Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Pennsylvania Comprehensive Program Integrity Review

Final Report

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Introduction

The Centers for Medicare and Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Pennsylvania Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Pennsylvania Department of Public Welfare (DPW). The MIG team also visited the office of the Medicaid Fraud Control Unit (MFCU), which in Pennsylvania is referred to as the Medicaid Fraud Control Section (MFCS).

This review focused on the activities of the DPW's Bureau of Program Integrity (BPI), which is responsible for Medicaid program integrity. This report describes four effective practices, three regulatory compliance issues, and five vulnerabilities in the State's program integrity operations.

The CMS is concerned that the review identified one partial repeat finding, one partial repeat and two repeat vulnerabilities from its 2008 review of Pennsylvania. The CMS plans on working 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 Pennsylvania improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Pennsylvania's Medicaid Program

The Office of Medical Assistance Programs (OMAP) within DPW administers the Pennsylvania Medicaid Program. As of January 1, 2011, the program served 2,084,087 beneficiaries, approximately 60 percent of whom were enrolled with a managed care entity (MCE) in HealthChoices, Pennsylvania's Medicaid managed care program. As of June 30, 2011, the State had enrolled 68,162 providers in the fee-for-service (FFS) program and had 71,512 managed care providers. The CMS expenditure reports indicate that Medicaid expenditures in Pennsylvania for the State fiscal year (SFY) ending on June 30, 2010 totaled $18,775,149,416.

Program Integrity Section

The BPI, within the Office of Administration, is the organizational component dedicated to the prevention and detection of provider fraud, abuse and overpayments. At the time of the review, BPI had approximately 79 full-time equivalent staff, including the bureau director, 2 division directors, 43 registered nurses, 7 data analysts and other State agency staff,

including clinicians, program specialists and administrative personnel. The table below presents the total number of investigations, sanctions, identified overpayments, and amounts recouped in the past four SFYs as a result of program integrity activities. These numbers only reflect the activities of BPI; global settlements are not included.

Table 1

SFY	Number of Preliminary & Full Investigations*	Number of State Administrative Actions or Sanctions (Approximation)	Amount of Overpayments Identified**	Amounts Recouped (includes past BPI settlement collections)
2008	2,849	2,025	$9,499,024	$17,692,280
2009	4,369	2,154	$10,403,401	$26,914,776
2010	5,471	1,885	$6,616,929	$28,334,176
2011	5,089	1,700	$11,094,673	$22,643,363

*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 was not able to distinguish between its preliminary cases and cases requiring full investigations.
**The State was unable to provide an explanation for the decrease in the amount of overpayments identified for SFY2010.

Methodology of the Review

In advance of an onsite visit, the review team requested Pennsylvania complete a comprehensive review guide and supply documentation in support of its answers to the review guide. The review guide included such areas as program integrity, provider enrollment/disclosures, 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 August 22, 2011, the MIG review team visited the DPW and MFCS offices. The team conducted interviews with numerous DPW officials, as well as with the MFCS director. To determine whether MCEs were complying with the contract provisions and other Federal regulations relating to program integrity, the MIG team reviewed the contract provisions and gathered information through interviews with representatives of four MCEs. 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 BPI, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, managed care oversight, and provider education. Pennsylvania's Children's Health Insurance Program operates under Title XXI of the Social Security Act and was, therefore, not included in this review.

Unless otherwise noted, DPW 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 DPW provided.

Results of the Review

Effective Practices

As part of its comprehensive review process, the CMS 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. Pennsylvania reported the State's enrollment of all qualified managed care network and FFS providers, use of multi-divisional teams for Medicaid process improvement and oversight, a web-based State exclusion list and expanded use of provider self-audits.

The State enrolls all managed care network providers and FFS providers

In Pennsylvania, all individuals, group practices, and all other qualified entities, such as clinics, nursing facilities and waiver agencies, must be licensed and registered or certified, or both, by the appropriate State agency to be enrolled as a Medical Assistance (MA) provider in the Pennsylvania Medicaid program. This requirement applies across the FFS and managed care delivery systems. The only exception to this policy applies to non-emergency medical transportation (NEMT) providers. Pennsylvania does not enroll staff who are employed and providing direct services by an enrolled waiver agency or vendors subcontracting to provide vendor services, such as home modifications or home delivered meals.

Provider enrollment in Pennsylvania is conducted by several Offices within the DPW. The Bureau for Fee-for-Service Programs (BFFSP) enrolls the majority of the various provider types. The Office of Long Term Living (OLTL) is responsible for the enrollment of nursing facilities, ICFs/MR, LIFE providers (nationally known as Program for the All-Inclusive Care for the Elderly), and specific home and community-based services waiver providers. The Office of Mental Health and Substance Abuse Services enrolls residential treatment facilities and certain other behavioral health providers.

The State has two types of provider enrollment applications. One is for group applicants and the other is for individual applicants. By requiring all providers to enroll centrally in the Medicaid program, the State is able to ensure that managed care network providers as well as FFS providers are subject to uniform enrollment criteria and standards. In particular, it allows the State to obtain common disclosures directly from all potential applicants.

Notwithstanding the value of a centralized enrollment process for FFS and managed care providers, the review team found some issues with the collection of disclosures

and the searches conducted for excluded and debarred parties in Pennsylvania. These are discussed later in the Findings and Vulnerabilities sections.

Use of multi-divisional teams for oversight of waiver services and the Medicaid claims processing system

The DPW has increased its oversight of waiver service providers and the Medicaid claims processing system through the use of multi-divisional teams which meet regularly. The Department's Medicaid program integrity unit is actively involved with these teams.

To increase oversight of waiver service providers, Pennsylvania's OLTL has been using Quality Management Efficiency Teams (QMETs) for over five years. The QMETs conduct quality and fiscal reviews of waiver services providers every two years and assess compliance and service delivery. The QMETs refer to BPI any issues of concern found during QMET reviews, such as aberrant patterns revealed through record reviews and interviews. Through their SFY 2009-2010 reviews, the QMETs discovered overpayments of $1,166,514 in either billing or documentation errors and are currently in the process of recovering that money. The BPI will be conducting its first joint review with the QMET team in the Pittsburgh area in late 2011 and, after evaluation, will determine if it will expand that effort. The BPI can also suggest to OLTL that expedited QMET reviews of specific providers be undertaken.

The DPW also uses cross-functional teams in conjunction with Medicaid claims processing. Claims Action Teams (CATs) were established in 2004 during the implementation of Pennsylvania's Medicaid Management Information System (MMIS). They have since expanded into 15 specific CATS covering all Medicaid service areas as well as prior authorization, cost reporting, managed care encounter data and capitation payments, provider enrollment, and third party liability. The use of CATs allows BPI and all other relevant DPW components to be informed of impending MMIS changes and to have an opportunity for input before changes are implemented.

State exclusion list on the DPW website

The BPI maintains a State exclusion list, known as Medi-check, which it refers to as a "preclusion" list. The BPI directs its providers to search its State exclusion list and provides real-time accessibility to that list on its website. This practice helps to restrict excluded providers from participation in Pennsylvania's MA program.

The State's internal Medi-check system contains the names and other identifying information on providers (individual or entities) who have been excluded from participating in its Medicaid program. Data entry into the internal database is restricted to two staff members in order to preserve its integrity. The Medi-check list on the DPW website is populated from this internal database. The internal database, which DPW staff can access, retains a historical record of all providers ever excluded from the State Medicaid program. While most exclusion periods are from one to five years, some providers are excluded for an indefinite period.

Expanded use of provider self-audits

Pennsylvania has been able to expand its audit recoveries using two well-developed provider self-audit programs. The first type of provider self-audit is initiated by BPI. Through the use of data mining, BPI staff identifies providers with billing patterns appearing to be out of compliance with its payment policies. The BPI notifies the provider of the issue and requests the performance of a voluntary self-audit. Both parties mutually agree to the claim sample, audit period, and methodology before the provider conducts the review. The BPI offers to provide computer-generated, statistically valid random samples of claims for the review and other background information, such as the period of the review, total number of claims, and total dollar amount comprising the universe. After providers conduct this type of self-audit, BPI validates it. Providers return identified overpayments and submit corrective action plans to BPI for review and approval.

For example, BPI initiated a self-audit project of the top 20 service locations billing for emergency supplies of medication which may have circumvented the normal prior authorization procedure for certain drugs. The BPI notified targeted providers that it intended to review selected claims for compliance with Medicaid regulations and offered the option of conducting a self-audit with BPI's subsequent validation of findings. At the time of the review, BPI had recovered $499,155 from this project.

The second type of provider self-audit in Pennsylvania consists of self-audits initiated by providers. Here, individual providers identify potential violations, perform audits of their own records, report their findings, submit corrective action plans, and return any inappropriate payments without penalty. This type of self-audit was established in 2001 when Pennsylvania issued a MA Provider Self-Audit Protocol, which was intended to facilitate resolution of potential violations of State administrative law, regulations or policies related to Medicaid or overpayments or errors that did not suggest violations of law. The protocol gives BPI the right to investigate information submitted by providers to determine if State criminal or Federal law may be violated and referral to a Federal or State agency is needed. The protocol is posted on the DPW website for public access.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to payment suspensions, required ownership and control 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; and 42 CFR § 455.23(d) requires that the

State Medicaid agency 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 CMS released an Informational Bulletin and Frequently Asked Questions to States on March 25, 2011. In addition, CMS has provided States numerous opportunities, including national teleconferences and sessions during two Medicaid Integrity Institute courses, to learn more about the payment suspension regulation since it became effective on March 25.

Although the State made 24 referrals to the MFCU since March 25, 2011, the program integrity director reported that the State did not suspend Medicaid payments in any of these cases and did not have a good cause exception not to suspend payment. Although a policy had been drafted to address this regulation, it had not been approved and was not in effect at the time of the review.

Recommendation: Implement the State's policy that addresses this regulation. When an investigation determines there is a credible allegation of fraud, suspend payments to providers or document a good cause exception not to suspend. Refer such cases to the MCFU and comply with the notification 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 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 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.

Pennsylvania's BFFSP uses two types of provider enrollment applications for all FFS and managed care providers. One form is used for individuals, the other for groups. In the CMS 2008 review, the team found that both forms did not have a place to list subcontractors in which the disclosing entity has a 5 percent or greater ownership. Therefore, subcontractor relationships with owners of the disclosing entity could not be determined. The 2011 team found that both forms had not been revised to address this issue. However, while the

individual provider application had been revised to come into compliance with the other requirements of the revised regulation at 42 CFR § 455.104, the group provider enrollment application was not fully updated. It did not solicit DOBs and enhanced address information on persons with ownership and control interests. Moreover, the group application did not collect any information on managing employees.

Additionally, the State does not collect all required disclosure information from the NEMT brokers. The NEMT providers are not enrolled in Pennsylvania's Medical Assistance Program. They are paid via grants to the 65 counties and by direct contracts with NEMT brokers in the counties of Philadelphia and Northumberland. As per the 2008 review, the grant agreements were updated to make collecting ownership and control disclosures part of the credentialing process for their subcontractors. However, although the counties and NEMT brokers captured some disclosure information, they did not capture DOB, SSN or enhanced address information for persons with ownership and control interests and managing employees.

Recommendations: Develop and implement policies and procedures for the appropriate collection of disclosures from disclosing entities and NEMT brokers regarding persons with an ownership or control interest, or who are managing employees of the disclosing entities or NEMT brokers. Modify disclosure forms as necessary to capture all disclosures required under 42 CFR § 455.104. While Pennsylvania has improved one of its enrollment applications in particular, the same recommendations made in the 2008 review report largely apply again.

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 the U.S. Department of Health and Human Services Office of Inspector General's List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System (EPLS) no less frequently than monthly.

Prior to implementation of this new regulation, 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.

Although DPW checks FFS and managed care network providers for exclusions and debarments on a monthly basis, no ongoing checks are performed on persons with an

ownership or controlling interest, agents and managing employees. The DPW has not set up a system to check all affiliated parties against the LEIE and EPLS monthly as required by this regulation.

Recommendations: Develop and implement 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 pursuant to 42 CFR § 455.436. Search the LEIE (or the Medicare Exclusion Database (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 five areas of vulnerability in Pennsylvania's Medicaid practices. These involved not verifying services with managed care enrollees, not capturing disclosures from NEMT network providers, not conducting complete searches for excluded or debarred individuals in the managed care and NEMT programs, and not maintaining adequate deactivation controls for sanctioned providers.

Not verifying with managed care and NEMT enrollees whether services billed were received. (Uncorrected Partial Repeat Vulnerability)

The regulation at 42 CFR § 455.20 requires the State Medicaid agency to have a method for verifying with beneficiaries whether services billed by providers were received.

Pennsylvania regularly sends explanations of medical benefits to 5 percent of its FFS beneficiaries. However, although the model MCE contract does require MCEs to perform service verifications, two of the four MCEs interviewed indicated that they perform no service verifications with managed care enrollees. The review team found a similar situation in the CMS 2008 review and it remains uncorrected. Additionally, in Pennsylvania's county-run NEMT program, there is no contract language requiring NEMT subcontractors to verify with NEMT beneficiaries whether services billed were received.

Recommendation: Develop and implement procedures to verify with MCE and NEMT enrollees whether services billed by providers were received, as required for FFS under 42 CFR § 455.20. The MIG made a similar recommendation in its 2008 review report.

Not capturing ownership and control disclosures from NEMT network providers. (Uncorrected Repeat Vulnerability)

Under 42 CFR § 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or MCE, must disclose to the State Medicaid agency the name, address, DOB, and 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 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 entity 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.

The provider enrollment and disclosure forms used in Pennsylvania's county-run NEMT program do not capture the SSN, DOB or enhanced address information that would otherwise be required of FFS Medicaid providers under 42 CFR § 455.104.

The commercial NEMT brokers used in Philadelphia and Northumberland also do not collect complete ownership and control disclosures from transportation providers. Although the commercial brokers' network provider enrollment forms do request information on persons with ownership and control interests, the provider enrollment forms do not capture the SSN, DOB or enhanced address information for individuals with 5 percent or more ownership as required under the revised 42 CFR § 455.104 regulation. Additionally, the provider enrollment forms do not capture the SSN, DOB or enhanced address information for any managing employee. This issue was identified as a finding in the 2008 CMS review and remains uncorrected.

Recommendations: Modify NEMT network provider contracts, or ensure that NEMT network provider enrollment forms require the disclosure of complete ownership, control, and relationship information from all NEMT network providers pursuant to 42 CFR § 455.104. Include contract language requiring NEMT providers to notify the brokers and/or the State of such disclosures on a timely basis. The MIG's 2008 review report recommended requiring NEMT providers to supply the full required disclosures.

Not adequately addressing business transaction disclosures in NEMT commercial network provider contracts. (Uncorrected Repeat Vulnerability)

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 information about certain business transactions with wholly owned suppliers or any subcontractors.

The network provider contract used by the NEMT commercial brokers does not require network providers to supply, upon request, the business transaction information that would otherwise be required from FFS providers under 42 CFR § 455.105(b)(2). This issue was identified as a finding in the 2008 CMS review and remains uncorrected.

Recommendation: Modify the NEMT commercial network provider contract to require disclosure upon request of the information identified in 42 CFR § 455.105(b). The same recommendation was made in the 2008 review report.

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 LEIE or the MED.

The CMS issued 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.

All providers, including those providing services through managed care plans, are enrolled with the State Medicaid agency. The State Medicaid agency, however, has not demonstrated that exclusion searches have been completed on all providers and persons associated with providers, nor that the responsibility for conducting exclusion searches of network providers and persons associated with providers has been addressed through managed care contracts.

Pennsylvania's MCEs do not conduct exclusion searches that are fully consistent with this guidance. One MCE does not check the managing employees on a monthly basis. A second MCE does not check either agents or managing employees on a monthly basis, while another MCE does not conduct exclusion searches through the EPLS.

In addition, the county-run NEMT program only checks network providers and persons with ownership and control interests for exclusions, not agents and managing employees. The counties only perform these checks on an annual basis. The State's commercial NEMT brokers only check the LEIE upon initial enrollment and annually thereafter. Moreover, the State agency could not substantiate whether or not the commercial brokers check all providers, owners, agents or managing employees on the EPLS.

Recommendations: Amend the MCE and NEMT contracts to require the 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. If the State does not undertake this directly, require all contractors to search the LEIE and the EPLS upon enrollment, reenrollment, credentialing or recredentialing of network providers, 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 pursuant to 42 CFR § 455.436.

Not maintaining adequate controls to deactivate sanctioned providers in the MMIS. The MIG team's review of a fraud case, as part of an onsite sample, identified a disconnect between actions taken internally in DPW to terminate a provider and that provider's suspension from payment in the MMIS. This was illustrated by a case involving the DPW organizational component that oversees Pennsylvania's Home and Community-Based Services waiver programs. In 2009, DPW learned that a provider had falsified information on her application while enrolling in Medicaid as a waiver provider four years earlier. The provider had concealed a health care-related criminal conviction. The provider was terminated from the waiver program shortly after this became known in 2009. However, the termination action was not communicated effectively to the component overseeing the MMIS. Although the provider had not submitted any bills since 2009, at the time of the MIG review in August 2011, the terminated provider was still found to be in active billing status. The inability of DPW to promptly deactivate or remove a terminated provider in Pennsylvania's MMIS system potentially allows a terminated provider to submit claims and continue receiving payments from the Medicaid program.

Recommendation: Modify DPW program integrity-related policies and procedures to ensure efficient communication of provider terminations among the various components overseeing the Medicaid services and the components who oversee the MMIS to deactivate sanctioned providers in a timely manner.

Conclusion

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

- the State's enrollment of all licensed FFS and managed care providers,
- use of multi-divisional teams for process improvement and oversight,
- use of a web-based State exclusion list, and
- enhanced use of provider self-audits.

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

The identification of three 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 is particularly concerned over the four repeat findings and vulnerabilities. The CMS expects Pennsylvania to closely examine the vulnerabilities that were identified in this review and correct them as soon as possible.

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

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

JUN 21 2012

Mr. Robb Miller, Director
Division of Field Operations
Medicaid Integrity Group
Centers for Medicare and Medicaid Services
1124 Rickard Road, Suite A
Springfield, Illinois 62704

Dear Mr. Miller:

On behalf of the Pennsylvania Department of Public Welfare's (DPW) Bureau of Program Integrity (BPI), thank you for the opportunity you provided through your review process in identifying areas we can strengthen to enhance our program integrity efforts. Additionally, we appreciate that you took the time to note several effective practices Pennsylvania employs.

Following is our response to the May 2012 Final Report from the Comprehensive Program Integrity Review conducted by the Centers for Medicare and Medicaid Services' (CMS) Medicaid Integrity Group (MIG). Our response will address both the Regulatory Compliance Issues as well as the Vulnerabilities identified in the report.

A. REGULATORY COMPLIANCE ISSUES

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

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

Response: The State has developed and implemented the attached Medicaid Payment Suspension Policy and Procedure that reflects the requirements for payment suspension per 42 CFR § 455.23 and additional CMS' guidance. Since implementation of this Policy and Procedure, all referrals for suspected provider fraud dating back to March 25, 2011, the effective date of this regulation, were reviewed for applicability of payment suspension. For

pending cases, the Medicaid Fraud Control Section sought law enforcement exceptions, and on this basis, we determined good cause existed not to suspend payments. On an ongoing basis, each instance of suspected provider fraud is reviewed and payment suspension is implemented if there is a credible allegation of fraud and no good cause exception applies. The Payment Suspension Policy and Procedure applies to credible allegations of fraud by a provider, not other individuals, such as personal assistance service workers who are not enrolled Medicaid providers, but may be involved in the delivery of Medical Assistance (MA) Program services.

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

Recommendation: Develop and implement policies and procedures for the appropriate collection of disclosures from disclosing entities and NEMT brokers regarding persons with an ownership or control interest, or who are managing employees of the disclosing entities or NEMT brokers. Modify disclosure forms ad necessary to capture all disclosures required under 42 CFR § 455.104. While Pennsylvania has improved one of its enrollment applications in particular, the same recommendations made in the 2008 review report largely apply again.

Response: **Provider Enrollment Corrective Action:** The State was in the process of finalizing the required new Ownership and Controlling Interest Form for the remaining group provider applications during the CMS MIG comprehensive Program Integrity review the week of August 22, 2011. The disclosures were already in the individual provider application. A copy of the final group form was provided during the review.

The group form (as an addendum), had been revised to include the date of birth (DOB) and enhanced address information was posted to the DPW's website on November 23, 2011, and can be found at:
http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/form/p_011861.pdf.

The group application can be found at:
http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/form/s_002840.pdf.

The revision also included the language from the Affordable Care Act (ACA) Provider Enrollment and Screening Provisions (42 CFR § 455). The State did inform the CMS MIG team that the disclosures were not presented in the same addendum for individual applications because individuals and owners are the same entity in this relationship, and the duplicative collection of this information was not necessary. However, provider disclosure statements were further updated to clarify the information needed on April 12, 2012 and are included in the individual application, which can be viewed on pages 16-18 of the application found at:
http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/form/s_002225.pdf.

Prior to posting the forms to the DPW's website, the DPW enrollment staff requested the disclosure information for newly enrolled providers manually, but did not have a way of entering disclosure information into the MMIS; however, the provider was entered into the MMIS and was, and continues to be, screened monthly against the List of Excluded Individuals/Entities (LEIE) through the Medicare Exclusion Database (MED file).

Data entry windows for recording ownership and controlling interest information in the MMIS were implemented in March 2012, and the next system changes to be scheduled relate to the monthly file checks which will finalize the requirements of this aspect of the provisions. Monthly file checks for disclosed information are expected to be implemented in the next State Fiscal Year (SFY), 2012-2013, as soon as funds are available for system changes.

It should be noted that monthly screening against the Excluded Parties List System (EPLS) cannot be conducted, nor system requirements defined, until the federal file contains the necessary identifiers (SSN, FEIN, or NPI) to complete a match for MA providers. Since this can only be researched on a per provider basis for complete verification at this time, SSN can be searched via lookup upon enrollment only.

Response: **NEMT Program Corrective Action:** The NEMT providers are not enrolled in Pennsylvania's MA Program. As a result of the 2008 MIG review, the grant agreements were updated to require the collection of ownership and control disclosures as part of the credentialing process for their subcontractors. However, although the counties and NEMT brokers captured some disclosure information, they did not capture DOB, SSN, or enhanced address information for persons with ownership and control interests and managing employees.

To address this regulatory compliance finding, the DPW's NEMT program will reemphasize to their NEMT grantees the need to ensure that their network enrollment forms require, and have, the disclosure of complete ownership control, and relationship information from all NEMT network providers pursuant to 42 CFR § 455.104.

The NEMT program is in the process of modifying disclosure forms to capture DOB, SSN, and enhanced address information on persons with ownership and controlling interests and managing employees; and has begun making the necessary changes to policies and to grant agreements to reflect the requirements, and to require that grantees notify the DPW in a timely manner on such disclosures.

The revised agreements will be sent to grantees for signature by July 1, 2012, the start of the DPW's new State Fiscal Year (SFY). The DPW will ensure that the disclosure information was collected through on-site performance reviews, and desk audits conducted by the NEMT program.

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

Recommendations: Develop and implement 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 pursuant to 42 CFR § 455.436. Search the LEIE (or the Medicare Exclusion Database (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.

Response: **Provider Enrollment Corrective Action**: While the provider enrollment operational changes to collect all relevant disclosure information are completed as described in regulatory compliance finding #2 above, system changes, testing, and implementation as outlined in regulatory compliance finding #2 above. Systems requirements are currently being refined to automate as many of the required searches as are currently possible. Upon implementation, all current SSNs and FEINs already entered in the MMIS Ownership and Controlling Interest fields will be screened for all records already in existence in the system, all records on enrollment, and all records every month thereafter.

Response: **NEMT Program Corrective Action**: The NEMT providers are not enrolled in Pennsylvania's MA Program. They are paid by direct contracts with NEMT brokers in the counties of Philadelphia and Northumberland and via grants in the other 65 counties. To address this finding, the DPW's NEMT program will modify its grantee agreements and policies to require searches of the LEIE and the EPLS at least monthly, to ensure that the state does not pay federal funds to excluded persons or entities pursuant to 42 CFR 455.436; and in June, 2012, will create, and distribute to grantees, a form to track these searches. The DPW will ensure that grantees are conducting and following up on their searches through on-site performance reviews, and desk audits conducted by the NEMT program.

B. VULNERABILITIES

1. Not verifying with managed care and NEMT enrollees whether services billed were received. (Uncorrected Partial Repeat Vulnerability).

Recommendation: Develop and implement procedures to verify with MCE and NEMT enrollees whether services billed by providers were received, as required for FFS under 42 CFR § 455.20. The MIG made a similar recommendation in its 2008 review report.

Response: **Managed Care Entity Enrollees' Verifications Corrective Action**:
The DPW's Office of Mental Health and Substance Abuse Services' (OMHSAS) HealthChoices managed care organization behavioral health (BH MCO) contracts, and the DPW's Bureau of Managed Care Operations' (BMCO) HealthChoices physical health (PH MCO) contracts were modified as a result of the 2008 Comprehensive Program Integrity Review conducted by the CMS MIG and, at the time of the 2011 review, did include the recipient verification requirements outlined in 42 CFR 455.20. To address this vulnerability and further emphasize the BH MCO and PH MCO contractual requirements, the DPW has taken the following corrective actions:

BH MCOs: Although this vulnerability did not apply to the two BH MCOs interviewed during the 2011 review, in the past year, each BH MCO was required to submit all of their policy and procedures related to fraud, waste and abuse including those related to verifying that services billed were received. A cross program office committee that included staff from the DPW's Bureau of Program Integrity (BPI) and the OMHSAS completed a joint review of all BH MCO policies and procedures. Three have received final approval and two are still in process, awaiting submission of corrections. Additionally, Appendix F in the BH MCO contract is being reviewed to develop stronger language and provide additional clarification of expectations to incorporate in the next contracting cycle.

PH MCOs: The HealthChoices PH MCO contracts were modified for 2009-2010 to include the requirements outlined in 42 CFR 455.20. The following language was added to the Fraud and Abuse section of the contract: "…The policies and procedures must contain the following, "A description of the methodology and standard operating procedures used to identify and investigate Fraud and Abuse, ***including a method for verifying with recipients whether services billed by providers were received,*** and to recover overpayments or otherwise sanction Providers." In addition, a requirement was added to the member handbook section which requires that the member handbook include language on ***Rights of members to receive information regarding cost of care.***

As a follow up to the contract additions, an Operations Memorandum dated March 14, 2012 (attached) was issued to all PH MCOs restating the requirements, clarifying the federal regulatory requirements, and emphasizing that although language had been added to the MCO contracts, not all PH MCOs were implementing sufficient steps to satisfy CMS and the DPW that they are proactively and sufficiently verifying with recipients that services billed were received as billed. The Operations Memorandum also indentified next steps which included submission of certain deliverables, including:

- Methodology and specific policy and procedures used to verify that services billed by a provider were received by the recipient.

- Recovery process/methodology for provider overpayments/sanctions; and

- Description of how recipient verification of services information is used in the MCO's overall plan for the detection of fraud/waste/abuse, including the recoupment of monies for non-legitimate claims.

A review of the PH MCO deliverables that were submitted is currently being conducted to identify whether they have implemented sufficient steps to come into compliance with the requirements. This review is to be completed by June 15, 2012. Meetings will be held with each PH MCO (as appropriate) to discuss the specific deficiencies and identify what corrective action is necessary to ensure their future compliance. These meetings are to be completed by July 15, 2012.

The DPW will conduct follow-up monitoring activities on an on-going basis to validate that any necessary corrective action has been implemented. Identification of occurrences where PH MCOs are not in compliance with these requirements will result in the requirement of corrective action plans or application of sanctions.

In addition to the requirements being added to the HealthChoices PH MCO contracts, the standards were also incorporated into the DPW's electronic monitoring system (SMART) to ensure that the core teams are monitoring the new requirements on a regular basis.

Additionally, the DPW has entered into an agreement with Mercer Consulting for assistance to evaluate and validate the PH MCOs' efforts in effectively preventing and detecting fraud/waste/abuse. This project is intended to build on the program integrity performance assessments conducted in March 2009, and is composed of three phases:

1. Generation of a set of key performance indicators (KPIs) and rate setting,

2. Identification of scoring criteria to support a periodic review process that is part of a building block approach, and

3. Desk reviews/on-site verification

One of the KPI areas is Member Verification and it includes specific indicators for use of EOBs, response rates, follow up activities, SIU cases opened, and referrals made as a result of this process. A linkage between targeted EOBs and post payment detection has also been incorporated into the KPIs.

In addition to the steps and processes outlined above, the BPI reiterated this requirement to the PH MCOs and the BH MCOs at the annual DPW/BPI-sponsored MCO Provider Compliance Meeting to be held with all HealthChoices' MCOs on June 19, 2012.

Response: **NEMT Enrollees' Verifications Corrective Action:** DPW will modify the 2012-2013 NEMT grant agreement in June 2012 to include the requirements outlined in 42 CFR 455.20 (effective July 2012). The language will outline the methods used to verify with recipients whether services billed by providers were received and to recover overpayments, or otherwise sanction providers. The agreements will be distributed to grantees for signature in July 2012 (the start of DPW's new SFY).

All grantees already require that all MA recipients receiving transportation via para-transit to sign and date a manifest/log indicating that they were picked-up to go a medical appointment. Verifications will be done on those signatures by the grantees and, in addition, DPW's NEMT program staff will perform periodic validations and verifications of trip data to ensure that recipients did receive a service.

In addition, DPW's NEMT Philadelphia contractor has the following procedures in place to guard against fraudulent billing for trips that never took place:

- Monthly reviews of all reserved subscription trips and confirmation with facilities that recipients were in attendance.

- Verification of every completed para-transit trip by recipient signature through signature verification software which can confirm that the recipient's signature on the trip log matches a previously collected signature.

2. Not capturing ownership and control disclosures from NEMT network providers. (Uncorrected Repeat Vulnerability)

Recommendations: Modify NEMT network provider contracts, or ensure that NEMT network provider enrollment forms require the disclosure of complete ownership, control, and relationship information from all NEMT network providers pursuant to 42 CFR § 455.104. Include contract language requiring NEMT providers to notify the brokers and/or the State of such disclosures on a timely basis. The MIG's 2008 review report recommended requiring NEMT providers to supply the full required disclosures.

Response: The DPW will reemphasize to our NEMT grantees the need to ensure that their network enrollment forms have, and require the disclosure of, complete ownership, control, and relationship information from all NEMT network providers pursuant to 42 CFR § 455.104. We will modify our grant agreements and policies to ensure that our grantees notify the state on such disclosures in a timely manner. The modifications to the grantee agreements will be completed by June 2012 to be distributed to grantees for signature July, 2012 (start of the new SFY). DPW will do onsite performance reviews and desk audits to ensure that network enrollment forms have the required information.

3. Not adequately addressing business transaction disclosures in NEMT commercial network provider contracts. (Uncorrected Repeat Vulnerability)

Recommendations: Modify the NEMT commercial network provider contract to require disclosure upon request of the information identified in 42 CFR § 455.105(b). The same recommendation was made in the 2008 review report.

Response: The DPW's NEMT program will ensure that sub-contractual agreements are modified to require disclosures upon request of the information identified in the provision and, in June 2012, will send notices to commercial brokers of the need to modify the subcontracts to reflect required changes. DPW NEMT program staff will conduct on-site performance reviews and desk audits to ensure that subcontracts have the required information and verify that amendments were made in July 2012.

4. Not conducting complete searches for individuals and entities excluded from participating in Medicaid.

Recommendations: Amend the MCE and NEMT contracts to require the 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 exercise operational or managerial control over the disclosing entity. If the State does not undertake this directly, require all contractors to search the LEIE and the EPLS upon enrollment, reenrollment, credentialing or recredentialing of network providers, 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 pursuant to 42 CFR § 455.436.

Response: Provider Enrollment Corrective Action: The State enrolls all providers, including those providing services through managed care plans, and as described in our responses to regulatory compliance findings #2 and #3 above, directly collects disclosure information; and will conduct screening of network providers and disclosed persons and entities against the LEIE upon enrollment, reenrollment, and monthly thereafter; therefore, the managed care plans would not be required to collect and maintain disclosure information. As described in regulatory compliance findings #2 and #3 above, while the provider enrollment operational changes to collect all relevant disclosure information are completed, system changes, testing and implementation to automate screening and tracking the disclosure information are partially implemented.

Systems requirements are currently being refined to automate as many of the required searches as are currently possible. Upon implementation, all current SSNs and FEINs already entered in the MMIS Ownership and Controlling Interest fields will be screened

for all records already in existence in the system, all records on enrollment, reenrollment, and all records every month thereafter.

Response: ***NEMT Program Corrective Action:*** NEMT providers are not enrolled in Pennsylvania's MA Program; therefore, disclosure information is not collected or screened against the LEIE or EPLS by the State. As described in the NEMT corrective action responses to regulation compliance findings #2 and #3 above, the DPW's NEMT program will ensure that their NEMT application forms require the required disclosures from all NEMT network providers.

Additionally, the DPW's NEMT program will modify its agreements and policies to require searches of the LEIE and the EPLS monthly to ensure that the State does not pay federal funds for services provided by excluded persons or entities pursuant to 42 CFR 455.436.

The DPW's NEMT program will create a form and send it to grantees in June 2012 for grantees to track their monthly searches for excluded providers and individuals and will conduct on-site performance reviews and desk audits to ensure that grantees are conducting the screening searches.

Additional Information: As per SMDL (#09-001) dated January 16, 2009, the DPW issued Medical Assistance Bulletin 99-11-05 to all providers instructing them to screen their own employees and subcontractors for excluded parties, including owners, agents, and managing employees (attached).

5. ***Not maintaining adequate controls to deactivate sanctioned providers in the MMIS.***

Recommendation: Modify DPW program integrity-related policies and procedures to ensure efficient communication of provider terminations among the various components overseeing the Medicaid services and the components who oversee the MMIS to deactivate sanctioned providers in a timely manner.

Response: This finding was based on a case involving an Office of Long Term Living (OLTL) Home and Community-Based Services waiver program. OLTL terminated a provider from the waiver program; however, the termination action was not communicated to the component overseeing the MMIS. To address this vulnerability, the OLTL will develop procedures to notify the Bureau of Program Integrity (BPI) of providers that the OLTL has dis-enrolled, terminated, or sanctioned so that appropriate steps can be taken to deactivate the provider in PROMISe™ (MMIS). Additionally, the OLTL will notify the BPI when any adverse information is discovered during the enrollment process, including when an applicant

indicates “yes” on their enrollment application as receiving a disciplinary action.

Thank you and your staff for sharing this valuable information with us so that we can strengthen our program. If you have any questions regarding this response, please do not hesitate to contact Ms. Laurie Rock, Director of the Bureau of Program Integrity, at (717) 772-4610 or lrock@pa.gov.

Sincerely,

Vincent D. Gordon
Deputy Secretary

Attachments