

State of Missouri Department of Social Services

Missouri Medicaid Audit and Compliance Unit



END OF YEAR REPORT

SFY 2016

MMAC Activities

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FOREWORD

MMAC MISSION STATEMENT

Our mission is to enhance the integrity of the Missouri State Medicaid program by detecting and deterring 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, auditing Program Integrity related provisions of contracted health plans (managed care organizations) and sanctioning providers who have failed to adhere to applicable laws and regulations.

MMAC also oversees the operations of the Recovery Audit Contractor, the Medicaid Integrity Contractor, the "Medi-Medi" Contractor, certain activities of the Third Party Liability contractor (specifically Credit Balance Audits) and the Electronic Health Records Incentive Program Contractor.

Jessica Dresner
Director, MMAC
June 30, 2016

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PROVIDER ENROLLMENT

PROVIDER ENROLLMENT AND CASE MANAGEMENT TECHNOLOGY

During SFY2016, MMAC continued its 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, prescribing 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 require collecting an application fee from certain institutional providers. As well, moderate risk providers require a pre-enrollment site visit, and high risk providers must provide fingerprints for a criminal background check, in addition to the site visit. During SFY2016, MMAC requested systems work to capture a risk indicator on each provider file in the MMIS. This measure was implemented during SFY2016.

During SFY2016, MMAC began revalidation efforts, including collecting application fees from newly enrolling or revalidating institutional providers, conducting pre-enrollment site visits for moderate and high risk providers, and implementing a system to request and review fingerprint-based criminal history checks of high risk providers.

During SFY2016, MMAC began the process to implement the NPI on claims in order to capture and ensure active enrollment of all Ordering, Prescribing, and Referring (OPR) providers.

In SFY2016, MMAC's Provider Enrollment Unit continued working more closely with audits and investigations. This was 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. MMAC contracted with the state's fiscal agent to provide subcontracted automated provider screening and monitoring.

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,

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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. MMAC recorded a 100% compliance rate in SFY2016.

PROVIDER FINANCIAL REPORTS

Certain Missouri Medicaid Home and Community Based Services providers are required to submit quarterly service and financial reports to MMAC, as well as annual service reports and financial audits. During SFY2015, MMAC reviewed these processes to ensure best practices and effectiveness.

Consequently, during SFY2016, MMAC redesigned the quarterly service and financial reports, annual service report and provided guidance for providers on the annual financial audit. The new reports were released for usage during SFY2016. MMAC enhanced its tracking efforts regarding compliance of these reports and began educating providers about the possibility of sanctions for non-compliance.

HOME AND COMMUNITY BASED PROVIDER DESIGNATED MANAGER TRAINING

MMAC conducts yearly designated manager training for home and community based services providers. During SFY2015, MMAC updated the designated manager training materials and processes. Online training materials were rewritten, an online registration for training and testing was created and implemented, and a three-hour classroom training course was designed and implemented. MMAC increased the number of classes presented. Attendees' pass rate increased from 50% to 85-90%. For SFY2016, MMAC researched the optimal number of training dates for best resource allocation, and continued to update training and testing materials.

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 training to provide current and pertinent information to providers.

In SFY2015, MMAC added a video presentation, additional speakers and new handout materials to the training. In SFY2016, MMAC began posting materials presented at the update training on its website, and included provider industry leaders and associations in the training presentations.

STATISTICS:

At the end of SFY 2016, MMAC provider enrollment had processed (finalized) 10,336 provider applications. This exceeds the expected number of new applications (expectations based upon

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preceding years). Personnel processed 16,949 provider enrollment updates during SFY2016, and answered 30,047 provider e-mails, both also exceeding expectations. Also, personnel finalized 3,041 provider revalidation packets. Revalidation efforts fell short of expectation (for finalization) due in large part to provider bad addresses.

During SFY 2016, MMAC began enrolling “OPR” providers, Physician Assistants, and Behavior Analysts.

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FINANCE

MMAC initiated a review of aged Account Receivables (ARs) in SFY2015. As a result, 84 accounts were referred to the Attorney General's Office (AGO) for collection. During SFY2016, MMAC used an updated process to more quickly refer problem or old accounts to the AGO, eliminating the possibility of another backlog of old cases. During SFY 2016, MMAC referred 55 problem or old accounts to the AGO for collection.

During SFY2015, MMAC also began a tax intercept program with the Department of Revenue, and ten accounts were referred to DOR for potential tax intercepts. DOR intercepted tax refunds on two of those providers. During SFY2016, finance referred 24 accounts to DOR for potential tax intercept; DOR intercepted tax refunds on four of those providers.

During SFY2016, identification of delinquent ARs and referrals to the AGO or DOR for collection continued to be a Finance Unit priority.

Provider self-disclosures continue an upward trend as seen in the table below.

| SFY 13 | SFY 14 | SFY 15 | SFY 16 |
|-----------|-------------|-------------|-------------|
| \$356,687 | \$1,046,307 | \$2,305,693 | \$2,767,072 |

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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 2016
 - Clinical Services personnel completed audits, special projects and processed provider self-disclosures, including
 - MMAC completed an audit of one Community Mental Health Center
 - MMAC completed audits of seven Independent Laboratories
 - MMAC added clinical resources, increasing audits of the physician program

- **Providers who contract with the Department of Mental Health**

- In 2016
 - MMAC completed audits of the Developmentally Disabled Waiver providers
 - MMAC completed audits of the Community Psychiatric Rehabilitation Program, including checking for correct licensure of staff.
 - MMAC completed audits of the Comprehensive Substance Treatment and Rehabilitation program (CSTAR), to also include checking for correct licensure of staff.
 - MMAC incorporated a check of overlapping state plan and waiver services into its audit tool

- **Home and Community Based Services**

In its High Risk Series GAO-15-290, the GAO states, "...spending has increased for services provided in the home and community based settings. Proper monitoring of these new programs...will prove essential," and "...better data and monitoring are needed to ensure...skilled providers are providing services commensurate with payments they receive."

- In SFY 2016 MMAC completed audits of In-Home and Consumer Directed Services providers, and monitored and tracked Electronic Visit Verification (EVV) compliance, formerly known as telephony, as part of the audit process. MMAC engaged in efforts to educate the provider community about the telephony or EVV requirements that took effect July 1, 2015.

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- During SFY2016, MMAC verified aide/attendant training and insurance requirements compliance, for quality assurance purposes, as part of the audit process.
 - MMAC incorporated a check of overlapping State Plan and Waiver services billed by personal care providers (In-Home and CDS) into its audit tool.
 - During SFY2016 MMAC began educating providers about the HCBS setting requirements. MMAC conducted on-site surveys of all Adult Day Care Waiver Services providers.
 - In the FY2016 HHS OIG Work Plan, it states Medicaid payments for adult day care services will be reviewed for compliance. The state of Missouri transitioned from the Adult Day Health Care program to the Adult Daycare Waiver program. MMAC began auditing the new program beginning January 2015. Additional resources have been assigned to audit the Adult Daycare Waiver and audits include reviewing the individual plans of care to monitor whether the providers are striving to maintain or restore optimal capability for self-care. Providers were also educated on the importance of maintaining adequate documentation such as transportation logs.
 - During SFY2016 MMAC completed a special project to identify overlapping hospital and in-home home services, and overlapping state plan and waiver services, resulting in a \$106,833 recoupment. Identifying overlapping services is now performed with each audit.
- **Behavioral Health**
 - In 2016
 - MMAC completed audits of psychologists, licensed clinical social workers and licensed counselors
 - MMAC began preparation of audit tools for newly enrolled Behavior Analysts treating Autism Spectrum Disorders

During SFY2016, the Provider Review section redesigned its audit tools. MMAC also began utilizing “Gov.Delivery” during 2016, an email alert system designed to easily communicate with providers. This assisted MMAC in communicating with providers regarding audit requirements and expectations. During SFY2016 MMAC utilized its website to post materials for providers, as well.

STATISTICS

In SFY 2016, MMAC’s Provider Review Section recovered \$5,398,027 (in addition to the MIC, the RAC, and Provider Self-Disclosures). Provider Review also saved \$41,746,552 in denied claims, participant reviews and in other cost-avoidance measures.

FRAUD, WASTE, AND ABUSE DETECTION SYSTEM (FADS)

MMAC utilizes TRUVEN Health Analytics Data Probe and Advantage Suite products for Fraud, Waste and Abuse Detection (FADS) activities. The tools provide analytic reporting capabilities.

In SFY 2016, TRUVEN ran and delivered multiple scheduled algorithms. Depending upon the scheduled month, between three (3) to 14 algorithms were run and reported to MMAC personnel. Truven also provided MMAC with an additional 10 special reports, analyses, and “dashboards,” and provided training sessions to MMAC personnel and assisted with investigating claims data.

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MANAGED CARE HEALTH PLANS AND PROVIDER AUDITS

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, focusing on the plans' compliance with the Fraud, Waste, and Abuse sections of their contracts with Missouri Medicaid.

In SFY2016, MMAC completed audits of Missouri's health plans to include a focus on the quality of their investigations, their procedures, case files, and outcomes to determine if the plans are appropriately identifying and investigating suspected fraud, waste, and abuse and making appropriate referrals to the state.

CMS Comprehensive Medicaid Integrity Plan, Fiscal Years 2014-2018, section 3.2 states, (to improve financial accountability of Medicaid managed care organizations, "We (CMS) will be conducting more detailed reviews of these contracts, identifying areas for in-depth examination by CMS actuaries and audit contractors, and determining whether additional steps are necessary to ensure rates are efficient and support the necessary contract terms to deliver high value, high quality service to enrollees."

Managed care oversight is also referenced in the CMS June 2014 Annual Summary Report of Comprehensive Program Integrity Reviews, from its Center for Program Integrity, and states, "The states should provide closer oversight of the program integrity policies and activities in managed care programs."

During SFY2016, MMAC implemented a schedule of quarterly meetings involving MMAC and MHD. The meetings address both compliance and policy issues and questions.

MMAC's 2016 audits also included a review of the contracts to ensure they have essential program integrity provisions.

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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.

In SFY 2016, the MIC continued auditing hospice providers and recovered \$877,414.

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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.

In 2016, AdvanceMed analyzed provider billing in the following categories:

- Risk-prone place of service payments
- Review ambulance provider billing
- Outpatient/ inpatient billing for dual-eligibles
- Hospice services related to dual-eligibles
- Services received from suspended or revoked providers
- Geo-dispersion of services
- Professional and Physician-Based Services
- Inpatient Hospital Claims
- Durable Medical Equipment
- Crossover Claims

STATISTICS

| # Providers reviewed | Overpayments Identified | \$ Recovered in 2016 |
|----------------------|-------------------------|----------------------|
| 251 | \$563,014 | \$535,067 |

RECOVERY AUDIT CONTRACTOR

THE RECOVER 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.

Missouri released an RFP for its RAC contract in July 2015 (the current contract expired at the end of 2015.) No bids were received and Missouri engaged in a second bid process which also resulted in no bids. During SFY2016, MMAC requested an exemption for the RAC requirement through the state plan amendment (SPA) process. MMAC awaits CMS' final answer and began utilizing HMS, the Third Party Liability contractor, to conduct Credit Balance Audits.

During SFY 2106, MMAC continued to receive RAC recoveries from previously identified overpayments. These recoveries totaled \$602,251.

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 aware 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 SFY 2016, MMAC reviewed and updated its Lock-In Regulation, making proposed amendments to it. During SFY 2016, the lock-in program resulted in cost avoidance of \$6,766,609 due to denied claims (this amount is included in the cost avoidance amount in the Provider Review section).

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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 2016

In SFY2016, MMAC Investigations conducted pre-enrollment investigations and site visits to work collaboratively with provider enrollment. Investigations also continued to assist Provider Review (auditors) with cases that required concurrent audits and investigations, and continued to take a proactive approach to deterring fraud through education of providers. The unit also utilized data analysis to identify potential fraud, waste, and abuse, to ensure a proactive approach to case management, and identified and collected on fraudulent claims.

In SFY2016, MMAC Investigations opened 137 cases for investigation, closed 132 cases, received 1397 hotline calls, and made 55 fraud referrals to the Medicaid Fraud Control Unit.

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, and the reasons for the terminations. MMAC continued to publish this information during SFY2016.

In SFY2016, the Terminations/sanctions personnel streamlined their record keeping processes so all data and supporting documentation will be readily available for all to see the status of a provider.

The Terminations/sanctions personnel also continued to participate in a payment suspension pilot project with CMS.

In SFY2016, MMAC imposed six provider participation suspensions, 19 provider payment suspensions and seven pre-payment reviews, all “for cause.” MMAC also imposed 901 terminations from the MO HealthNet program, with 26 of these “for cause.”

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Contact Information

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