Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Oklahoma Comprehensive Program Integrity Review

Final Report

August 2011

Reviewers:
Jeff Coady, Review Team Leader
Annette Ellis
Theodore Jackson
Gretchen Kane
Steven Gatzemeier, Review Manager

Table of Contents

Introduction

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Oklahoma Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Oklahoma Health Care Authority (OHCA). The review team also visited the office of the Patient Abuse and Medicaid Fraud Control Unit (PAMFCU).

This review focused on the activities of the Policy, Planning, and Integrity Division (PPID), the component of OHCA which is responsible for Medicaid program integrity. This report describes five effective practices, four regulatory compliance issues, and five vulnerabilities in the State's program integrity operations.

The Review

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Oklahoma improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Oklahoma's Medicaid Program

The OHCA administers the Oklahoma Medicaid program through a fee-for-service (FFS) primary care case management (PCCM) program. As of January 1, 2010, the program served 682,616 beneficiaries. The State had 27,466 providers participating in the program as of January 1, 2010. Medicaid expenditures in Oklahoma for the State fiscal year (SFY) ending June 30, 2010 totaled $4,248,861,337.27. The Federal medical assistance percentage (FMAP) for Oklahoma for Federal fiscal year (FFY) 2010 was 64.43 percent. However, with adjustments attributable to the American Recovery and Reinvestment Act of 2009, the State's effective FMAP was 75.83 percent in the first quarter of FFY 10, and 76.73 percent in the second, third, and fourth quarters.

Program Integrity and Accountability Unit

The Program Integrity and Accountability Unit (PIAU), within the PPID, is the primary organizational component dedicated to Medicaid fraud and abuse activities. At the time of the review, the unit had 22 full-time equivalent employees. The table below presents the total number of preliminary and full investigations, the number of State administrative actions, and amount of overpayments identified and collected for the last four SFYs as a result of program integrity activities. The amount of overpayments collected includes program integrity activities and recoveries for inpatient hospital claims, but does not include inpatient recoveries from contracted entities.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Number of State Administrative Actions	Amount of Overpayments Identified	Amount of Overpayments Collected
2007	1,503	1,411	not available	$8,516,628.20	$7,573,399.45
2008	907	796	not available	$4,527,852.21	$4,527,787.57
2009	1,292	1,204	not available	$2,549,952.51	$2,172,201.85
2010	1,201	1,092	3	$16,337,542.11	$15,522,648.05

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition.

Methodology of the Review

In advance of the onsite visit, the review team requested that Oklahoma complete a comprehensive review guide and supply documentation in support of its answers to the review guide. The review guide included such areas as provider enrollment and disclosures, program integrity, and the MFCU. A four-person review team reviewed the responses and documents that the State provided in advance of the onsite visit.

During the week of February 7, 2011, the MIG review team visited the OHCA and PAMFCU offices. The team conducted interviews with numerous OHCA officials, as well as with staff from the PAMFCU. In addition, the team conducted sampling of provider enrollment applications, selected claims, case files, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the PIAU, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, non-emergency medical transportation (NEMT), and the Program for All- Inclusive Care for the Elderly (PACE). The Children's Health Insurance Program (CHIP) in Oklahoma operates as an expansion under Title XIX of the Social Security Act. The same findings, vulnerabilities, and effective practices in relation to the Medicaid program also apply to CHIP.

Unless otherwise noted, PIAU provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that PIAU provided.

Results of the Review

Effective Practices

As part of its comprehensive review process, CMS also invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Oklahoma reported quality case referrals to PAMFCU, integration of the program integrity operations, expanded Medicaid Management Information System (MMIS) capacity for multiple names, provider enrollment issues shared among State agencies, and an annual State-developed provider accuracy measurement.

Quality case referrals to PAMFCU

During interviews with the PAMFCU and the PIAU, it was noted that PIAU referred 62 cases over the past 4 SFYs (2007-2010) and PAMFCU accepted all of the cases. The PAMFCU indicated that all of the cases were accepted due to the high quality of the preliminary investigations. The OHCA referral process follows the CMS *Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units* guidance issued in September 2008. The OHCA began revising its referral form to meet the Best Practices guidance in October 2008. The revised form was fully implemented in February 2009.

Integration of program integrity operations

The OHCA, as the single State Medicaid agency, is responsible for administering the Medicaid program and has communicated that program integrity is each employee's responsibility. This leadership message is evident in the effective collaboration between PIAU and other OHCA departments. The PIAU staff, Quality Assurance Committee, Medical Authorization Unit, and policy department have monthly scheduled meetings. These meetings provide a forum to ensure program integrity is integrated across all departments. Another example of the integration of program integrity operations occurred when the Quality Assurance-Quality Improvement unit investigated a durable medical equipment provider and identified a respiratory suction pump claim that should have had a modifier attached to the billing code. The PIAU has placed an edit in the MMIS to prevent any further improper payments and is conducting an audit and expects to recoup $4,087.09. An additional example of effective program integrity integration occurred when the PIAU identified providers who were billing for unnecessary laboratory services. The OHCA did not have a current policy restricting laboratory tests only to those that are medically necessary. The PIAU consulted with the policy unit to develop a policy to support the implementation of an edit limiting laboratory tests to those that are medically necessary. The PIAU unit conducted an audit on this issue and recouped $69,018.

Expanded MMIS capacity for multiple names

The State's database in its MMIS allows the provider enrollment section to capture, monitor, and maintain all disclosure information submitted by providers during the enrollment and re-enrollment process. Although the State is not

capturing all required disclosure information as cited later in this report, the file database has the expanded capacity to enter the names of all individuals disclosed. The names entered in the database are cross-checked against the Medicare Exclusion Database (MED) monthly. This expanded provider file database provides the State the opportunity to monitor excluded individuals at all levels of a business entity.

Provider enrollment information shared among State agencies
The Office of Legal Services (OLS) is responsible for provider enrollment within OHCA. The OLS shares provider enrollment information with relevant State agencies such as the Oklahoma Department of Mental Health and Substance Abuse Services (DMHSAS), the Oklahoma Department of Human Services (DHS), and the Oklahoma Juvenile Authority. The OLS has arranged that provider contracts for each specific provider type expire on the same date. Prior to the renewal period, OLS notifies the other State agencies of the upcoming renewal period for that provider type. If an agency has information about a provider of concern, they can alert OLS, who can consider not renewing a contract with a particular provider. This sharing of information provides a greater network of direct and indirect State oversight by varying agencies, and provides OLS with additional input to which they may not normally have access.

State-developed payment accuracy measurement (PAM)
The OHCA participated in the Federal demonstration program PAM in 2002. The State recognized the benefits of this pilot program in being able to identify and track payment errors. In 2006, the State Legislative Session passed a new law requiring OHCA to establish and evaluate methods to deter abuse and reduce errors in Medicaid billing. The law requires OHCA to achieve a payment error rate measurement of no more than 5 percent. The OHCA annually implements a PAM that mirrors the Federal Provider Error Rate Measurement (PERM) program. The State believes the annual State PAM has helped OHCA achieve the lowest 2009 three year cycle PERM rate in the country.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to certain disclosure and notification requirements.

The State does not capture all required ownership, control, and relationship information from FFS providers.
Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any

subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

The State submitted a paper version of their individual and institutional enrollment forms, along with a sample of their electronic versions. The State's paper form for institutional providers does not solicit the disclosure of officers or partners as part of the ownership and control information, and does not ask for relationship information as required by § 455.104 (a)(2). In addition, the paper version did not capture the name of any other disclosing entity in which a person with an ownership or control interest in the applying entity also had ownership or control interest.

The electronic version of the institutional form has a drop-down box to enter relationship information under § 455.104 (a)(2) only if the applicant lists individual owners or persons with control interest (as opposed to corporate owners), and is not capturing the relationship information for all individuals such as officers, directors, partners, owners, and those with controlling interest. The electronic version did not solicit for any other disclosing entity information, as required by § 455.104 (a)(3).

NOTE: The CMS review team reviewed FFS agreements and other provider agreements for compliance with 42 CFR § 455.104 as it was effective at the time of the review. That section of the program integrity regulations has been substantially revised and the amendment was effective on March 25, 2011. The amendment adds requirements for provision of Social Security Numbers and dates of birth as well as more complete address information regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any actions the State takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

Recommendation: Modify the FFS provider enrollment application to capture all required ownership, control, and relationship information.

The State does not require all providers to submit business transaction information upon request from the NEMT broker and PACE provider.

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or U.S. Department of Health and Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors.

The State's contracts with the NEMT broker and the PACE provider do not contain language requiring the timely provision of the required business transaction information in 42 CFR § 455.105 when authorized requests are made.

Recommendation: Modify contracts with the NEMT broker and the PACE provider to meet the requirements of 42 CFR § 455.105(b).

The State does not request health care-related criminal convictions from all required parties in the FFS, NEMT and PACE programs.

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-Office of Inspector General (HHS-OIG) whenever such disclosures are made.

The State's paper and electronic versions of their enrollment forms do not solicit criminal information disclosures for all required parties. The paper form for institutional providers does ask about criminal convictions, but only relates it to those with ownership or controlling interest of 5 percent. The paper form for institutional providers does not solicit information for officers, partners, agents, or managing employees. A Board of Directors is listed on the form after the criminal conviction question, so those disclosures are not captured.

The electronic version of the enrollment application for both individuals and institutional providers does not collect information on agents and managing employees, and no disclosure of criminal conviction information was found. On renewals, if an institutional provider identified individual owners or persons with control interest, a drop-down box solicits criminal conviction information for these individuals.

The State's contracts with the NEMT broker and PACE provider do not collect information on agents and managing employees, and no disclosure of criminal conviction information was found for agents or managing employees.

Recommendation: Modify FFS paper and electronic provider enrollment forms and the State's contracts with the NEMT broker and PACE provider to meet the requirements of 42 CFR § 455.106.

The State is not notifying all required parties when it initiates an exclusion of a FFS provider.

Under the regulation at 42 CFR § 1002.212, if a State agency initiates exclusion pursuant to the regulation at 42 CFR § 1002.210, it must provide notice to the individual or entity subject to the exclusion, as well as other State agencies; the State medical licensing board, as applicable; the public; beneficiaries; and other provided in §§ 1001.2005 and 1001.2006.

The OHCA does have permissive exclusion authority under Oklahoma Statutes § 56-1007.C and Oklahoma Administrative Code (OAC) 317:30-3-19 for Administrative Sanctions. When the State initiates an exclusion, it notifies the provider, the provider's beneficiaries, and relevant State agencies such as DMHSAS and DHS, and the provider

no longer appears on the OHCA public provider directory. Although the State does provide some notification of exclusion of an FFS provider, the State does not notify the public, the State medical licensing board (where applicable), or other beneficiaries who may seek services with this provider, as required by the regulation.

Recommendation: Develop and implement policies and procedures to ensure that all parties identified by the regulation are notified of a State-initiated exclusion.

Vulnerabilities

The review team identified five areas of vulnerability in Oklahoma's program integrity practices. These involved not capturing managing employee information on FFS, NEMT, and PACE provider enrollment forms, not collecting required ownership and control disclosures from NEMT subcontractors, not requiring NEMT providers to disclose business transaction information upon request, not requiring disclosure of health care-related criminal conviction information during the NEMT subcontractor credentialing process, and not conducting complete exclusion searches.

Not capturing managing employee information on FFS, NEMT, and PACE provider enrollment forms.

Under 42 CFR § 455.101, a managing employee is defined as "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency."

The State does not solicit managing employee information on FFS provider enrollment forms. The State's paper and electronic forms for individual practitioners do not collect any information on agents or managing employees. The paper form for institutional providers does not solicit information for officers, partners, agents, or managing employees. The NEMT and PACE provider enrollment forms do not include the collection of managing employee names at enrollment. Thus, the State would have no way of knowing if excluded individuals are working for providers or health care entities in such positions as billing managers and department heads.

Recommendations: Develop and implement policies and procedures to ensure that FFS, PACE, and NEMT subcontractor forms solicit and collect managing employee information during subcontracting and on all enrollment forms or in some manner on attachments to those forms. This information should also be captured in the application database for comparison during the enrollment process and routinely thereafter.

Not collecting all required ownership and control disclosures from NEMT subcontractors.

The contract between the State of Oklahoma and the NEMT broker does not require the entities to collect the full range of ownership and control disclosures from providers that the regulation at 42 CFR § 455.104 would otherwise require from providers participating in Oklahoma's PCCM program. The credentialing process, applications, and forms

used by the NEMT broker with subcontractors do not collect the names and addresses of persons with ownership and control interests in the provider, information on family relationships among such persons, and information on interlocking relationships of ownership and control with subcontractors. Consequently, it is difficult to determine if individuals in key ownership and control positions are excluded from Federal health programs. To the extent that providers receiving Medicaid dollars are subcontracted outside the enrollment process, the State is vulnerable to having excluded parties in ownership and control positions or as subcontractors serving Medicaid beneficiaries.

NOTE: The CMS review team reviewed the NEMT contracts and other provider agreements for compliance with 42 CFR § 455.104 as it was effective at the time of the review. That section of the program integrity regulations has been substantially revised and the amendment was effective on March 25, 2011. The amendment adds requirements for provision of Social Security Numbers and dates of birth as well as more complete address information regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any actions the State takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

Recommendation: Modify or amend the NEMT contracts to require the collection of ownership, control, and relationship information from NEMT subcontractors.

Not requiring NEMT subcontractors to disclose business transaction information upon request.

The OHCA contract with the NEMT broker does not require subcontractors to disclose the business transaction information upon request which Federal regulations at 42 CFR § 455.105 would otherwise require of FFS providers. The NEMT broker provider agreement does not require the disclosure of business transaction information.

Recommendation: Revise the contract with the NEMT broker and develop and implement policies and procedures to ensure that NEMT subcontractors disclose business transaction information upon request to meet the requirements of 42 CFR § 455.105(b).

Not requiring the disclosure of health care-related criminal conviction information from NEMT subcontractors.

The NEMT subcontractor provider application does not require disclosure of health care-related criminal convictions from all parties that would otherwise be required in the FFS Medicaid program under 42 CFR § 455.106. The provider enrollment form does not specifically ask about health care-related criminal convictions on the part of the full range of parties affiliated with applying entity, such as persons with ownership or control interest, agents and managing employees.

Recommendation: Develop and enforce NEMT subcontractor contract provisions mandating the appropriate collection and reporting of required health care-related criminal conviction disclosures.

Not conducting complete searches for individuals and entities excluded from participating in Medicaid.
The regulations at 42 CFR §§ 455.104 through 455.106 require States to solicit disclosure information from disclosing entities, including providers, and require that provider agreements contain language by which the provider agrees to supply disclosures upon request. If the State neither collects nor maintains complete information on owners, officers, and managing employees in the MMIS, then the State cannot conduct adequate searches of the List of Excluded Individuals/Entities (LEIE) or the MED.

The CMS issued a State Medicaid Director Letter (SMDL) #08-003 dated June 16, 2008 providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the MED upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties, including owners, agents, and managing employees. A new regulation at 42 CFR § 455.436, effective March 25, 2011, now requires States to check enrolled providers, persons with ownership and control interests, and managing employees for exclusions in both the LEIE and the Excluded Parties List System (EPLS) on a monthly basis.

The State's NEMT and PACE contracts do not solicit employee information during the contracting process. Thus, the State would have no way of knowing if excluded individuals are working for the NEMT broker or PACE provider in positions of responsibility or authority.

Recommendation: Develop policies and procedures for appropriate collection and maintenance of disclosure information about disclosing entities, and about any person with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity. Search the LEIE (or the MED) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded person or entities.

Conclusion

The State of Oklahoma applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. These practices include:

- quality case referrals to PAMFCU,
- integration of the program integrity operations,
- expanded MMIS capacity for multiple names,
- provider enrollment issues shared among State agencies, and
- State developed provider accuracy measurement.

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

However, the identification of four areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, five areas of vulnerability were identified. The CMS encourages the State of Oklahoma to closely examine the vulnerabilities that were identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require OHCA to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Oklahoma will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If Oklahoma has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Oklahoma on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

Aug 31, 2011

Mr. Robb Miller, Director
Division of Field Operations, Medicaid Integrity Group
Centers for Medicare and Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Re: Oklahoma Comprehensive Program Integrity Review
Final Report, August 2011

Dear Mr. Miller,

Enclosed is our corrective action plan to address the findings and vulnerabilities identified in the Oklahoma Comprehensive Program Integrity Review, Final Report dated August 2011.

Also attached is a copy of our Disclosure of Ownership and Control Statement. Paper and electronic fee-for-service applications have been modified to require completion of this form as part of the application process for SoonerCare providers and fiscal agents. This fulfills our corrective action plan related to this item.

Our Contracts Development Department plans to amend our PACE and Logisticare contracts to require business transaction information upon request as well as modify our NEMT and PACE provider enrollment forms to capture required information. We will send you the documentation referenced as soon as it becomes available.

OHCA disagrees that the public notice requirement is not met and therefore does not have a corrective action to address this finding. When OHCA terminates or excludes a provider, that provider's file is inactivated in the MMIS and the provider no longer appears on OHCA's public provider directory.

Please feel free to contact me if you have questions or need clarification on the information provided. I can be reached at (405) 522 – 7131 or Kelly.Shropshire@okhca.org.

Sincerely,

Kelly Shropshire

Kelly Shropshire, CPA
Director, Program Integrity & Accountability

Enclosures: Oklahoma Corrective Action Plan Spreadsheet
SoonerCare Provider or Fiscal Agent Disclosure of Ownership and Control Statement

cc: Cindy Roberts, CPA, CGFM, Deputy Chief Executive Officer of Program Integrity and Planning
Howard Pallotta, JD, General Counsel of Legal Services
Beth Van Horn, BSW, MBA, Legal Operations Director