prevention of 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.

One of the PMHPs reported that it had made no effort to confirm whether its providers were disseminating the required False Claims Act education policies.

Recommendation: Implement policies and procedures to monitor compliance of all contractors in accordance with the statutory requirement.

Conclusion

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

- expanded database capacity for capturing disclosure information on owners, directors and managing employees, and
- frequent and productive communication between OIA-PI and the MFCU.

The CMS supports the State's efforts and encourages it to 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, 12 areas of vulnerability were identified. The CMS encourages DOH to closely examine the vulnerabilities that were identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require Utah 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 Utah 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 Utah 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 correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

State of Utah

GARY R. HERBERT
Governor

GREG BELL
Lieutenant Governor

Utah Department of Health

W. David Patton, PhD
Executive Director

Division of Medicaid and Health Financing

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

March 14, 2012

Robb Miller
Director of Field Operations
Center for Program Integrity
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Miller:

I have attached our response to the Medicaid Integrity Program, Utah Comprehensive Program Integrity Review January 2012. Our proposed corrective action is incorporated in our response to each finding or vulnerability. We appreciate the assistance of your staff. Please let me know if you have any questions or need additional information.

Sincerely,

Michael Hales
Deputy Director, Department of Health
Director, Medicaid and Health Financing

Cc: Jackie Gardner, CMCHO
Richard Allen, DMCHO
Noleen Warrick, Program Integrity Manager, OIG
Robert Steed, MFCU, Director

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