State of Missouri Department of Social Services

Missouri Medicaid Audit and Compliance Unit

END OF YEAR REPORT

State Fiscal Year 2015

MMAC Activities

Jessica Dresner

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FOREWARD

MMAC MISSION STATEMENT

Our mission is to enhance the integrity of the Missouri State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high quality patient care.

MMAC'S RESPONSIBILITIES

MMAC is responsible for oversight of audit and compliance measures of Missouri Medicaid providers and participants. We are responsible for detecting, investigating, and preventing fraud against the Missouri Medicaid program.

MMAC'S FUNCTIONS

MMAC 's functions include enrolling eligible Missouri Medicaid fee-for-service providers, administering the Participant Lock-in Program, auditing and educating fee-for–service providers, conducting investigations into allegations of fraud and abuse, and sanctioning providers who have failed to adhere to applicable laws and regulations.

MMAC will also oversee the operations of the Recovery Audit Contractor, the Medicaid Integrity Contractor, the "Medi-Medi" Contractor, and the Electronic Health Records Incentive Program Contractor.

Jessica Dresner
Director, MMAC
June 30, 2015

PROVIDER ENROLLMENT

PROVIDER ENROLLMENT AND CASE MANAGEMENT TECHNOLOGY

During SFY2015, MMAC continued efforts to implement an automated system to screen, monitor, and enroll Medicaid providers.

PROVIDER SCREENING AND ENROLLMENT REQUIREMENTS

The federal regulations at 42 CFR 455 subpart E require that all enrolling and revalidating providers be screened according to categorical risk levels, and that all ordering and referring professionals be enrolled as participating providers. States must complete revalidations of enrolled providers to include rescreening and collecting updated disclosures. Enrollment and revalidation will require collecting an application fee from certain providers. As well, moderate risk providers require a pre-enrollment on-site visit, and high risk providers must provide fingerprints for a criminal background check in addition to the site visit.

During SFY2015, MMAC assigned provider risk categories and designed a revalidation schedule and revalidation process, to include site visits, collection of application fees, and fingerprint submissions for criminal history checks of high risk providers.

DEFICIT REDUCTION ACT (DRA) ATTESTATIONS

The Employee Education Provision of the Deficit Reduction Act of 2005 directs the states to provide that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, to establish written policies that provide detailed information about the federal False Claims Act and any State laws pertaining to civil or criminal penalties for false claims. The requirements include the provider maintaining an employee handbook. During SFY2015, MMAC reviewed its DRA attestation process to ensure thorough oversight and compliance measures. MMAC implemented a system of follow up communications with providers to ensure compliance.

During SFY2015, Missouri's provider compliance rate with DRA attestation requirements was 100%.

PROVIDER FINANCIAL REPORTS

Certain Missouri Medicaid Home and Community Based Services providers are required to submit a financial report to MMAC. During SFY2015, MMAC began reviewing this process to ensure best practices and effectiveness and update the process as was deemed appropriate.

Consequently, MMAC is in the process of redesigning the quarterly service and financial reports, annual service report, and annual financial audit. The new reports will be ready for release and usage during SFY2016.

HOME AND COMMUNITY BASED PROVIDER CERTIFIED MANAGER TRAINING

MMAC conducts yearly certified manager training for home and community based services providers. During SFY2015, MMAC updated the certified manager training materials and processes. On-line training materials were rewritten, an online registration for training and testing was created and implemented, and a 3-hour classroom training course was designed and implemented. MMAC increased the number of classes presented. Attendees' pass rate increased from 50% to 85-90%.

HOME AND COMMUNITY BASED PROVIDER UPDATE TRAINING

MMAC conducts regular home and community based services provider update training. MMAC is committed to incorporating provider feedback to continually enhance update training to provide current and pertinent information to providers.

In SFY2015, MMAC added a video presentation, additional speakers, and new hand-out materials to the training.

PE WORKING GROUP

CMS'S June 2014 Annual Summary Report of Comprehensive Program Integrity Reviews, from its Center for Program Integrity, states "cooperation and collaboration" is a noteworthy practice. MMAC chairs the Provider Enrollment working group (PE) of the Technical Advisory Group (TAG) to the Medicaid Integrity Institute (MII.) MMAC has successfully chaired this group for most of 2015, working together with the states and CMS to share information and provide guidance to the states regarding enrollment activities. MMAC will continue to be involved in this group during SFY2016.

The Annual Summary Report also gives note to practices to safeguard programs, such as centralized program integrity functions. MMAC's Provider Enrollment unit has been, over the past year, and will continue in SFY2016, to work more closely with audits and investigations. This is achieved by regular meetings involving all units to discuss suspicious enrollment materials along with suspicious provider billing, and reports and complaints received by the various units.

The Office of Inspector General's Fiscal Year 2015 Work Plan mid-year update states, "We will determine the extent to which States and CMS collect and verify required ownership information for provider entities enrolled in Medicare and Medicaid." The report also states, "We will review States' use of enhanced screenings that assess risk for fraud, waste, and abuse for moderate and high-risk enrolling and revalidating Medicaid providers and suppliers."

MMAC currently collects all required ownership and disclosure information. During SFY2015, MMAC assigned provider risk categories, and developed processes for pre-enrollment on-site visits and fingerprint-based criminal background checks.

STATISTICS:

During SFY2015, MMAC enrollment personnel processed 7,314 new applications, 14,634 provider updates, and answered 19,855 email messages from providers. At the end of SFY2015, there were approximately 49,200 enrolled fee-for-service providers

SFY15 Providers Enrolled
7,314
SFY15 Updates Processed
14,634
SFY15 Emails and phone inquiries
19,855

FINANCE

MMAC initiated a review of aged Account Receivables (ARs) in SFY15. As a result, 84 accounts were referred to the Attorney General's Office (AGO) for collection. The AGO in turn provided updated case status on previously referred cases. The status updates show the AGO closed 24 collection cases. Those accounts have been written off in MMIS.

During SFY2015, MMAC also began a tax intercept program with the Department of Revenue. Ten accounts have been referred to DOR for potential tax intercepts. DOR has intercepted tax refunds on two of those providers.

Account Receivables Initiated	FY14	FY15
RAC	130	442
Provider Self Disclosures	985	2,777
All Others	2,768	2,429
Total	**3,883**	**5,648**

PROVIDER REVIEW

PROVIDER REVIEW GROUPS

MMAC has four areas in its Provider Review section, each responsible for auditing certain provider types. Each group has broad responsibilities and therefore, each year the groups' focus areas are reviewed and updated for the coming year.

Clinical Services

- In 2015, Per the HHS OIG 2014 work plan, MMAC planned to collaborate with its contractors to review Medicaid payments for multiuse vials of Herceptin. The Office of Inspector General's Fiscal Year 2015 Work Plan mid-year update states, "We will review States' claims for the Federal share of Medicaid payments for the drug Herceptin, which is used to treat breast cancer, to determine whether providers properly billed the States for the drug."
    - During SFY2015, MMAC determined this is currently a policy area as opposed to an audit area. The department allows providers to bill for a whole vial when the whole vial is not dispensed. Medicare has different requirements (the providers must billed only what is used.)
  - MMAC completed audits of Community Mental Health Centers
  - MMAC completed audits of physician services
  - MMAC completed audits of hospital services

Providers who contract with the Department of Mental Health

- Per the HHS OIG 2014 work plan, MMAC focused on underlying documentation to support billed claims (documentation to support the nature and extent of services provided).
- MMAC also reviewed state payments for outpatient mental health services to identify questionable billing practices
- MMAC completed audits of DD Waiver providers' services
- MMAC completed audits of Targeted Case Management services

Home and Community Based Services

- The state of Missouri transitioned from its Adult Day Health Care program to its Adult Daycare Waiver program. MMAC began auditing the new program beginning January 2015. Additional resources were assigned to audit the Adult Daycare Waiver and audits include reviewing the individual plan of care to monitor whether the provider is striving to maintain or restore optimal capability for self-care.
- MMAC audited In-home and Consumer Directed Services providers and tracked audit results for telephony and non-telephony providers.
- During SFY2015, MMAC began revising its Home and Community Based services audit tool to include more "quality assurance" measures

- Behavioral Health

  - MMAC increased its number of personnel conducting behavioral health audits and utilized our personnel in 2015 to identify questionable billing practices and increase the number of audits conducted

PROVIDER REVIEW AUDITS

According to the 2013 PERM report, nearly 84% of Medicaid fee-for-service improper payment dollars were the result of documentation errors and policy violations. A 3-year summary of similar data also revealed mistakes in # of units billed accounted for the highest dollar errors among mental health services claims. Understanding the causes and addressing them can ensure timely payment of claims and reduction in improper payments found through auditing and monitoring.

In SFY2015, MMAC Provider Review strived to increase educational efforts for all programs, particularly the Behavioral Health program, concerning documentation requirements. Improbable and overlapping services are monitored as part of each audit.

CMS' June 2014 Annual Summary Report of Comprehensive Program Integrity Reviews, from its Center for Program Integrity, gives note to practices to safeguard programs.

END OF YEAR REPORT 2015

The Provider Review section has focused on increasing communication with providers both during and after the audit. Exit conferences are now held with providers at the time of the on-site visit to answer questions and provide general observations. Providers are contacted during the documentation review process regarding any missing documentation. This assists in our prevention and education efforts to increase provider compliance.

MMAC continues to work with the MO HealthNet Division regarding audit findings and policy manual clarifications and revisions. Provider Review processed 2,650 self-disclosures in FFY 15.

SFY15 Fee For Service Audits
3759
SFY15 Recoveries
16,027,973
SFY15 Cost Avoidance
45,921,386

MANAGED CARE AUDITS

MANAGED CARE HEALTH PLANS AND PROVIDER AUDITS

The Office of Inspector General's Fiscal Year 2015 Work Plan mid-year update states, "We will determine whether Medicaid MCOs identified and addressed potential fraud and abuse incidents."

State Medicaid agencies contract with Managed Care Organizations to provide health services in return for a capitated payment. In 2015, MMAC completed audits of Missouri's three health plans which focused on the plans' compliance with the Fraud, Waste, and Abuse sections of their contracts with Missouri Medicaid.

All three plans were placed on corrective action plans.

In 2016, MMAC will complete audits of Missouri's health plans to include a focus on the medical loss ratio to determine if the state was appropriately reimbursed if required, and whether or not expenses were properly classified as medical or administrative. The 2016 audits with also address whether or not the plans properly identify and address potential fraud and abuse incidents.

MEDICAID INTEGRITY CONTRACTOR

THE MEDICAID INTEGRITY CONTRACTOR (MIC)

In February 2006, the Deficit Reduction Act (DRA) of 2005 was signed into law and created the Medicaid Integrity Program under section 1936 of the Social Security Act. The Centers for Medicare and Medicaid Services (CMS) has the responsibility to hire contractors to review Medicaid provider activities, conduct audits of submitted claims and identify any overpayments, and to educate providers about program integrity efforts.

MISSOURI'S MIC

Missouri's MIC is Health Integrity, LLC. The MICs are assigned by geographic location. Currently, Missouri's MIC is conducting audits of Missouri hospice providers. The MIC may request documentation that supports Medicaid-enrolled participants' eligibility for hospice, and other documents to ensure proper billing.

The MIC continued auditing hospice providers in SFY2015 and recovered $375,926.00.

MEDI-MEDI (MEDICARE/MEDICAID) CONTRACTOR

CMS Comprehensive Medicaid Integrity Plan, Fiscal Years 2014-2018, section 3.1, to eliminate duplication by integrating Medicare and Medicaid audits and investigations, states "CMS is developing a Unified Program Integrity Contractor (UPIC) to 'conduct Medicare, Medicaid, and Medi-Medi investigations and audits within designated geographic jurisdictions."

Missouri is a Medi-Medi state and utilizes AdvanceMed as its Medi-Medi contractor.

During SFY2015, AdvanceMed maintained routine/ongoing projects:

- Time bandit analysis
- Analysis of Medicaid payments to Medicare-compromised beneficiaries
- Trending and outlier reports
- Regular monthly meetings with MMAC investigative personnel

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RECOVERY AUDIT CONTRACTOR

THE RECOVERY AUDIT CONTRACTOR (RAC)

Section 6411 of the Affordable Care Act, Expansion of Recovery Audit Contractor (RAC) Program, amends section 1902(a)(42) of the Social Security Act and requires states to contract with a RAC vendor and allows states to reimburse contractors who assist in the identification and recovery of improper payments. The Recovery Audit Contractor is tasked with identifying and correcting improper payment, and collecting those overpayments.

MISSOURI'S RAC

Missouri contracted with Cognosante, LLC in December, 2011 to serve as Missouri's RAC.

During SFY2015, the Missouri RAC conducted audits of pharmacy and durable medical equipment providers. The RAC also developed a plan to audit hospital inpatient vs. outpatient stays, as well as observation billing. These audits will take place during 2016.

The Office of Inspector General's Fiscal Year 2015 Work Plan mid-year update states, "We will review providers' patient accounts to determine whether there are Medicaid overpayments in accounts with credit balances."

In 2015, the RAC conducted credit balance transfer (patient accounts) audits of hospitals and nursing homes.

In 2015, the RAC recovered $1,435,727.00. Of that, $904,961 was due to credit balance transfer audits.

PARTICIPANT LOCK-IN PROGRAM

MMAC is responsible for reviewing participants who may be subjecting the Medicaid program to fraud, waste and abuse. This includes a review of a variety of factors which include:

- The number of physicians prescribing services to a particular participant;
- The number of pharmacies used to obtain prescriptions;
- The frequency of refills or overlapping prescriptions;
- The number of emergency room visits, and
- The services received.

If a MO HealthNet participant is found to be misutilizing MO HealthNet benefits, the individual can be restricted to a physician/clinic, pharmacy, or both in accordance with **13 CSR 70-4.070**, and may also be referred to the appropriate authorities for possible healthcare fraud investigation and prosecution. MMAC is committed to keeping the community apprised of its efforts and activities and will continue to publish Lock-In information on the MMAC website. This information will continue to be updated monthly.

In 2015, MMAC's Participant Lock-in Program totaled a savings (cost avoidance) of $8,424,463.00.

PARTICIPANT REVIEWS	**SFY2015**
Number of No-abuse cases reviewed	30
Lock-In Participants (new cases)	488
Biennials Completed (2yr follow up - LockIns)	628
Watch Participants	50
Watch Participants (6 month follow up)	334
Total Participant Reviews	**1530**

INVESTIGATIONS

MMAC Investigations is responsible for conducting investigations into allegations of fraud, waste and abuse by providers and participants. Investigators conduct interviews with witnesses as well as those suspected of violating state regulation, state statute and federal regulation.

In the event the investigation reveals a credible allegation of fraud by a provider, MMAC will forward the information to the Medicaid Fraud Control Unit (MFCU) with the State of Missouri Attorney General's Office or other prosecutorial entity for review.

SFY 2015

In SFY2015, MMAC Investigations completed 142 investigations and referred 71 cases to the Medicaid Fraud Control Unit (MFCU).

In SFY2015, MMAC investigators utilized a system to routinely make referrals to the managed care health plans, via MO HealthNet, so the plans are able to determine if the providers are also enrolled with them, and if so, investigate the managed care billing for any fraud, waste, or abuse. Investigations will likewise receive referrals from the plans to (a) alert the MFCU and (b) determine if the providers are enrolled as fee-for-service (FFS) providers, and if so, investigate FFS claims for any fraud, waste, or abuse. MMAC Investigators will continue to work with the Medi-Medi Contactor, receive and investigate referrals from the RAC, and investigate any suspicious findings from EHR audits.

CMS' June 2014 Annual Summary Report of Comprehensive Program Integrity Reviews, from its Center for Program Integrity, gives note to practices to safeguard programs. In SFY2015, Investigations provided 13 in-service trainings to HCBS providers. These training sessions reached approximately 1030 personal care aides. Investigators gave additional presentations at conferences throughout the year. MMAC has seen an increase in provider self-disclosures and self-referrals.

Investigations recovered $690,000 in improperly paid claims, separate and above the amounts identified by MMAC's provider review auditors.

SFY2015 Provider Investigations
142
SFY2015 Medicaid Fraud Control Unit referrals
71
SFY2015 Hotline calls received
1472
SFY2015 Provider education
17 presentations

TERMINATIONS AND SANCTIONS

In the event a provider is deemed to be in violation of a provider manual, state statute, state regulation or federal regulation, MMAC is responsible for determining whether or not to impose a sanction on the provider. In determining an appropriate sanction, MMAC takes into account aggravating and/or mitigating circumstances in accordance with **13 CSR 70-3.030** and may determine to impose any one of the following sanctions:

- Education
- Overpayment
- Prepayment Review
- Payment Suspension
- Suspension
- Termination

MMAC has made available on its website a list of providers who have had their enrollment in the Missouri Medicaid program terminated for cause, and the reason(s) for the terminations. MMAC continued to publish this information during SFY2015.

In SFY2015, the Terminations personnel terminated 848 providers. 30 of those terminations were "for cause."

In SFY2015, MMAC personnel began participation in a pilot project with CMS regarding suspension of payments

SFY2015 Provider Terminations and Suspensions
848
SFY2015 Provider Fraud Payment Suspensions
14

Contact Information

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