State of Missouri Department of Social Services

Missouri Medicaid Audit and Compliance Unit

END OF YEAR REPORT

SFY2017

MMAC Activities

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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, 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, and the Unified Program Integrity Contractor, (ensuring a smooth transition away from the MIC and Medi-Medi and toward the UPIC), certain activities of the Third Party Liability contractor (specifically Credit Balance Audits and the disallowance project) and the Electronic Health Records Incentive Program Contractor.

Jessica Dresner
Director, MMAC
June 30, 2017

PROVIDER ENROLLMENT

PROVIDER ENROLLMENT AND CASE MANAGEMENT TECHNOLOGY

During SFY2017, MMAC continued efforts to implement a complete enrollment solution to include an automated system to screen, monitor, **and enroll** Medicaid providers. **The first draft of the provider enrollment RFP was completed and will be sent for internal review in July 2017. In the interim, MMAC began utilizing LexisNexis' services to provide automated screening and monitoring for all enrolling and enrolled FFS providers. This was fully implemented in SFY2017.**

In SFY2017, MMAC began enrolling the new provider type, "Community Behavioral Health Centers" (CCBHC).

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 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 SFY 2016, MMAC requested and saw implemented systems work to capture a risk indicator on each provider file in the MMIS.

During SFY2017, MMAC continued revalidation efforts and will complete revalidation of all approximately 59,000 providers by December 2019. MMAC fully implemented processes to collect application fees and to conduct pre- and post-enrollment site visits.

During SFY 2017, MMAC saw the complete implementation of NPI on claims in order to capture and ensure active enrollment of all Ordering, Prescribing, and Referring (OPR) providers, for durable medical equipment (DME), labs, imaging, home health, and pharmacy claims. Systems work was requested and is underway to capture the NPI on all other institutional claims.

In SFY 2016, 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. **In SFY 2017, MMAC enhanced this relationship and collaboration by providing additional training for enrollment personnel to spot concerns on provider reports and application materials, and during on-site visits.**

During SFY 2016, MMAC contracted with the state's fiscal agent to provide subcontracted automated provider screening and monitoring. **MMAC investigative and sanctions personnel worked closely with enrollment personnel during SFY 2017 to open cases when necessary to investigate suspicious screening and monitoring results.**

DEFICIT REDUCTION ACT (DRA) ATTESTATIONS

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

During SFY2017, MMAC saw 100% compliance with this requirement. MMAC coordinated closely with the Department of Mental Health to ensure compliance of mental health providers.

PROVIDER FINANCIAL REPORTS

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

Consequently, during SFY 2016, 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. **In SFY 2017, MMAC began a process to notify non-compliant providers that they failed to submit reports. This will lay the basis for sanctioning non-compliant providers in SFY2018 and expecting 100% compliance in SFY2019.**

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. 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%. For 2016, MMAC researched the optimal number of training dates for best resource allocation. **In SFY 2017, MMAC continued with its current designated manager training format and schedule, and plans to continue the same in SFY2018.**

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. In SFY2016, MMAC began posting materials presented at the update training on its website. **In SFY 2017, MMAC incorporated feedback from providers regarding reformatting the training and requesting presenters make their presentations "scenario-based" or "case study-based".**

PROVIDER UPDATES AND BAD ADDRESSES

Enrolled providers are required to update MMAC when changes occur. However, this does not always occur and in **SFY 2017 MMAC committed to updating/ correcting "bad" physical addresses by focusing on Home and Community Based providers, and through revalidation efforts. As well, MMAC met with the MO HealthNet Division to coordinate with contractors that do mailings for the department, in order to identify appropriate processes that will cut down on "bad" addresses.**

HCBS SETTING REQUIREMENTS

During SFY 2017, MMAC enrollment personnel began including information about the CMS Final Rule regarding Setting Requirements for HCBS providers, during onsite visits and during the enrollment process.

STATISTICS

In SFY 2017, MMAC continued its efforts to maintain quick turnaround time for new applications and updates, with an additional emphasis on increasing the number of revalidation finalizations. Personnel completed 10,435 new enrollments, 20,240 updates, rejected 755 applications and an additional 76 contracts, and processed 7,356 revalidations.

FINANCE

MMAC's review of aged Account Receivables (ARs) in SFY15 resulted in 84 accounts being referred to the Attorney General's Office (AGO) for collection, and receiving an updated case status on previously referred cases. In SFY2016, MMAC used updated processes to more quickly refer problem or old accounts to the AGO. During SFY 2016, MMAC referred 20 problem or old accounts to the AGO for collection. **During SFY 2017, MMAC referred 36 problem or old accounts to the AGO for collection.**

MMAC's tax intercept program with the Department of Revenue, that began in SFY2015, began with ten accounts being referred to DOR for potential tax intercepts. DOR intercepted tax refunds on two of those providers. During SFY 2016, finance referred 24 accounts to DOR for potential tax intercept; DOR intercepted tax refunds on four of those providers. **During SFY 2017, finance referred 21 accounts to DOR for potential tax intercept; DOR intercepted tax refunds on one of those providers.**

Identification of delinquent ARs and referrals to the AGO or DOR for collection continues to be a Finance Unit priority. During SFY2016, MMAC began pursuing a federal-level tax intercept program as well. **During SFY2017, MMAC completed arrangements for this; CMS may now withhold funds on DSS' behalf.**

Provider self-disclosures continue to trend upward. The chart below shows provider self-disclosure amounts for the past five fiscal years.

Provider self-disclosures				
SFY13	SFY14	SFY15	SFY16	SFY17
$356,687	$1,046,307	$2,305,693	$2,767,072	$3,648,402

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 SFY2017
  - MMAC's Clinical Services began including Physician Assistants in their audit efforts, opening one case and continuing to audit PA services in other clinical audits.
  - Completed a special project on Telehealth services with $7,865 in improper payments identified and will continue to review telehealth in 2018.
  - Completed audits of Independent Laboratories: Two completed with one resulting in a termination, 11 underway, with $86,700 in improper payments identified thus far.
  - Completed a special project regarding Hospice overlaps with $510,193 recovered for improperly paid claims.
  - Focused on HCY screenings, which will continue in SFY2018.
  - Focused on dental providers per OIG indications; 10 dental reviews were completed with $99,099 in improper billing identified.
  - Conducted a special project focusing on physician billing in the Emergency Room setting. Not all reviews are complete but thus far $44,671 in upcoding has been identified.
  - Processed 1,883 self-disclosures resulting in $2,199,538 being returned to the state.
  - Completed other clinical services audits and special projects.

- Providers who contract with the Department of Mental Health SFY2017
  - MMAC's DMH audit group completed special projects with an emphasis on inpatient hospital and skilled nursing home overlaps with the Community Psychiatric Rehab (CPR) and Comprehensive Substance Treatment and Rehab (CSTAR) programs. $835,944.91 has been returned to the state due to this project thus far.

- Validated ISL Variance self-disclosures, resulting in $1,084,370 being returned to the state.
- Dedicated an analyst to identify services billed after a participant's date of death, resulting in $327,019 being returned to the state in SFY2017.
- Completed audits of other DMH providers.

- Home and Community Based Services SFY2017
    - MMAC's HCBS group completed 139 audits of In-Home and Consumer Directed Services providers, as well as Adult Day Care and Residential Care providers. Aide/attendant training records were reviewed, and MMAC reviewed CDS payroll taxes to ensure payroll taxes were filed; and, MMAC verified in-home services providers' insurance certificates.
    - Dedicated an analyst to be the EVV liaison.
    - Assigned an analyst to conduct a special audit, along with investigations, regarding EVV compliance. The special audit was completed at the end of SFY2017 with analysis and sanction consideration to be completed in early 2018.
    - Dedicated an analyst to be the HCBS Settings Requirements liaison and this analyst reviewed potential "heightened scrutiny" providers and continues to work with DHSS on the heightened scrutiny component of the settings requirements.
    - Completed a special project to reveal overlapping State Plan & Waiver services and overlapping hospital services billed by personal care providers (In-Home and CDS)
    - Processed 21 provider self-disclosures with a recovered amount of $57,826.00.
    - Presented information at provider update trainings and association conferences.

- Behavioral Health Providers SFY2017
    - MMAC completed 39 audits of psychologists, licensed clinical social workers and licensed counselors representing 55 providers, with $190,905 in improper billing identified thus far.
    - MMAC planned to begin auditing newly enrolled Behavior Analysts treating Autism Spectrum Disorders. MMAC identified the need for regulatory language governing this program and communicated with the MO HealthNet Division regarding that process.

See Provider Review statistics in the Statistics section.

ELECTRONIC HEALTH RECORDS INCENTIVE CONTRACTOR

Beginning in 2012, the Health Information Technology and Clinical Health Act (HITECH) offered incentive payments to encourage eligible professionals and hospitals to adopt certified Electronic Health Records (EHRs). The rule established the basis on which eligible hospitals and professionals participating in the MO HealthNet Program were eligible to receive payments when they successfully demonstrated that they had adopted, implemented, or upgraded to certified EHR technology during the first year, and met “meaningfully use” standards in subsequent years.

MMAC is currently contracted with Brown Smith Wallace LLC (BSW) to perform post-payment audits of provider eligibility as set forth in 42 CFR Part 495 subpart D.

In FFY 2017 $27,598,913.52 was paid to eligible professionals and $2,731,122.86 was paid to eligible hospitals (for a total of $30,308,786.38) in various stages of the program. During SFY2017, MMAC recovered $132,172.23 due to the work BSW completed.

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

In 2016, MMAC completed follow up audits of Missouri's health plans to ensure corrective action plans were in place where deficiencies were noted, and to further investigate whether or not the plans properly identified and addressed potential fraud and abuse incidents.

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 area 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."

MMAC's 2017 audits of the three plans began with readiness reviews because the state had entered into new contracts. First, the plans' policies and procedures were reviewed, and then, processes were reviewed. This second step is still in progress and will continue into SFY2018 with an emphasis on provider screening and monitoring, and disclosure collection, as well as FWA provision adherence, and the plans' "lock-in" programs.

MMAC began conducting quarterly meetings with health plans and MO HealthNet, during SFY2017 and will continue this in 2018.

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 was Health Integrity, LLC. The MICs were assigned by geographic location. **During SFY2017, CMS began phasing out the MICs and the Medi-Medi Contractors and replacing them with the UPIC, or Unified Program Integrity Contractor. Missouri's UPIC is AdvanceMed. MMAC has begun regular meetings with the UPIC to determine processes moving into SFY2018. The MIC's work has concluded.**

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 was a Medi-Medi state and utilized AdvanceMed as its Medi-Medi contractor.

In 2016, AdvanceMed analyzed

- 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

In SFY2017, the Medi-Medi contractor was replaced by the UPIC.

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 payments, and collecting those overpayments.

MISSOURI'S RAC

During SFY2017, Missouri was granted a waiver by CMS, exempting it from its requirements to contract with a RAC. The exemption was granted due to a variety of factors, including MMAC's own recoveries, certain claims being outside the RAC's purview (managed care), and utilizing the TPL contractor to pursue credit balance (patient account) 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.

During SFY2017, MMAC Lock-In personnel opened 593 new Lock-in cases. See a complete listing of Lock-in statistics in the Statistics section.

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.

In SFY2016, MMAC Investigations conducted pre-enrollment investigations and site visits to work collaboratively with provider enrollment, and also continued to assist Provider Review (auditors) with larger or complex cases.

In SFY2017 investigations continued to take a proactive approach to deterring fraud through education of providers, as well, at provider update trainings, conferences, and during meetings with the providers. Investigations also helped focus on HCBS provider issues such as EVV and payroll taxes by investigating these factors during their HCBS investigations.

During SFY2017, investigations served as the MMAC coordination point for Medi Medi and UPIC activities.

In SFY2017, MMAC investigations opened 164 cases for investigation, closed 157 cases, received 518 hotline calls, and made 69 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 "for cause," and the reasons for the terminations. MMAC will continue to publish this information during SFY2018.

In SFY 2016, Terminations streamlined their record keeping process so all data and supporting documentation are readily available for all to see the status of a provider, and Terminations continued to participate in a payment suspension pilot project with CMS.

In SFY2017, Terminations took part in the revalidation process by following up with non-responsive providers, and effecting terminations when appropriate. Also in SFY2017, Terminations began a new process of reviewing and processing closed businesses and expired licenses, deceased provider notifications and criminal history "hits" as MMAC began utilizing automated provider screening and monitoring.

Terminations personnel completed 2237 terminations in SFY2017, with 27 being "for cause." They also completed three full payment suspensions and seven partial payment suspensions.

STATISTICS

Provider Enrollment

	SFY2016	SFY2017
New Providers Enrolled	10,336	10,435
Revalidations Processed	4,048	7,356
Applications Rejected	1,012	755
Updates Processed	16,949	20,240
Email Inquiries	30,047	37,836

Provider Enrollment Home and Community Based Contracts

New Proposals & Applications Received	Proposals & Applications Returned/ Rejected	Proposals & Applications Pending	Executed Participation Agreements/ Enrolled	Terminated or Placed on Closed-End	# of Agencies Currently Enrolled	
143	30	114	131	5	507	Consumer Directed SFY2016
197	47	116	147	14	645	Consumer Directed SFY2017
68	25	44	63	6	448	In-Home Agencies SFY2016
75	26	47	45	16	481	In-Home Agencies SFY2017
---	---	---	---	---	---	Adult Day Care SFY2016
10	3	2	11	7	126	Adult Day Care SFY2017

Participant Lock-In Program

Participant Reviews	SFY2016	SFY2017
Number of No-Abuse Cases reviewed	50	58
Lock-In Participants (new cases)	542	593
Biennial Reviews Completed (Two-year follow up)	641	584
Watch Cases	45	84
Watch Cases at six-month follow up	408	525
Total Participant Reviews	1,687	1844

Cost Avoidance (Provider Review and Participant Lock-In:

	SFY2016	SFY2017
Denied Claims (actual claims denied due to pre-payment reviews)	8,609,492	5,506,699
Provider Audits and Special Projects (calculation based on projected cost savings over a period of one year, taking into consideration actions MMAC has taken)	26,370,451	20,275,401
Participant Reviews (actual claims denied due to lock-in program)	6,766,609	6,938,315
Total	41,746,552	32,720,415

Provider Review Audits, Special Projects, and Self Disclosures

	SFY2016	SFY2017
Recoveries from Audits and Special Projects	5,702,938	4,536,508
Recoveries from Self Disclosures	2,767,072	3,648,402
Recoveries from Credit Balance Audits	N/A	458,399
Recoveries from the RAC	602,251	14,086
Recoveries from the MIC	877,414	149,072
Recoveries from the AGO (MMAC cases)	195,953	126,577
MO HealthNet Pharmacy Administration	775,969	191,926
DSS Total	10,921,597	9,124,970
AGO non-MMAC related recoveries	6,784,802	1,982,482
Total	17,706,399	11,107,452

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Investigations

	SFY2016	SFY2017
Investigations Completed	132	157
Medicaid Fraud Control Unit Referrals	55	69
Hotline Calls Received	1,397	518
Provider Education Presentations	9	9

Provider Terminations and Payment Suspensions

	SFY2016	SFY2017
Provider Terminations	901	2237
Provider Payment Suspensions	25	10

Contact Information

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