Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Wisconsin Comprehensive Program Integrity Review

Final Report

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Table of Contents

Introduction

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Wisconsin Medicaid Program. The MIG review team conducted the onsite portion of the review at the Wisconsin Department of Health Services (DHS) offices. The review team also met with the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Bureau of Program Integrity (BPI) within the Division of Health Care Access & Accountability (DHCAA) of DHS, which is primarily responsible for Medicaid program integrity oversight. This report describes one noteworthy practice, four regulatory compliance issues, and six 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 Wisconsin improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Wisconsin's Medicaid Program

The DHS administers the Wisconsin Medicaid program. As of January 2011, the program served 1,161,122 beneficiaries. Of that total, 719,636 were enrolled in 17 managed care organizations (MCOs) and the remaining beneficiaries were served on a fee-for-service (FFS) basis. The State had approximately 66,048 FFS participating providers and 2,956 MCO providers.

Wisconsin's total computable Medicaid expenditures for State fiscal year (SFY) 2010 were approximately $3.2 billion. Following the passage of the American Recovery and Reinvestment Act of 2009, the Federal medical assistance percentage for Wisconsin for all four quarters of Federal fiscal year 2010 was 70.63 percent.

Program Integrity Section

The BPI, located within DHCAA, is the primary organizational component dedicated to Medicaid fraud and abuse activities. Long-Term Support (LTS) in DHS is responsible for oversight of Medicaid waiver program fraud and abuse activities. At the time of the review, BPI had approximately 51 full-time equivalent employees focusing on Medicaid program integrity. The authorized positions included 13 auditors, 9 nurses, 1 data analyst, administrative support, collection specialists, and provider enrollment staff. In addition, there were 29 contract staff embedded within BPI.

The table below presents the total number of investigations and overpayment amounts identified and collected for the last four SFYs as a result of program integrity activities overseen by BPI.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Overpayments Identified Through Program Integrity Activities***	Overpayments Collected Through Program Integrity Activities
2007	20	22	$6,219,881	$5,136,165
2008	60	38	$8,927,285	$7,651,493
2009	35	22	$1,396,353	$1,071,782
2010	45	24	$4,047,725	$3,134,472

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation. The report lists the total number of Medicaid post-payment claims reviews and audits undertaken in the past four SFYs.
**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. The figures represent cases referred to the MFCU.
***The decrease in overpayments identified and collected during SFY 2008 – 2009 was due to a State hiring freeze that reduced the number of auditors.

Methodology of the Review

In advance of the onsite visit, the review team requested that Wisconsin complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosure, managed care, and the MFCU. A five-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week March 21, 2011 the MIG review team visited the offices of DHS. The team conducted interviews with numerous DHS officials, contractor staff, and the MFCU director. Finally, to determine whether the MCOs were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team interviewed staff within the Managed Care Unit. The team also reviewed the managed care contract provisions and gathered information through interviews with representatives of five MCOs. In addition, the team sampled provider enrollment applications, program integrity case files, and other primary data to validate Wisconsin's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of BPI, but also considered the work of other departments within DHS responsible for a range of program integrity functions, including provider enrollment and managed care. Wisconsin operates an expansion Children's Health Insurance Program (CHIP) under Title XIX of the Social Security Act. The State's CHIP operates under the same managed care model and FFS billing and provider enrollment policies as Wisconsin's Title XIX program. The same findings, vulnerabilities, and effective practices discussed in relation to the Medicaid program also apply to the Medicaid portion of CHIP.

Unless otherwise noted, DHS 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 DHS provided.

Results of the Review

Noteworthy Practices

As part of its comprehensive review process, the CMS review team has identified one practice that merits consideration as a noteworthy or "best" practice. The CMS recommends that other States consider emulating this activity.

Managed care network providers must be enrolled in the FFS program

The State's MCOs are contractually required to only use providers who have been enrolled by the State, except in emergency situations. This practice affords the State the opportunity to maintain disclosure information on most providers receiving payment through a managed care plan. This endeavor minimizes the risk of an excluded provider receiving State and Federal funds through an MCO.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations regarding disclosure requirements and the False Claims Act.

The State does not capture all required ownership, control and relationship information from FFS providers, the fiscal agent and MCOs. (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 language in the State's FFS provider enrollment forms does not fully meet the disclosure requirements of the regulation. For example, institutional and non-institutional forms do not request 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. The DHCAA relies on a blanket statement in provider agreements requiring the disclosing entities to comply with disclosure requirements specified in 42 CFR Part 455, subpart B. Additionally, the State-fiscal agent contract did not include the disclosure requirements in the regulation. This issue remains uncorrected from CMS' 2008 program integrity review.

Additionally, the Badger Care managed care contract does not ask for relationship information or if any of the persons identified as having ownership and control interest are related to another as parent, child, sibling or spouse as required by the regulation at 42 CFR § 455.104(a)(2).

NOTE: The CMS team reviewed the managed care and fiscal agent 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 provider enrollment forms and managed care contracts to request all disclosures required by 42 CFR § 455.104. Additionally, request disclosure information from the fiscal agent regarding ownership and control interest.

The State does not require submission of business transaction information, upon request, from MCOs.

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 managed care contract does not require submission of business transaction information, upon request, within the specified 35-day time period.

Recommendation: Modify the MCO contract to require disclosure of business transaction information upon request.

The State does not collect all criminal conviction disclosures in the FFS, managed care and Home and Community Based Services programs.

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 and Human Services Office of Inspector General (HHS-OIG) whenever such disclosures are made.

The DHCAA FFS provider enrollment forms do request most of the health care-related criminal conviction information required by 42 CFR § 455.106. However, the forms do not request any health care-related criminal convictions for agents.

The LTS county office worker enrolls Home and Community Based Services (HCBS) waiver providers using a Medicaid Waiver Provider Registration form. The form does not request health care-related criminal conviction information required by 42 CFR § 455.106, although a criminal background check is completed before services are rendered. Additionally, the State-MCO contracts do not require agents to disclose health care-related criminal convictions.

Recommendations: Modify the FFS provider application forms to solicit health care-related criminal conviction information from agents as specified in 42 CFR § 455.106. Develop and implement policies and procedures to capture health care-related criminal convictions in the HCBS and managed care programs.

The State has not complied with the State Plan requirement to review providers' policies and employee handbooks pertaining to 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 protection, 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.

The BPI management told the review team that BPI has not begun compliance oversight reviews in accordance with Section 4.42 of Wisconsin's State Plan. Therefore, no monitoring of entities for the establishment of appropriate policies and procedures and incorporation into employee handbooks when appropriate has taken place.

Recommendations: Develop and implement policies and procedures for requiring providers and contractors to include fraud, waste and abuse detection and prevention in employee handbooks. Begin compliance oversight reviews to ensure provider compliance with the State Plan.

Vulnerabilities

The review team identified six areas of vulnerability in the State's program integrity practices. These involve the lack of policies and procedures, verification of managed care services, capture of managing employee information on provider enrollment forms, reporting of adverse actions and incomplete exclusion searches.

Not having written program integrity policies and procedures specific to managed care.
The Managed Care Unit was unable to provide documented evidence that it had established policies and procedures regarding managed care oversight. The State indicated that it has contractual language related to fraud and abuse requirements; however there were no operational procedures for the managed care contracts currently in place.

Recommendation: Develop and implement written policies and procedures addressing all program integrity functions specific to managed care.

Not requiring MCOs to verify with beneficiaries whether services billed by providers were received.
Although Wisconsin meets the requirements of 42 CFR § 455.20 by sending Explanations of Medical Benefits to FFS beneficiaries, the current DHS contract with the MCOs does not require that they conduct verification of services with beneficiaries. Four of the five MCOs interviewed indicated that they did not verify receipt of Medicaid services with their beneficiaries.

Recommendation: Modify the managed care contract to include the requirement for verification of services.

Not capturing managing employee information on LTS enrollment 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." The LTS enrollment applications do not solicit managing employee information from HCBS waiver providers. 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.

Recommendations: Modify LTS provider enrollment applications to collect 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.

Not reporting adverse actions taken on managed care network provider applications for participation in the program.
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 current DHS-MCO contracts do not require the reporting of all network provider denials or terminations. None of the five MCOs interviewed inform DHS when a provider's application is being denied and of the reason for the denial. This leaves DHS, therefore, unable to report such adverse actions to HHS-OIG.

Recommendations: Modify the MCO contracts to require notification to DHS when adverse actions are taken against a provider's participation in the program, including the denial of credentialing for fraud-related concerns. Develop and implement policies and procedures to report to HHS-OIG all adverse actions taken against and limits placed on providers enrolled or applying to participate in the program.

Not conducting complete exclusion 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 (MMIS), then the State cannot conduct adequate searches of the List of Excluded Individuals/Entities (LEIE) or the Medicare Exclusion Database (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 Excluded Parties List System (EPLS) on a monthly basis.

The SMDL #08-003 specifically directs States to conduct monthly exclusion checks on providers, owners and managing employees within the Medicaid program. The review team observed the fiscal agent conduct an exclusion search for a provider. However, no search was conducted for owners and managing employees, which does not adhere to the guidance provided in the SMDL.

The SMDL #09-001 provides guidance to States on how to instruct providers on screening their own staff and subcontractors for excluded parties. However, the State does not have policies or procedures for instructing providers on screening their staff and subcontractors for excluded parties.

Further, the Medicaid agency does not maintain the names of all owners and managing employees in the MMIS. While Wisconsin's LTS provider applications collect the names of owners, operators and in some instances managing employees, the fiscal agent does not enter this information into the MMIS or another searchable data repository. The LTS division does not require the county offices to maintain a database to include managing employees and owners.

This precludes automated exclusion checks on all relevant individuals from being undertaken on an ongoing basis.

Recommendations: Develop policies and procedures for appropriate collection and maintenance of disclosure information about disclosing entities, and 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. 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 persons or entities.

Not having policies and procedures on initiating provider exclusions.
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 State has no written policies or procedures on initiating exclusions of providers for any reason that OIG could exclude. The absence of written policies and procedures leaves the State vulnerable to paying providers who could otherwise be excluded from the Medicaid program.

Recommendation: Develop and implement policies and procedures on initiating provider exclusions.

Conclusion

The State of Wisconsin applies one noteworthy practice that demonstrates program strength and the State's commitment to program integrity. This practice is the use of Medicaid enrolled providers in managed care networks.

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

However, the identification of four areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, six areas of vulnerability were identified. The CMS encourages DHS 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 DHS 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 Wisconsin 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 Wisconsin 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 Wisconsin on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

Official Response from Wisconsin
March 2012

Scott Walker
Governor

Dennis G. Smith
Secretary

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March 8, 2012

Robb Miller, Director
Division of Field Operations
Medicaid Integrity Group
Centers for Medicare & Medicaid Services

Dear Mr. Miller:

On January 11, 2012 Wisconsin Medicaid Director Brett Davis received a final version of the Medicaid Integrity Group's review of Wisconsin Medicaid's Program Integrity procedures and processes. The cover letter that accompanied the review required our agency to provide your office with a written response to the review. This letter and the attachments are in response to that requirement

First, I would like to thank the review team for their efforts to fairly assess our program as to both its strengths and its areas of concern. We were pleased to note that the review was generally favorable toward our overall approach and the outcomes of our efforts and that it gave us the opportunity to highlight some of our more effective practices. We believe that we have a successful program and with your comments and some of the recent changes in our structure as well as increases in our financial and personnel resources we can improve upon what we already have accomplished.

Immediately after his inauguration, Wisconsin Governor Scott Walker created the Governor's Commission on Fraud, Waste and Abuse. During the first six months of its work the Commission identified areas in State government where there was a significant lack of investment in fraud prevention. Two of the areas identified were the Medicaid and FoodShare (Food Stamp) programs, both programs are managed by this Department. These weaknesses were also recognized in the State's 2011-13 biennial budget (2011 Wisconsin Act 32), when the State Legislature and the Governor allocated an additional $2.0 million and 19.00 FTE state positions to the Department, starting in July 2012, to support expanded fraud prevention and integrity activities. The Budget also authorized an additional 15 contract positions specifically designed to identify and recover Medicaid provider overpayments.

In October, 2012 the Governor announced the creation of an Office of the Inspector General (OIG) within the Department of Health Services.

Official Response from Wisconsin
March 2012

One of the key objectives for the creation of the OIG was to more effectively organize existing audit resources to ensure that funding, benefits, and other assets the Department provides to vendors, recipients and others are used responsibly and in a cost-effective manner.

The OIG does this by:

a. Reporting directly to the Department Secretary;

b. Ensuring that the Department's resources for preventing, detecting, and investigating fraud, waste, and abuse are utilized in an efficient, effective manner;

c. Elevating education for providers and recipients as an essential component of efforts to reduce fraud and abuse;

d. Promoting both an internal focus on the use of resources by Department staff and contractors and an external focus on how providers and recipients claim and use funds provided; and

e. Increasing the visibility and expands the utility of the Department's existing fraud and abuse hotline and creates and promotes a new Department new web portal for reporting suspected fraud and abuse.

The additional resources will also enable us to correct some of the deficiencies found in your review of our program integrity efforts and will assist us in implementing the many changes required by enactment of the Patient Protection & Affordable Care Act.

The report noted four minor regulatory compliance issues and six areas of potential vulnerability. This letter contains our response to the team's recommendations and the changes we have made or will be making to bring us into compliance with federal regulations, as well as the steps that are being taken to reduce our risks related to the vulnerability mentioned in the review

To correct the issues related to provider screening and enrollment, we will be including the collection of this information as a part of our compliance with the enrollment and screening provisions of the Affordable Care Act. Attached below are the system requirements that we have directed our fiscal agent to implement. These include the collection of addition information and revisions to our application and enrollment process.

Signed
Version_Screening &

Several of the report's issues were related to items that are not being collected by our enrollment process. To remedy that situation we assigned staff the task of thoroughly reviewing 42 CFR 455, as amended following the passage of the ACA, to identify any areas of non-compliance and create solutions to remedy those deficiencies. The plan they developed includes over 300 specific system modifications. It is obvious that this level of effort will require time and resources and they must compete with other requirements placed on State Medicaid

programs. However we have already accomplished many of our goals and will soon have completed all of the necessary changes. One of the major changes that we are making is eliminating the use of a paper application form and going to a portal only application process. All of the information changes recommended in your report will be incorporated into that portal process.

Another area of concern had to do with our oversight of managed care entities. The Department recognized the fact that its program integrity efforts have been fragmented and that the Bureau of Program Integrity had limited authority over some of the enrollment and screening activities of the Department's various Medicaid programs. Now with the creation of the OIG, program integrity for all DHS programs, including providers in the Medicaid managed care networks' or the Managed Care Entities serving recipients through our waivers. With this re-alignment of the Medicaid provider enrollment function and the oversight of the HMOs and MCEs provider selection to an enterprise level activity, we will have greater oversight of those functions.

One example of this change in the scope of our responsibilities was a report to the DHS Secretary pointing out some of the areas of vulnerability in the Family Care waiver program. The OIG has now been charged with ensuring the appropriateness of payments made and that the eligibility and enrollment procedures of that program are in compliance with federal requirements.

Additionally to address the Review Team's concerns related to oversight of the Managed Care Organizations and Entities, the OIG has established routine quarterly meetings with the MCO/E compliance officers and program integrity contacts to discuss issues related to compliance with federal regulations and State contracts and policies. We have also arranged for the HMO compliance officers' participation in the U.S. Attorneys' Health Care Fraud Task Force Stakeholders' meeting, where issues involving problematic providers are shared between the law enforcement and the private sector companies.

In closing we would, again, like to thank the review team and the management of the Medicaid Integrity Group for the knowledge and professionalism that they displayed during the review. The review experience is a useful tool in that it requires States to evaluate their efforts and to use the insights gained from the review to enhance their efforts to detect and prevent fraud, waste and abuse in their Medicaid program.

So thank you for the opportunity to respond to the review, and please convey our appreciation to your team.

Sincerely,

Alan S. White, Inspector General
Office of the Inspector General