State of Missouri Department of Social Services

Missouri Medicaid Audit and Compliance Unit

END OF YEAR REPORT

SFY-2020

MMAC Activities

Dale Carr - Director

TABLE OF CONTENTS

Contents

END OF YEAR REPORT SFY-2020

MMAC MISSION STATEMENT

We protect the integrity of the Missouri State Medicaid Program by detecting and preventing fraud, waste, and abuse, and recovering improperly expended Medicaid Funds, while ensuring high quality care for Missouri citizens.

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 and managed care 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 Unified Program Integrity Contractor, certain activities of the Third Party Liability contractor (specifically Credit Balance Audits and the disallowance project) and the Electronic Health Records Incentive Program Contractor.

Dale Carr
Director, MMAC
August 31, 2020

PROVIDER ENROLLMENT

PROVIDER ENROLLMENT AND CASE MANAGEMENT TECHNOLOGY

Federal regulations at 42 CFR § 455, Subpart E, require that all Medicaid providers must "revalidate" their enrollment records at least every five years. During SFY2019, MMAC implemented a new electronic portal for MO HealthNet providers to revalidate their enrollments. Previously, Missouri Medicaid providers had been submitting their revalidation applications to MMAC on paper application forms. The increased automation of the electronic portal allowed MMAC provider enrollment clerks to process and approve three times as many revalidation applications per day.

MMAC intends to seek budget authority from the Missouri legislature and the Centers for Medicare and Medicaid Services (CMS) to implement a new, 100% electronic enrollment portal during SFY-2022. In the interim, MMAC has continued to utilize Lexis-Nexis' services to provide automated screening and monthly monitoring of all new and currently enrolled fee-for-service (FFS) and managed care network providers.

During SFY2020, enhancements were made to the Lexis-Nexis screening and monitoring program to expand the number of professional licenses and sanctions provided to MMAC.

During SFY2021, MMAC intends to further enhance the revalidations portal to address some limitations that were identified by providers and enrollment staff. MMAC will also be working with a nationally recognized vendor, Docusign, to add electronic signature capabilities to provider enrollment applications.

PROVIDER SCREENING AND ENROLLMENT REQUIREMENTS

Effective January 1, 2018, the 21st Century Cures Act requires all Managed Care Organization (MCO) network providers to be enrolled with the State Medicaid Agency (SMA) within 120 days of contracting with the MCO, or their contract must be terminated. MCO network providers have the option of enrolling as a performing or billing provider with the ability to submit claims to MO HealthNet for services provided to FFS participants, or as a MCO Network Provider that cannot submit FFS claims. During SFY2018, MMAC conducted outreach to the MCOs and their network providers to facilitate the required enrollments. MMAC implemented a new, streamlined MCO network provider enrollment application and began providing regular reports to the contracted MCOs regarding any active, pending, or

Recently terminated providers. During SFY2019, MMAC continued to work with the MCOs to comply with the federal requirement that their in-network providers be enrolled with the the State Medicaid Agency (SMA). While the MCOs have 120 days to enroll with the SMA, most MCOs are requiring their in-network providers to be enrolled with the SMA prior to contracting with the MCO. MMAC prioritized the processing of those applications to reduce delays in contracting.

Federal regulations require all newly enrolling and revalidating providers be screened according to categorical risk levels, and site visits must be conducted on moderate and high level providers. To conserve state resources and speed up the revalidations process, MMAC began coordinating with other state departments, such as the Department of Mental Health, to leverage site visits they may have conducted. MMAC staff completed 1,367 site visits during SFY2019.

Federal regulations at 42 CFR § 455.410(b) require all ordering, prescribing, referring and attending (OPRA) professionals be enrolled as participating Medicaid providers. 42 CFR § 455.440 requires the National Provider Identifier (NPI) of the OPRA professional to be listed on all Medicaid claims for items and services. During SFY2018, system edits were implemented to deny claims submitted by durable medical equipment (DME), independent labs, imaging, and home health providers if the NPI of the OPR provider was not present on the claim, or if the OPR provider was not enrolled. Systems work continued to capture the NPI requirements on all other institutional claims. During SFY2019, MMAC and MO HealthNet implemented system edits to deny all remaining claim types where the NPI of the OPRA providers are required to be listed on the claim.

During SFY2020, MMAC's Provider Enrollment unit continued working closely with the Provider Review and Investigations units. This was achieved by regular meetings involving all units to discuss suspicious enrollment materials and provider billing, along with external reports and complaints received by the various units. SFY2019 saw an increase in referrals from the MMAC PEU to the Investigations unit.

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 SFY2020, MMAC ensured 100% compliance with this

requirement. MMAC coordinated closely with the Missouri Department of Mental Health (DMH) to ensure compliance of mental health providers.

PROVIDER FINANCIAL REPORTS

Certain Missouri Medicaid Home and Community Based Services (HCBS) providers are required to submit quarterly service and financial reports to MMAC, as well as annual service reports and financial audits.

During SFY2020, continued to notify non-compliant providers that they failed to submit reports. In certain cases, MMAC imposed administrative sanctions against non-compliant providers.

HOME AND COMMUNITY BASED PROVIDER DESIGNATED MANAGER TRAINING

MMAC conducts quarterly Designated Manager training and certification for certain HCBS providers delivering in-home personal care services under the state plan. During SFY2020, MMAC updated the designated manager training materials and processes. On-line training materials were rewritten and a three-hour classroom training course was redesigned to focus on prospective Designated Managers being able to locate information about the program requirements in state regulations and program policy manuals. The pass rate of attendees increased from 50% to approximately 90% for most training sessions. During SFY2020, a total of 312 providers attended a quarterly training session in Jefferson City.

HOME AND COMMUNITY BASED PROVIDER UPDATE TRAINING

In the spring and fall of each year, MMAC hosts three consecutive days of training sessions in Jefferson City to update all enrolled HCBS on program requirements, new federal or state legislation, new technology being implemented by the state, and provider compliance issues. Besides MMAC staff, there are normally presentations by MO HealthNet and the Missouri Department of Health and Senior Services (DHSS). The DHSS presentations include staff from the Division of Senior and Disability Services (DSDS), Family Care Safety Registry (FCSR), and the Special Investigations Unit (SIU). Occasionally, a volunteer HCBS provider will present “peer to peer” information.

MMAC has historically incorporated provider feedback to enhance the update training and present pertinent information to the attendees. 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”.

During SFY-2020, MMAC presented six provider update sessions, attended by 1,289 provider representatives.

PROVIDER UPDATES AND BAD ADDRESSES

Enrolled providers are required to update MMAC when changes occur. However, this does not always happen. As a result, MMAC staff experience difficulties contacting providers when it is time to revalidate their Medicaid enrollment, conduct an on-site or desk audit, conduct a fraud investigation, and/or get correspondence to the owners or authorized representative(s). Other state agencies like MO HealthNet, DHSS and DMH frequently send correspondence to the providers' address listed in the master Provider Enrollment file.

During SFY2020, MMAC provider enrollment staff continued their efforts to verify the physical and mailing addresses, email addresses, and telephone numbers of enrolled providers. This was primarily accomplished during the enrollment revalidation process.

STATISTICS

During SFY2020, MMAC continued its efforts to maintain quick turnaround time for new provider enrollment applications and updates, with an additional emphasis on increasing the number of revalidation and MCO application finalizations.

MMAC PEU staff processed and approved 15,765 new enrollment applications, 20,909 updates, 9,128 revalidations, and answered 44,920 email inquiries. MMAC rejected 1,181 provider enrollment applications.

The MMAC PEU Contracts section executed new participation agreements for 62 In-Home Services (IHS) providers, 134 Consumer Directed Services (CDS) vendors, and 20 Adult Day Care (ADC) waiver providers. They closed or terminated the participation agreements of 21 IHS providers, 28 CDS vendors, and six (6) ADC waiver providers. At the end of SFY2020, there were 584 enrolled IHS providers, 956 CDS vendors, and 129 ADC waiver providers. At the end of SFY2020, there were also 40 pending applications from prospective IHS providers, 54 from CDS vendors, and three (3) from ADC waiver providers.

FINANCE

MMAC's review of aged Account Receivables (ARs) in SFY2020 resulted in 25 accounts referred at the Attorney General's Office (AGO) for collection.

MMAC's tax intercept program with the Department of Revenue began in SFY2015 with ten accounts referred to DOR for potential tax intercepts. During SFY2019, MMAC referred 12 accounts to DOR for potential tax intercept. During SFY2020, MMAC referred three accounts to DOR for potential tax intercept. DOR collected $114.07 during SFY2020 for MMAC accounts.

The amount of improper Medicaid payments recovered through Provider "Self-Disclosures" dropped during SFY2020. The number of self-disclosures submitted by enrolled Medicaid providers dropped from 15,215 in SFY2019 to 8,535 during SFY2020. The chart below shows provider self- disclosure amounts submitted to MMAC for the past five fiscal years:

Provider Self-Disclosures				
SFY2016	SFY2017	SFY2018	SFY2019	SFY2020
$2,767,072	$3,648,402	$5,125,743	$4,3995,887	$3,834,352

Finance staff manage the findings and recoveries for the Health Management Systems (HMS) audits. During SFY2020, MMAC created 993 accounts and closed 805 with a total recovery amount of $5,848,570. The MMAC Medicaid Specialist assigned to the HMS account attended a Medicaid Integrity Institute Conference at the National Advocacy Center in South Carolina in January 2020. The conference titled "How Third Party Liability (TPL) Impacts Medicaid" was very informative and provided valuable networking opportunities with many other states that also perform TPL audits.

The Payment Error Rate Measurement (PERM) was conducted by CMS and its contractors for SFY2018. The PERM audit was actually conducted during SFY2020. For CHIP FFS, the error rate was 28.22%. Out of 912 claims, 300 claims were found to have errors. For Medicaid FFS, the error rate was 16.40%. Out of 1,566 claims, 319 were found to have errors. There were no Managed Care errors for either program. The Finance Unit continues to work with CMS on the Corrective Action Plan for all cycle errors.

For SFY2020, the State Audit Sample reviewed all MO HealthNet provider types for SFY2019. There were 332 claims selected and reviewed for all provider types.

All Accounts Receivable (AR) transactions for MMAC are processed by Finance. For SFY2020, Finance posted 28,374 completed AR transactions. Once Finance sets the Accounts Receivable to recoup, the MMIS system automatically posts all recoupment transactions after each financial cycle. There were 9,291 posted recoupment transactions for SFY2020.

During SFY2020, Finance also processed 138 Facility Requests, 57 ITSD Requests, and 27 Travel Requests. There were 463 invoices processed for payment and 775 Medicaid providers were reviewed for possible bankruptcy filings.

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.

During April 2018, the Missouri Office of Administration (OA) awarded a contract for MMAC to be provided with a new Program Integrity Solution. The new solution will replace the current Fraud Abuse Detection System (FADS), Surveillance Utilization Review System (SURS), other legacy program integrity applications, and provide an Electronic Case Management (ECM) solution. Eight MMAC Provider Review staff were designated as Subject Matter Experts (SME) for the project. The project started on July 1, 2018 and is currently scheduled to be implemented during October 2020. Work on the project includes requirements analysis and validation. Time spent working on the project has ranged between five (5) and twenty (20) hours per week per SME.

- Clinical Services Reviews during SFY2020
    - Two personnel completed training to attain certification as a Certified Professional Coder (CPC) and Certified Program Integrity Professional (CPIP).
    - Completed a special project regarding Hospice overlaps with $413,250 recovered for improperly paid claims.
    - Completed special projects regarding the county Hospice rate. The MMIS system does not have editing in place to determine the Hospice care rate which is established within the first 60 days of hospice care and rate for care after the first initial 60 days. Two special projects were completed with $214,432 recovered.
    - A new process was implemented to streamline the self-disclosure (SD) process. The new process allows some SDs to be processed as Special Projects. A total of 43 SD Special Projects, accounting for 1,321 providers and 554 regular cases, were processed. The new process resulted in $3,835,336 being recovered by the state. This total includes ISL Variances and HCBS services listed below.
    - Completed other clinical services audits and special projects.

- Department of Mental Health provider reviews during SFY2020:
    - MMAC's DMH audit group completed special projects with an emphasis on inpatient hospital and skilled nursing home overlaps with the Developmental Disabilities Waiver, Community Psychiatric Rehab (CPR), and Comprehensive Substance Treatment and Rehab (CSTAR) programs. MMAC reviews resulted in $361,986 being returned to the state.
    - MMAC validated 236 Individualized Supported Living (ISL) Variance self-disclosures, resulting in $2,364,264 being recovered by the state.
    - Dedicated an analyst to identify services billed after a Medicaid participant's date of death, resulting in $415,498 being recovered by MMAC during SFY2019.
    - Completed audits of other DMH providers
    - Attended two Targeted Case Management (TCM) association meetings to answer questions about MMAC's auditing processes.

- Home and Community Based Services provider reviews in SFY2020
  - MMAC's HCBS group completed 88 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 Electronic Visit Verification (EVV) liaison.
  - Participated in meetings with other state agencies to develop a Request for Proposal (RFP) for the state EVV aggregator system.
  - 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). A total of $213,539 in improper billing was identified.
  - Processed 24 provider self-disclosures with a recovered amount of $36,339.
  - Presented information at provider update trainings, CDS new provider orientation, and association conferences.
  - Completed a special project to address over billing relating to multiple prior authorizations in the system. A total of $707,622 in improper billing was identified.
  - Initiated a special project to address the growing number of CDS vendor unpaid payroll tax issues. The project consists of special tax training offered at the annual provider update meetings, posting of information on the MMAC website, and mailing 725 letters to CDS providers requesting information that verifies payroll taxes were paid under the participant's federal Employee Identification Number (EIN).
  - Throughout the year, MMAC conducted unannounced on-site visits to verify if providers were complying with program requirements to have staff in their office during posted business hours per program requirements.
  - MMAC mailed 528 letters to enrolled CDS vendors requesting copies of required quarterly CDS Service and Financial Reports that had not been submitted timely. Reminders of due dates for quarterly and annual CDS reports were posted on MMAC's website and quarterly report training was offered during annual update meetings.

- Behavioral Health Providers SFY2020
    - MMAC completed 30 audits of psychologists, licensed clinical social workers and licensed counselors representing 67 individual enrolled providers, with $145,930 in improper billing identified.
    - MMAC completed five audits of Applied Behavior Analysts (ABA) for Children with Autism Spectrum Disorders. The audits represented services provided by seven individual providers. There was $33,567 in improper payments identified. During SFY2020, MMAC will continue to review the Behavior Analysts treating Autism Spectrum Disorders.
    - MMAC Medicaid Specialists attended and presented at two MO HealthNet Behavioral Health workshops and two Applied Behavior Analyst workshops.

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.

For SFY2019, the EHR audit contract was awarded to Myers & Stauffer LLC. Results of the SFY2020 audit are currently pending.

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 Annual Summary Report of Comprehensive Program Integrity Reviews (June 2014), 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 SFY2017 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. MMAC's SFY2018 and SFY2019 audits reviewed MCO network provider screening, monitoring, and self-disclosure collection; as well as FWA provision adherence, and the plans' "lock-in" programs. For SFY2020, those meetings were conducted virtually due to the COVID health emergency.

A dedicated analyst was assigned as the liaison to monitor referrals from all three plans. The analyst reviews each referral for accuracy of information, determines if issues exist, and disperses referral to the appropriate unit within MMAC and/or MHD.

MMAC conducted quarterly meetings with health plans and MO HealthNet during SFY2017 through SFY2020. Those meetings will continue in SFY2021.

UNIFIED PROGRAM INTEGRITY CONTRACTOR (UPIC)

UPICs perform fraud, waste, and abuse detection, deterrence and prevention activities for Medicare and Medicaid claims processed in the United States. Specifically, the UPICs perform integrity related activities associated with Medicare Parts A, B, Durable Medical Equipment (DME), Home Health and Hospice (HH+H), Medicaid, and the Medicare-Medicaid data match program (Medi-Medi). The UPIC contracts operate in five (5) separate geographical jurisdictions in the United States. AdvanceMed Corporation, a NCI company, has been the UPIC for IL, IN, IA, KS, KY, MI, MN, MO, NE, OH, and WI since October 2016.

MMAC has found AdvanceMed to be a strong partner in efforts to identify fraud in Missouri's Medicaid program. Additionally, AdvanceMed has provided MMAC access to expert healthcare consultants for questions on claims and they agreed to have a statistics consultant review MMAC's audits that utilize a Disproportionate Stratified Sampling Technique on claims reviews allowed under state regulation.

During SFY2020, UPIC provided MMAC with the results of studies involving:

- Risk-prone place of service payments
- Aberrant Utilization of Laboratory Services
- Duplicate billings by multiple laboratories
- Duplicate billing of FFS and Medicare/Medicaid crossover claims
- Home and Community Based Services during Long Term Care Stays
- Excessive/High Frequency of Services per Beneficiaries
- Ambulance provider billing
- Medicare/Medicaid Crossover Claims

During SFY2020, the UPIC helped evaluate the Ambulance billing policies and provided analysis regarding which areas needed to be updated. The Ambulance Provider Manual was updated to be more aligned with CMS's policy.

UPIC provided subject matter experts who analyzed our state regulation on statistical sampling. After update of our sampling regulation, several reviews were completed which resulted in MMAC recouping improperly paid Medicaid claims.

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

For calendar years 2016 through 2019, 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) audit.

During SFY2020, MMAC intended to issue a Request for Proposal (RFP) for a new RAC vendor. An RFP was drafted and submitted to the Missouri Office of Administration (OA) during January 2020, but was withdrawn once the COVID health emergency started and OA had many high priority COVID related state contracts to process and award. During May 2020, DSS requested CMS extend Missouri's RAC waiver. During June 2020, CMS approved the request and granted an extension of the RAC waiver until March 31, 2022.

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 SFY2020, MMAC Lock-In personnel opened 438 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.

During SFY2020, MMAC Investigations completed 97 fraud investigations and 66 fraud referrals to the MFCU. As a direct result of MMAC's Investigative referrals, MFCU filed criminal charges and/or received criminal convictions on 19 individual cases in SFY2020.

During SFY2020, investigations conducted by the MMAC Investigations Unit led to the recovery of $257,339.82 in fraudulent Medicaid funds. In addition, data mining of Medicaid claims and subsequent MMAC investigations prevented $1,816,366.84 in improper claims from being paid to Missouri Medicaid providers.

During this past year, the MMAC Investigations Unit focused on reinforcement and improvement of the unit through expansion, development, and training. The Missouri legislature recognized the need for a strong Medicaid program integrity effort and authorized MMAC to hire four additional Investigators. Additionally, an MMAC Investigator received their Certified Program Integrity Professional (CPIP) certification from the Medicaid Integrity Institute (MII), and an additional MMAC Investigator served as MII faculty for courses designed to improve the interviewing skills of Medicaid investigators from all 50 states and U.S. territories. Two MMAC Investigators attended the National Health Care Anti-Fraud Association (NHCAA) Annual Training Conference; three investigators attended The Reid Technique "Power of Positive Persuasion" training; and three investigators attended Detection Deception training provided by the Public Training Council. Finally, the MMAC Investigations Manager attended and presented at the National Association of Medicaid Program Integrity (NAMPI) annual conference.SFY2020. Throughout the past year, MMAC Investigations fostered collaboration with other state investigative units to improve working relationships in the areas of communications, investigative referrals, and cooperative investigations among agencies.

In March 2020, the COVID health emergency made its way into Missouri, affecting how MMAC Investigators conduct investigations. Investigators began working remotely the week of March 19th, 2020, using laptops and VPN and continued conducting thorough investigations into Medicaid provider fraud. With a few alterations to the investigative process, MMAC Investigators easily adjusted to successfully working remotely. With travel for state business initially suspended, Investigators met the challenge by using their personal cell phones to make contact with hotline callers and providers, as well as potential fraud suspects. In May 2020, Investigators were provided with state issued cell phones and the Cisco Jabber Softphone application allowing them to continue working remotely indefinitely.

In addition to their normal investigative duties, the MMAC Investigators assisted with extensive User Acceptance Testing (UAT) of the new Program Integrity Solution and electronic case management system called I-Sight.

TERMINATIONS AND SANCTIONS

In the event a provider violates a provider manual, state statute, state regulation, or federal regulation, MMAC is responsible for determining whether to impose an administrative 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 or more of the following sanctions:

- Attendance at provider education session
- Referral to a state licensing board or peer review committee
- Referral to a state licensing board for investigation
- Referral to appropriate federal or state legal agency for investigation, prosecution, or both, under applicable federal and state laws
- Transfer to a closed-end provider agreement
- Required prior authorization of services
- Recoupment of Identified Overpayment from future Medicaid payments
- Placement on 100% Prepayment Review
- Suspension of Medicaid payments or participation
- Termination of Medicaid participation

In SFY2020, as in previous years, the Terminations Unit continued to review results of the automated provider monitoring system as well as processing terminations and suspensions from many sources. The Terminations Unit completed 1,730 individual Medicaid provider termination and suspension letters. There were 43 “for cause” terminations completed as well as a record number of 35 payment suspensions. Terminations also assisted the MMAC Provider Enrollment Unit (PEU) by updating 129 provider enrollment files and notifying the PEU of deficiencies in Medicaid provider’s general information in the Provider Master files of eMMIS.

The COVID health emergency presented the Terminations Unit with several limitations, as well as new opportunities. The Terminations Unit’s two Benefit Program Senior Specialists began working remotely almost immediately using VDI and to compete almost all their normal duties. CMS granted waivers allowing the lessening of restrictions surrounding license expirations of providers, causing the Terminations Unit to cease sending termination letters to providers with expired or invalid licenses. To compensate for the temporary decreased workload, the Terminations Unit assisted the MMAC PEU by updating over 10,000 Provider Practice Code Types in EMMIS, updated over 800 files for migration to the new PI Solution, and they logged many hours writing test cases for UAT of the new PI solution to verify the new software would meet MMAC’s requirements.

END OF YEAR REPORT SFY-2020

STATISTICS

Provider Enrollment

	SFY2018	SFY2020
New Providers Enrolled	13,902	15,765
Revalidations Processed	18,703	9,128
Applications Rejected	1,309	1,181
Updates Processed	19,010	20,909
Email Inquiries	63,040	44,920

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	
161	93	96	96	27	840	Consumer Directed SFY2019
188	98	54	134	28	956	Consumer Directed SFY2020
83	42	53	36	17	532	In-Home Agencies SFY2019
103	55	54	62	21	584	In-Home Agencies SFY2020
19	3	3	11	15	115	Adult Day Care SFY2019
17	9	3	20	6	129	Adult Day Care SFY2020

END OF YEAR REPORT SFY-2020

Participant Lock-In Program

Participant Reviews	SFY2019	SFY2020
Number of No-Abuse Cases reviewed	251	227
Lock-In Participants (new cases)	460	438
Biennial Reviews Completed (Two-year follow up)	621	577
Watch Cases	231	225
Watch Cases at six-month follow up	696	649
Total Participant Reviews	2,259	2,116

Cost Avoidance (Provider Review and Participant Lock-In:

	SFY2019	SFY2020
Denied Claims (actual claims denied due to pre-payment reviews)	4,044,875	5,645,178
Provider Audits and Special Projects (calculation based on projected cost savings over a period of one year, taking into consideration actions MMAC has taken)	17,175,788	21,793,090
Participant Reviews (actual claims denied due to lock-in program)	6,376,672	8,105,460
Total	27,597,335	35,543,728

Provider Review Audits, Special Projects, and Self-Disclosures

	SFY2019	SFY2020
Recoveries from Audits and Special Projects	5,916,717	3,595,135
Recoveries from Self Disclosures	4,395,887	3,834,352
Recoveries from Credit Balance Audits	7,544,985	5,832,155
Recoveries from the RAC	0	0
Recoveries from the MIC	0	0
Recoveries from the AGO (MMAC cases)	2,841,891	100,876
MO HealthNet Pharmacy Administration	0	0
DSS Total	20,699,480	13,362,518
AGO non-MMAC related recoveries	4,477,953	2,183,071
Total	25,177,433	15,545,589

END OF YEAR REPORT SFY-2020

Investigations

	SFY2019	SFY2020
Investigations Completed	99	97
Medicaid Fraud Control Unit Referrals	50	66
Hotline Calls Received	328	294
Provider Education Presentations	8	7

Provider Terminations and Payment Suspensions

	SFY2019	SFY2020
Provider Terminations	9,368	3,460
Provider Payment Suspensions	24	35

Contact Information

Missouri Medicaid Audit and Compliance (MMAC)

205 Jefferson Street, Second Floor

Jefferson City, MO 65102

Main Telephone: 573-751-3399

MMAC Fraud Hotline: 573-751-3285

MMAC Report Fraud: MMAC.ReportFraud@dss.mo.gov