Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Maryland Comprehensive Program Integrity Review

Final Report

January 2011

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Maryland Department of Health and Mental Hygiene (MDDHMH) Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of MDDHMH and also visited the office of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the State's Office of Inspector General (OIG), which is responsible for Medicaid program integrity. The MDDHMH Office of Health Services (OHS) is responsible for provider enrollment, managed care oversight, education, overpayment recoveries, and third party liability recoveries. This report describes three effective practices, two regulatory compliance issues, and four 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 Maryland improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Maryland's Medicaid Program

The MDDHMH administers the Maryland Medicaid program. As of the State fiscal year (SFY) ending June 30, 2008, the program served 740,000 recipients, approximately 77 percent of whom were enrolled in a managed care plan. Medicaid fee-for-service (FFS) expenditures totaled $3,935,868. The Federal medical assistance percentage for Maryland during that same time period was 50 percent. The State had 39,750 participating providers actively submitting claims.

Program Integrity Section

The Division of Program Integrity (DPI), located within the OIG, is dedicated to the program integrity function within the MDDHMH. The DPI consists of 34.5 authorized full-time equivalent staff. At the time of the review, DPI had vacancies for a data analyst and a physician. The DPI maintains an array of responsibilities that include, but are not limited to: (1) provider reviews, (2) surveillance utilization review subsystem (SURS), (3) assisting the auditors in conducting claims reviews of Medicaid providers and investigating non-conforming billing patterns detected by SURS, (4) recipient fraud investigations, (5) Medicaid special projects, (6) administrative services, and (7) conducting biweekly meetings.

The table below presents the total number of investigations, sanctions, and identified overpayments in the past four SFYs as a result of program integrity activities.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Number of State Administrative Actions	Amount of Overpayments Identified	Amount of Overpayments Collected
2005	317	7	83	$8,689,701	not available
2006	342	18	103	$13,418,102	not available
2007	256	35	86	$17,612,353	not available
2008	201	13	46	$20,952,007	not available

* 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 Maryland complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosure, and the MFCU. A five-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of May 18, 2009, the MIG review team visited the MDDHMH and MFCU offices. The team conducted interviews with numerous MDDHMH officials, as well as with staff from the State's transportation providers, managed care organizations (MCOs), and the MFCU. The team also conducted sampling of provider enrollment applications, case files, selected claims, 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 OIG DPI, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment and non-emergency medical transportation (NEMT). Maryland's Children's Health Insurance Program (CHIP) operates as an expansion program under Title XIX of the Social Security Act. The majority of CHIP recipients are enrolled in the managed care program, with a small number enrolled in the Home and Community Based Services waiver program. Unless otherwise noted, MDDHMH 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 MDDHMH provided.

RESULTS OF THE REVIEW

Effective Practices

The State has highlighted several practices that demonstrate its commitment to program integrity. These practices include a broker system for NEMT, an automatic tracking system, and OIG biweekly meetings.

Broker system for NEMT

The NEMT broker system safeguards services and results in fiscal savings. In 1993, Maryland initiated a broker system for NEMT, which has been a cost saving mechanism for the State agency. Currently, the State agency provides transportation grants to 24 local health departments (LHDs) to provide NEMT services. The health departments may arrange transportation services directly or provide these services through a subcontractor. The State believes that necessary medical care is provided in an efficient and cost-effective manner, and through all modes of transportation as appropriate. The LHD or its subcontractors are responsible for conducting criminal background checks and verifying licensure renewals on all drivers. All drivers' invoices are validated to ensure services were provided prior to payment. One subcontractor uses road supervisors to conduct driver spot checks for assurance that the vehicle reported on file is in use and recipients are being transported. Each driver has at least one spot check completed per year.

Fraud and abuse automatic tracking system

Maryland's fraud and abuse tracking system has a direct link to the List of Excluded Individuals/Entities (LEIE). Investigators can type in a provider's name and attach a case file and it is automatically checked against the LEIE by Maryland's automatic tracking system.

The tracking system allows the State to upload information directly to the Fraud Investigation Database, which is maintained by CMS. This allows States to communicate and share information on investigations. The tracking system provides a collaborative environment in which investigators investigating suspicious activity cases are able to share knowledge and information with other members of the investigative team, regardless of their geographical location.

OIG biweekly meeting

The OIG DPI holds a workgroup meeting every other week. Attendees include representatives from the MFCU, Medicaid, Mental Hygiene and Department of Disability Administration, and the Office of Health Care Quality (OHCQ). These workgroup meetings have improved communication among the parties and have helped to increase recoveries by increasing awareness within the group. For example, OHCQ surveyors are in the field on a daily basis and can review facilities and programs for issues related to quality. The surveyors' attendance at the biweekly OIG meeting has made them aware

that quality issues can and should be tied to payments. As another example, Maryland's Outpatient Mental Health Clinics (OMHCs) are required to employ a physician medical director who must be onsite a minimum of 20 hours per week. The OHCQ used to merely write a deficiency if it found an OMHC not employing such a director (or employing one for less than 20 hours/week). As a result of exposure to the payment issues under the purview of the OIG, OHCQ now regularly informs the OIG when they find a quality issue such as this and the OIG immediately audits that provider. If a quality standard isn't met, the OIG recommends recovery of funds received by the provider during the time of that deficiency.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to required disclosure of ownership and control and criminal conviction information.

Maryland does not require disclosure of ownership and control information in its FFS operations.

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 MDDHMH provider enrollment form does not solicit the addresses of persons with ownership and control interest in the disclosing entity or in subcontractors in which the disclosing entity has a 5 percent or more interest.

Recommendation: Revise the provider enrollment form to include the request for address information for those persons with ownership and control interest in the disclosing entity or in subcontractors in which the disclosing entity has a 5 percent or more interest.

Maryland does not capture criminal conviction information from personal care providers.
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 the U.S. Department of Health and Human Services (HHS-OIG) whenever such disclosures are made.

While MDDHMH solicits the required health care-related criminal conviction disclosures from FFS providers, the local health department that enrolls personal care providers who are assigned a provider number does not request disclosure of criminal convictions related to health care crimes.

Recommendations: Modify provider enrollment applications for personal care providers to meet the full criminal conviction disclosure requirements of the regulation. Develop and implement a procedure to report criminal conviction information to HHS-OIG within 20 working days.

Vulnerabilities

The review team identified several areas of vulnerability in Maryland's practices regarding disclosure of business transactions, criminal conviction reporting by MCOs, not reporting adverse actions taken on managed care applications, and lack of oversight over external partners.

Not requiring MCOs to collect disclosure of business transactions from network providers.
The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractors.

The MDDHMH does not require MCOs to collect disclosure of business transaction information, upon request, in MCO contracts with providers. Instead, Maryland relies on language in the Code of Maryland Regulations (COMAR) that does not specifically address the requirements at § 455.105. None of the MCOs interviewed require network providers to provide business information upon request.

Recommendation: Modify the State's MCO contracts and MCO enrollment packages to require disclosure of business transaction information, upon request.

Not requiring MCOs to report criminal conviction information to the State.
Under requirements at 42 CFR § 455.106 (b)(1), the Medicaid agency must notify the HHS-OIG of any disclosures made under paragraph (a) of this section within 20 working days from the date they receive the information.

The State agency does not require that MCOs report criminal conviction disclosures made by providers during the credentialing process. Therefore, the State is unable to report this information to HHS-OIG.

Recommendations: Develop and implement a procedure for MCOs to notify the State of criminal conviction disclosures. Develop and implement a procedure to report criminal conviction information to HHS-OIG within 20 working days.

Not reporting to HHS-OIG adverse actions taken on managed care provider applications.
The State agency does not require that MCOs report to the State whenever they deny enrollment of a provider into their network based on concerns related to fraud, integrity or quality. Therefore, the State is not in a position to be able to report these actions to HHS-OIG, as the regulation at 42 CFR § 1002.3(b) would require in the FFS program.

Recommendations: Require MCOs to notify the State when taking adverse action against a provider's participation in the program. Develop and implement procedures to report to HHS-OIG all adverse actions taken against and limits placed on providers' participation in the program during the enrollment and credentialing process.

Not providing sufficient oversight of managed care program integrity activities.
The MDDHMH is not providing sufficient oversight of program integrity activities in the managed care setting. The MIG review team identified the following concerns: 1) MCOs have not been provided clear direction for reporting fraud and abuse to the appropriate department; 2) the annual Systems Performance Review (SPR) conducted by the External Quality Review Organization (EQRO) does not include a review of how actual cases are handled; and 3) MCOs are not provided ongoing training related to program integrity activities within the State.

Maryland regulation COMAR 10.09.65.02T requires MCOs to report fraud and abuse cases to MDDHMH and the MFCU. However, the monthly MCO reports which include suspected cases of fraud or abuse are submitted to a staff member in OHS Recoveries and are not subsequently disseminated to the MDDHMH's OIG DPI or the MFCU. The MCOs reported submitting obvious fraud cases directly to the MFCU. However, all other cases which were reported on the monthly report were not reaching the OIG or MFCU for screening and determination of any necessary action.

Although the EQRO conducts an annual SPR, the SPR only addresses the existence and adequacy of fraud and abuse policies and procedures. It does not include a review of how actual cases are handled. This concern was further supported by an MCO reporting that the determination of whether a case gets referred to the MFCU lies with its Compliance Committee. Cases that are not referred to the MFCU are handled internally. The MFCU indicated to the MIG review team that it would prefer all suspected cases (regardless of source) be referred to the MFCU for screening and determination of fraud.

Interviews with Maryland's MCOs revealed that MDDHMH provides the MCOs with little to no guidance or education. The State's MCOs are not provided ongoing education about changes or updates to relevant laws and training on MDDHMH policies and procedures for reporting fraud and abuse, including expectations for what to report, to whom to report, and when to report.

Recommendations: Develop and implement a procedure to track and report all MCO fraud referrals in accordance with State regulation. Modify the EQRO review requirements to include a review of how provider fraud and abuse cases are handled. Provide MCOs with clear direction on what to report, to whom to report, and when to report potential provider fraud and abuse cases, and update the MCOs on changes to the laws.

CONCLUSION

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

- oversight of the NEMT program,
- a fraud and abuse automatic tracking system, and
- biweekly meetings with the State OIG

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

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

It is important that these issues be rectified as soon as possible. To that end, we will require MDDHMH 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 Maryland 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 Maryland 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 Maryland on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.