Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Maine Comprehensive Program Integrity Review

Final Report

August 2012

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Introduction

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Maine Medicaid Program. The MIG conducted the onsite portion of the review at the Office of MaineCare Services (OMS) offices. The MIG review team also visited the office of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Program Integrity Unit (PIU) within the Division of Audit, which is responsible for Medicaid program integrity. This report describes one noteworthy practice, two effective practices, four regulatory compliance issues, and two vulnerabilities in the State's program integrity operations.

The CMS is concerned that the review identified two uncorrected partial repeat findings from its 2009 review of Maine. The CMS will work closely with the State to ensure that all issues, particularly those that remain from the previous review, are resolved as soon as possible.

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 Maine improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Maine's Medicaid Program

The OMS administers the Maine Medicaid Program. As of January 1, 2012, the program served 311,511 beneficiaries, all of whom were enrolled in fee-for-service (FFS). The State had 25,297 providers participating in the Medicaid program. Per CMS data, total computable Medicaid expenditures in Maine for the State fiscal year (SFY) ending on June 30, 2011 were approximately $2.5 billion.

Medicaid Program Integrity Section

The PIU is the organizational component dedicated to the prevention and detection of Medicaid provider fraud, abuse and overpayments. At the time of the review, the PIU had approximately 13 full-time equivalent positions. The table below presents the total number of investigations, sanctions, and overpayments identified and recouped in the past four SFYs as a result of program integrity activities.

Table 1

SFY	Number of Preliminary & Full Investigations*	Number of State Administrative Actions or Sanctions (Approximation)	Amount of Overpayments Identified**	Amounts Recouped (includes past PIU settlement collections)
2008	366	23	$4,533,009	$7,032,352
2009	432	51	$15,878,742	$7,423,123
2010	667	30	$18,637,873	$7,411,458
2011	470	39	$11,587,478	$2,980,043***

*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. The State did not make a distinction between preliminary and full investigations for tracking purposes.
**Amounts do not include any overpayments identified through processes other than preliminary and full investigations. The State attributed the significant increase in overpayments identified from SFY 2008 to SFY 2009 to an increase in PIU staffing. The noticeable decrease from SFY 2010 to SFY 2011 was attributed to a slowdown in processing during a leadership transition.
***The amount of overpayments recouped in SFY 2011 was attributed to a slowdown in processing due to new staff inexperience and a leadership transition.

Methodology of the Review

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

During the week of January 23, 2012, the MIG review team visited the OMS and MFCU offices. The team conducted interviews with numerous OMS officials and the MFCU. The team also conducted sampling of provider applications, case files, and other primary data to confirm that Maine program integrity practices complied with Federal regulations.

Scope and Limitations of the Review

This review focused not only on the activities of the PIU, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment and provider training. Maine operates its Children's Health Insurance Program (CHIP) both as a stand-alone Title XXI program and a Title XIX Medicaid expansion program. The expansion program operates under the same billing and provider enrollment policies as Maine's Title XIX program. The same noteworthy and effective practices, findings and vulnerabilities discussed in relation to the Medicaid program also apply to the expansion CHIP. The stand-alone program operates under the authority of Title XXI and is beyond the scope of this review.

Unless otherwise noted, the PIU 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 the PIU provided.

Results of the Review

Noteworthy Practice

As part of its comprehensive review process, the CMS review team has identified one practice that merits consideration as a noteworthy or "best" practice. The CMS recommends that other States consider emulating this activity.

Providers must attest to reading the MaineCare Benefits Manual prior to enrollment

During the enrollment process, all providers must attest to having read the terms and conditions of participation in MaineCare and certify that they understand key sections of the MaineCare Benefits manual. An enrolling provider must read and agree to abide by the terms and conditions and check the appropriate box before his/her application is processed. Therefore, the State can document that each provider has attested to having read and understood the policies and rules for participating in the MaineCare program. This procedure strengthens the State's ability to have enforcement actions upheld during the appeals process in civil cases where the State later find providers who falsified their applications in some way or engaged in fraudulent or abusive billing practices.

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. Maine reported a centralized enrollment process for all providers and OMS' participation in a broader State fraud and abuse workgroup.

The State centrally enrolls all providers in the State Medicaid program

Maine's centralized enrollment process allows the State to review the applications of all prospective entities and providers which seek to serve Medicaid beneficiaries. Potential Medicaid providers may enroll on line with a web-based enrollment application or a provider can send the identical paper enrollment application to the State.

The only exception to direct provider enrollment is for personal care attendants (PCAs). The State enrolls PCAs through health agencies in its home and community based services waiver programs. The health agencies are directly enrolled by MaineCare. Maine also contracts with a fiscal intermediary to enroll PCAs in its consumer-directed personal care services (PCS) program.

Notwithstanding the value of a centralized enrollment process, the review team found some issues with the collection of disclosures and the searches conducted for excluded

and debarred parties in Maine. These are discussed later in the Findings and Vulnerabilities sections.

Medicaid Fraud and Abuse Workgroup

The State's formation of a fraud and abuse workgroup in December 2010 has been successful in identifying and outlining ways to improve the detection of fraud by both providers and beneficiaries and the ability to conduct prosecutions. The workgroup consists of members from the Commissioner's Office, OMS, and the Attorney General's (AG's) Office, which represents both the MFCU and the Governor's Office. Within OMS, both the PIU and a group within the Division of Audit known as the Fraud Investigation and Recovery Unit (FIRU) are represented. The workgroup meets weekly and discusses recommendations that are presented to the Governor on an annual basis. The workgroup currently is working on strategies for identifying and preventing fraud and abuse prior to Medicaid payments being made. Among the successful initiatives resulting from the efforts of the workgroup are the following:

- Creation of a web-based form for reporting any suspected fraud as well as a hotline number for persons wishing to report fraud;
- Conducting of post mortems on cases completed with the AG's office and PIU or FIRU. These are aimed at identifying those activities and approaches that worked well and those that could be improved to help in the prosecution of cases;
- Provision of law enforcement training to investigators by the AG's Office to improve the quality of referrals; and
- A systematic review of all Medicaid program policies to identify areas that need to be rewritten to help prevent fraud and close loopholes.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to payment suspensions, required disclosures, and searches for excluded and debarred individuals and entities.

The State has not implemented the new provisions of the regulation to suspend payments in cases of credible allegations of fraud.

The Federal regulation at 42 CFR § 455.23(a) requires that upon the State Medicaid agency determining that an allegation of fraud is credible, the State Medicaid agency must suspend all Medicaid payments to a provider, unless the agency has good cause to not suspend payments or to suspend payment only in part. Under 42 CFR § 455.23(d) the State Medicaid agency must make a fraud referral to either a MFCU or to an appropriate law enforcement agency in States with no certified MFCU. The referral to the MFCU must be made in writing and conform to the fraud referral performance standards issued by the Secretary.

The State is not suspending Medicaid payments upon referral to the MFCU as required by the revised regulation. The PIU said it adheres to a section of the Maine statutes[1] which currently hinders its ability to suspend payments. This section states:

> "The department may impose a sanction or withhold payment when the department has obtained an order from Superior Court allowing interim sanctions upon showing a substantial likelihood that overpayment or fraud has occurred and that substantial harm to the department will result from further delay or when the department has taken final agency action and the provider has waived or exhausted its right to judicial review."

Although the Medicaid agency was not suspending payments at the time of the review, the PIU was using the referral performance standards issued by the Secretary in those referrals it had developed for the MFCU. The program integrity director also indicated that the Medicaid agency had drafted new legislative language[2] in order to comply fully with 42 CFR § 455.23. This new legislative language was submitted as part of a Governor's bill on fraud in January 2012. Additionally, the State has written policies and procedures on the suspension of Medicaid payments when cases are referred to the MFCU involving credible allegations of fraud. These policies and procedures are in place should new legislation pass.

According to the PIU, eight cases were referred to the MFCU since March 25, 2011 without payments being suspended as required under § 455.23(a)(1). Three of these cases were reported in error and are being handled by the State. The total amount that was paid since March 25, 2011 was reported to be slightly under $185,000 as of December 31, 2011. The review team found no evidence that the MFCU or the State had requested a good cause exception in writing on any of these cases to block the payment suspensions.

Recommendations: Implement the State's policy that addresses this regulation. Suspend payments to providers or document a good cause exception not to suspend when an investigation determines there is a credible allegation of fraud. Refer such cases to the MCFU and comply with the documentation requirements of 42 CFR § 455.23.

The State does not capture all required ownership and control disclosures from disclosing entities. (Uncorrected Partial Repeat Finding)

Under 42 CFR § 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or managed care entity (MCE), must disclose to the State Medicaid agency the name, address, date of birth (DOB), and Social Security Number (SSN) of each person or entity 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. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under § 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must

[1] Maine Revised Statutes [MRS], Title 22 Health and Welfare, Subtitle 1, Chapter 1, Subchapter 1, Section 13-Human Services Fraud Investigation Unit, paragraph 6.
[2] 22 MRS § 1714-D.

disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling. Moreover, under § 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under § 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under § 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

MaineCare's paper and web-based provider enrollment forms were revised and updated to address several issues related to 42 CFR § 455.104 identified during the 2009 Maine program integrity review. However, the current forms are not fully in compliance with the revised requirements of the regulation at 42 CFR § 455.104 that took effect on March 25, 2011. Specifically, the enrollment application does not collect DOBs and does not solicit the enhanced address information that must be provided by corporate entities. Likewise, the forms ask for the submission of SSNs on an optional basis when in fact these must be provided.

Additionally, the application forms do not solicit the names of managing employees, their DOBs or SSNs. During the review sampling process, it was noted that on some applications, the chief executive officer (CEO) and chief financial officer (CFO) were signing the provider agreements while disclosure information was not collected on them as managing employees. The review team also found that the fiscal agent did not supply disclosure information required under § 455.104(c).

Maine has eight non-emergency medical transportation (NEMT) providers that provide services to Medicaid beneficiaries throughout the State. Since the eight NEMT providers are enrolled in the same manner as all other providers in the Maine Medicaid program, the issues with DOB, enhanced address and optional SSN on the State's paper and web-based provider enrollment forms apply to those NEMT providers that qualify as disclosing entities.

Recommendations: Develop and implement policies and procedures for the appropriate collection of disclosures from disclosing entities, fiscal agents, and NEMT providers regarding persons with an ownership or control interest, or who are managing employees of the disclosing entities, fiscal agents or NEMT brokers. Modify disclosure forms as necessary to capture all disclosures required under the regulation. While the State has improved its enrollment applications in general, the same recommendations made in the 2009 review report largely apply again.

The State does not capture criminal conviction disclosures from providers or contractors. (Uncorrected Partial Repeat Finding)

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 & Human Services-Office of Inspector General (HHS-OIG) whenever such disclosures are made. In addition, pursuant to 42 CFR § 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

The State's paper and web-based provider enrollment forms were revised and updated to address issues related to 42 CFR § 455.106 identified during the 2009 Maine program integrity review. They now list all the required parties who must be asked about health care-related criminal convictions. However, the State's paper enrollment application only requests a general explanation if a criminal conviction is found. There are no instructions to identify the names of persons who have been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX. Although paper enrollment forms comprise a small percentage of the provider applications submitted in Maine, this omission prevents the State from meeting the full requirements of the regulation. To the extent that they use paper provider enrollment applications, the failure to solicit specific health care-related criminal conviction information applies to PCS and NEMT providers as well.

Recommendations: Develop and implement policies and procedures for the appropriate collection of disclosures from providers regarding persons with an ownership or control interest, or persons who are agents or managing employees of the providers, who have been convicted of a criminal offense related to Medicare, Medicaid or Title XX since the inception of the programs. Modify disclosure forms as necessary to capture all disclosures required under the regulation. While the State corrected this issue regarding web-based enrollment applications, a similar recommendation made in the 2009 review report still applies to the paper applications.

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid.

The Federal regulation at 42 CFR § 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System (EPLS) no less frequently than monthly.

Although the State is checking all providers as required by the regulation, the names of agents and managing employees of all Medicaid applicants (for example the previously noted CFOs and CEOs who signed off on provider agreements) are not always requested in the enrollment process. Therefore, searches of the LEIE[3] or the Medicare Exclusion Database (MED) and EPLS cannot include all affiliated parties who must be checked for exclusions upon initial enrollment, re-enrollment and on an ongoing basis. Additionally, the EPLS is not being checked as required by the regulation.

[3] At the end of July 2012, the EPLS along with Federal Agency Registration, the Central Contractor Registration, and the Online Representations and Certifications Application, will be migrated into the new System for Award Management.

Maine only checks NEMT providers for exclusions against the LEIE upon initial enrollment, re-enrollment and if the provider makes any updates to the enrollment application during the time period prior to re-enrollment. Monthly checks are not being done as required by 42 CFR § 455.436. Nor are persons with ownership and control interests, agents or managing employees of NEMT providers being searched in the LEIE, as these names are not currently collected. The EPLS, again, is not consulted at all.

Recommendations: Develop policies and procedures for appropriate collection and maintenance of disclosure information about the provider, any person with an ownership or control interest, or who is an agent or managing employee of the provider. 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 persons or entities.

Vulnerabilities

The review team identified two areas of vulnerability in Maine's program integrity practices. These included the failure to capture health care-related criminal conviction disclosures and to conduct complete searches for excluded and debarred individuals and entities within the consumer-directed PCA program.

Not capturing criminal conviction disclosures from contracted PCA 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 HHS-OIG whenever such disclosures are made. In addition, pursuant to 42 CFR § 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

The State hires PCAs through the fiscal intermediary for services within the consumer-directed PCS program. However, Maine's enrollment application does not ask disclosure questions regarding criminal convictions, as is required for FFS providers.

Recommendation: Modify the fiscal intermediary contract to require, or ensure that PCA provider enrollment forms require, the disclosure of health care-related criminal convictions. Include contract language requiring the fiscal intermediary to notify the State of such disclosures on a timely basis.

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 Medicaid Management Information System, then the State cannot conduct adequate searches of the 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 EPLS on a monthly basis.

Maine's fiscal intermediary, which hires PCAs within its consumer-directed personal care service program, is required to perform background checks on all PCAs rendering care to Medicaid beneficiaries. However, the State could not verify that its contract with the fiscal intermediary required the performance of exclusion checks against both the LEIE or MED and EPLS. In addition, the State was unable to verify whether the fiscal intermediary was checking the LEIE or MED and EPLS no less than monthly as required by the regulation.

Recommendations: Amend the contract to require the appropriate collection and maintenance of disclosure information about disclosing entities. Require the contractor to search the LEIE and the EPLS upon enrollment, reenrollment, credentialing or re-credentialing of network providers, and at least monthly thereafter, by the names of the disclosing entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

Conclusion

The State of Maine applies some noteworthy and effective practices that demonstrate program strengths and the State's commitment to program integrity.

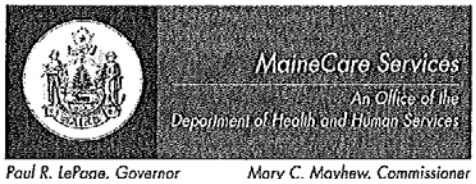
The CMS supports the State's efforts and encourages the State to look for additional opportunities to improve overall program integrity. However, the identification of four areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, two areas of vulnerability were identified. The CMS is particularly concerned over the two uncorrected partial repeat findings. The CMS expects the State to correct them as soon as possible.

To that end, we will require Maine 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 that 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 Maine 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 Maine 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 Maine on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

Official Response from Maine
September 2012



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September 20, 2012

Angela Brice-Smith
Director, Medicaid Program Integrity Group
Center for Program Integrity
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Brice-Smith:

A team from the Medicaid Integrity Group conducted an onsite comprehensive review of the Maine Medicaid program integrity procedures and processes during the week of January 23, 2012. The team's approach to the review was very professional and they exhibited an exceptional knowledge and understanding of the areas reviewed.

We received a draft report on June 27, 2012 requesting informal comments by July 27, 2012. The draft report was reviewed and comments were submitted to your office on July 17, 2012.

On August 21, 2012, the final review was mailed. The review identified four separate areas of non-compliance with Federal regulations. In addition, two areas of vulnerability were identified in the review. Thank you for incorporating Maine's comments on the draft into your final review.

As a result of the findings, you are requiring Maine to submit a corrective action plan for each of the areas of non-compliance within 30 days of the date of the letter. Further, you have requested a plan and description of how the areas of vulnerability shall be addressed. You have instructed the State to include how it will ensure that the deficiencies will not occur again, timeframes for each correction, steps expected to occur, and an explanation if any of the corrections take more than 90 calendar days.

Please accept this letter and corrective action plan as our formal response to the final report as requested. Per your instructions, an electronic copy of the corrective action plan is being sent to Robb Miller, Director of Field Operations, at Robb.Miller@cms.hhs.gov .

Should you have any questions or concerns, please contact Herbert Downs at (207) 287-2778 or by email at Herb.F.Downs@maine.gov .

Sincerely,

Stefanie Nadeau
Director of MaineCare Services

cc: Herb Downs, Director of Audit
Beth Ketch, Office of MaineCare Services
Greg Nadeau, Program Integrity