Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

West Virginia Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the West Virginia Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Bureau for Medical Services (BMS), which is the State Medicaid agency. The MIG also visited the offices of the Medicaid Fraud Control Unit (MFCU) and the Medicaid fiscal agent.

This review focused on the activities of BMS' Office of Quality and Program Integrity (OQPI). The OQPI is responsible for Medicaid program integrity activities. This report describes two effective practices, four regulatory compliance issues, and nine 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 West Virginia improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of West Virginia's Medicaid Program

The BMS administers the West Virginia Medicaid program. As of January 2009, the program served 311,917 beneficiaries. West Virginia has enrolled 162,284 of these beneficiaries in its managed care organizations (MCOs), and 20,000 are enrolled in the Physicians Assured Access System which is a primary care case management program. The BMS had approximately 23,000 participating Medicaid providers at the time of the review, and 11,848 providers were affiliated with West Virginia's MCOs. Medicaid expenditures for the State fiscal year (SFY) ending June 30, 2008 totaled $1,964,907,600. During Federal fiscal year 2008, the Federal medical assistance percentage for West Virginia was 74.25 percent.

Program Integrity Division

The OQPI, within the Administrative Services section of BMS, is the organizational component dedicated to fraud and abuse activities. At the time of our review, OQPI had five full-time equivalent employees (FTEs) focusing on Medicaid program integrity. This represents a significant drop since 2002 when there were 17 State employees performing program integrity or surveillance and utilization review (SUR) activities. During SFYs 2005 and 2006, OQPI recovered an average of $14,000,000 annually in Medicaid funds. In SFY 2007, it recovered $888,000, and in SFY 2008 approximately $5,000,000.

Methodology of the Review

In advance of the onsite visit, the review team requested that West Virginia complete a comprehensive review guide and supply documentation in support of its answers. The review

guide included such areas as program integrity, provider enrollment/disclosures, managed care, and the MFCU. A four-person team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of April 20, 2009, the MIG review team visited the BMS, MFCU and fiscal agent offices. The team conducted interviews with numerous BMS officials, as well as with staff from the State's provider enrollment contractor and the MFCU. In order to determine whether managed care plans were complying with the contract provisions and Federal regulations relating to program integrity, the MIG team reviewed the State's MCO contracts. The team conducted in-depth interviews with three MCOs and met with State staff to discuss managed care oversight and monitoring efforts. 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 OQPI, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment and overpayment collection. West Virginia'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, BMS 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 BMS provided.

RESULTS OF THE REVIEW

Effective Practices

The State of West Virginia has highlighted two practices that demonstrate its commitment to program integrity. These are the involvement of OQPI in larger Medicaid agency meetings to discuss systems issues and the use of additional State staff to conduct certain types of provider reviews.

Active involvement in BMS meetings to review system edits

In 2003, BMS reorganized as part of an effort to break down silos hindering communication among various departments. Since the reorganization, program managers in the various areas meet regularly to discuss coverage and payment policy, system edits, and other issues. The discussions help ensure that West Virginia's Medicaid Management Information System (MMIS) claims processing policies are consistent with the full range of State Medicaid program policies. The OQPI staff began participating actively in these meetings in 2008. The OQPI indicated during interviews that the meetings have been very beneficial in alerting the office when other program areas make policy changes or update MMIS edits that may have program integrity implications. The meetings also offer OQPI an opportunity to propose new or modified edits that may be helpful in limiting fraud, abuse, and waste.

Use of additional State staff to conduct provider reviews in waiver programs
Bureau of Behavioral Health employees who work in the State's Mentally Retarded/Developmentally Disabled and Aged and Disabled waiver programs conduct reviews of waiver providers and report fraud and abuse findings and overpayment information to BMS. The reviews have helped to maintain a level of provider monitoring and oversight at a time when OQPI is short-staffed. The OQPI collects and monitors overpayments discovered by these reviews.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations regarding disclosures and reporting and notification requirements.

The State does not capture all required ownership, control, and relationship information from fee-for-service (FFS) providers, the fiscal agent, and contracting MCOs
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.

West Virginia's provider enrollment form does not solicit the addresses of persons with ownership and control interests in the provider entity or in subcontractors; nor does the State collect this information from the fiscal agent. In addition, the State agency did not provide evidence that it collected MCO ownership, relationship, or subcontractor disclosures at the time of contracting, or that it requested periodic updates, although the State's Uniform Managed Care Contract obligates MCOs to complete CMS forms designed to capture this information.

Recommendations: Modify all provider enrollment applications to capture the required ownership, control, and relationship information. Develop and implement policies and procedures to obtain the necessary disclosures from all providers, fiscal agents and MCOs.

West Virginia does not notify the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) of disclosures regarding health care-related criminal convictions in its FFS operations.

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.

While BMS solicits the required health care-related criminal conviction disclosures from FFS providers, it does not notify HHS-OIG of disclosures regarding criminal convictions within 20 working days. The State indicated to the review team that it relies upon the MFCU to do such reporting, even though this is not addressed in the State's Memorandum of Understanding (MOU) with the MFCU, and it was not clear how the MFCU could receive information on disclosures issued during the Medicaid provider enrollment process.

Recommendation: Develop and implement a procedure to report criminal conviction information to HHS-OIG within 20 working days.

The State does not report to HHS-OIG adverse actions taken on provider applications.

The regulation at 42 CFR § 1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. The BMS indicated to the review team that it never had to meet this requirement because it has never denied enrollment to a FFS provider. However, BMS affirmed that when terminating a FFS provider agreement, it does not notify the HHS-OIG, which is also required. The State indicated to the review team that it reports such terminations to the MFCU instead.

Recommendation: Develop and implement procedures to report to HHS-OIG all adverse actions taken against and limits placed on providers applying to participate in the program.

West Virginia does not notify all required parties when there is a State-initiated exclusion.

The regulation at 42 CFR § 1002.212 stipulates that when a State initiates an exclusion, it must provide notification to the other State agencies, the State medical licensing board, the public, beneficiaries, and others as provided in §§ 1001.2005 and 1001.2006. Chapter 800.5.1 of BMS' policies and procedures manual does not stipulate the notification of any parties of mandatory or permissive exclusions. Staff indicated in interviews that while they notify the MFCU of permissive exclusions, they do not notify the appropriate State licensing board or any other parties.

***Recommendation*:** Develop and implement policies and procedures to notify the individual/entity, State agencies, licensing boards, the general public and others when BMS initiates exclusion.

Vulnerabilities

The review team identified nine areas of vulnerability in West Virginia's practices. These involved limited SUR operations, coordination with the MFCU, managed care oversight, collection and reporting of information on MCO disclosures and adverse actions, and verification of services provided to MCO enrollees.

Less than effective SUR operation.

The regulation at 42 CFR § 455.13 requires a State Medicaid agency to have methods and criteria for identifying suspected fraud cases and investigating those cases. It also requires agencies to have procedures for referring suspected cases of fraud to law enforcement officials.

At the time of the 2002 CMS review of the State's program integrity functions, the SUR director reported to the BMS Commissioner and supervised a staff of 17 FTEs. The SUR Office contained active Data Analysis and Utilization Review Sections which developed cases and made a variety of referrals to the MFCU, certification agencies, licensing boards and other State agencies as appropriate. It also undertook the recovery of overpayments through substantial numbers of administrative actions.

In contrast, OQPI currently has only five full-time positions assigned to program integrity functions, and the program integrity director position has been vacant since October 2008. As the number of in-house program integrity positions declined, the State was able to continue some effective SUR and recovery activities through contractors, in particular through a data mining contract signed in September 2001. This contract, however, was terminated in October 2008 and since then, the State has not hired a replacement contractor or developed an alternate mechanism to carry on the equivalent functions. As roughly 40 percent of West Virginia's total overpayment recoveries had previously occurred through contractor activities, this has resulted in a significant decline in recoupments. While West Virginia still was able to recover an average of $2,900,000 per year during SFYs 2007 and 2008, in the first half of SFY 2009 (through March 2009), State-reported recoveries were down to $245,552.

Even allowing for the lag time that is often seen in recoupments, the loss of data analysis capacity and expertise is concerning. The State's decreased commitment to its SUR Unit has negatively affected the MFCU's ability to obtain information necessary for investigations. The MFCU director indicated that the State's current SUR capabilities do not yet match the former contractor's data retrieval proficiency. In general, the loss of the contractor-supported decision support system, in-house audit staff and a permanent program integrity director have all contributed to a less effective SUR operation.

Recommendations: Increase the State's commitment to its SUR operation. Develop and implement policies and procedures to effectively recover payments through in-house staff and/or effective contractors.

Ineffective communication and coordination with the MFCU.

The regulation at 42 CFR § 455.21 requires States to cooperate with the State MFCU in referring

suspected fraud cases and providing open access to case information. While the State-MFCU relationship in West Virginia was satisfactory in past years, communication and coordination between the two entities appear to have deteriorated with the gradual loss of SUR staff, followed by the resignation of the program integrity director in October 2008. The deputy commissioner, who currently also serves as the acting program integrity director, has not maintained regular contact with the MFCU.

In general, there have been a limited number of referrals to the MFCU. Although OQPI made eight referrals in SFY 2008, it made five in 2007, none in 2006 and one in 2005. In addition, there are no regularly scheduled meetings between OQPI and the MFCU, and there are irregularities and inconsistencies in the tracking of referrals. The OQPI reports that in instances where it has made referrals to the MFCU, the MFCU does not always provide case status reports. The MOU between OQPI and the MFCU, instituted on August 1, 2005, does not describe the expectations of each unit. For example, the document does not include timeframes, status reports, and performance standards for referrals, even though both the State and the MFCU have clear expectations in these areas.

Recommendations: Establish more effective communication with the MFCU. Work with the MFCU to renegotiate an MOU that specifically addresses the performance expectations of both parties. As a starting point, the State should reference the September 2008 CMS/MIG publication entitled "Best Practices for Medicaid Integrity Units' Interaction with Medicaid Fraud Control Units." The document provides guidance on establishing cooperative relationships between State Program Integrity Units and MFCUs and contains specific examples of actions taken by States that have created well-functioning and committed partnerships.

Inadequate oversight of managed care program integrity activity.
The State's Uniform Managed Care contract requires that MCOs report suspected cases of fraud and abuse to the State agency within 30 days of detection. Based on interviews with MCO staff, West Virginia's MCOs show a wide divergence in program integrity activity, although all have Special Investigative Units and strategies intended to detect fraud and abuse. In the last 4 SFYs, one MCO reported 24 cases, while a second reported 2, and a third reported none. The fact that little has been done by BMS to stimulate increased reporting and activity is symptomatic of a general lack of program integrity oversight of the managed care sector.

The BMS is not apprised of ongoing MCO investigations. Nor is the State fully apprised of cases as they occur. In addition, BMS does not actively review whether MCO providers who are under plan scrutiny are also causing problems in the FFS program.

Moreover, the State does not provide or sponsor training, conferences or periodic meetings with the MCOs, either individually or as a group. Although one MCO developed an extensive disclosure form to obtain ownership, managing employee and subcontractor disclosures from all of its providers in direct response to the CMS State Medicaid Director Letter of June 12, 2008, the State failed to take advantage of MCO initiatives in advancing policy in this area and has not required the other MCOs to follow this example. Overall, the limited State oversight of MCOs

reduces the opportunity for BMS to collaborate with its health plans in preventing and identifying fraud and abuse.

Recommendations: Develop and implement policies and procedures for organizing periodic meetings with MCOs, requiring MCOs to report fraud, waste and abuse cases, and proactively reviewing such reports. Develop and implement policies and procedures for incorporating existing MCO noteworthy practices into future contracts.

Not capturing ownership, relationship and control information in the managed care credentialing process.

Two of the State's three MCOs do not collect ownership, relationship and control information to ensure that providers are not working in operations owned or controlled by excluded individuals. Likewise, the MCOs do not routinely report ownership disclosures to the State. There was no language in the MCO contract requiring the collection and reporting of such information. The MCOs stated during interviews that they check providers on a monthly basis against the Federal exclusion and/or debarment lists and also check for criminal history at the point of credentialing and recredentialing (every three years). However, they do not also check individuals with ownership and control interests and do not have clear guidance from the State on doing so. This leaves the State unable to determine if the owners of MCO network providers may be excluded individuals.

Recommendations: Develop MCO contract provisions mandating the appropriate collection, review, and reporting of ownership information. Require MCOs to conduct exclusion searches of persons with ownership and control interests in their network providers using the HHS-OIG's List of Excluded Individuals/Entities or CMS' Medicare Exclusion Database at the time of enrollment, reenrollment, and at least monthly thereafter. Please refer to CMS' June 12, 2008 (#08-003) and January 16, 2009 (#09-001) State Medicaid Director letters on disclosure requirements and exclusion searches, which can be found on the CMS website.

Not requiring MCO network provider agreements to meet existing FFS business transaction disclosure requirements.

In accordance with 42 CFR § 455.105(b)(2), all Medicaid FFS provider agreements must contain language requiring providers, upon request, to 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. West Virginia's managed care contracts do not stipulate that MCOs require the same of their providers. The review team studied three sets of provider agreements (for distinct provider types) used by the MCOs and noted that these contained no reference to the business transaction disclosure requirements.

Recommendation: Modify MCO provider agreements to require disclosure upon request of the same business transaction information required of Medicaid FFS providers.

Not collecting and reporting health care-related criminal conviction disclosures.
Two of the three MCOs do not collect ownership and managing employee disclosures to ensure that providers do not have relationships with individuals or entities that have been convicted of health care-related criminal offenses consistent with 42 CFR § 455.106(a). The State Department of Insurance mandates that MCOs use the West Virginia Uniform Credentialing Application, which requires only providers to answer a series of questions about whether they have been investigated, sanctioned or convicted of a criminal charge, had fraud charges brought against them or have been the subject of an adverse action. The State agency does not have clear policies and procedures directing the MCOs to collect health care-related criminal conviction information on persons with ownership and control interests and managing employees.

Likewise, the MCOs do not routinely report health care-related criminal convictions, when disclosed, to the State agency or to the HHS-OIG following 42 CFR § 455.106(b)(1). The review team was unable to find language in the MCO contract requiring such reporting; and the MCOs stated during interviews that they have received no instructions on reporting from the State.

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

Not capturing complete managing employee information on managed care credentialing forms.
Under 42 CFR § 455.101, a managing employee is defined as "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency." West Virginia's MCOs, with the exception of one contractor, are not capturing complete managing employee information. The MCOs, as required by the State Department of Insurance, use the West Virginia Uniform Credentialing Application, applicable to physician and allied health professional practices. This form captures the name of office managers and nurse managers only. It is also not clear that managing employee information is collected from all network providers or health care entities. Without collecting information on the full range of managing employees, neither MCOs nor the State have a way of knowing if excluded individuals are working in such positions as billing managers and department heads in all network providers.

Recommendations: Modify managed care credentialing packages and applications to require information on the full range of managing employees. Maintain such information in a database where it can be used to search for exclusions at the point of initial enrollment and periodically thereafter.

Not verifying with recipients whether services billed by managed care providers were received.
Although West Virginia's FFS program makes use of explanations of medical benefits (EOMBs) to verify with recipients whether services billed by providers have been actually received, the State's contracted MCOs, except in limited circumstances, do not. The MCOs report that they use Health Care Effectiveness Data and Information Set measures collected by the External Quality Review Organization and periodic medical records audits to verify that services are received. However, they do not routinely verify the receipt of specific services with recipients through phone calls, surveys or EOMBs. The EOMBs are used only when investigating specific providers.

Recommendation: Require MCOs to develop and implement a method for verifying with recipients whether billed services were received.

Not reporting to HHS-OIG adverse actions taken on MCO provider applications.
The State does not have a policy or contractual language that obligates MCOs to report either to the Medicaid agency or directly to the HHS-OIG providers whose credentialing applications the MCOs deny or whom they sanction, terminate or otherwise restrict in some way. This may make it easier for problem providers to find a way into other MCOs and the FFS program undetected. The failure of MCOs to notify the State of adverse actions taken for program integrity reasons also precludes the Medicaid agency from reporting such actions to the HHS-OIG, as the regulation at 42 CFR § 1002.3(b) would require in the FFS program.

Recommendation: Require MCOs to report to BMS or directly to HHS-OIG all denials of provider credentialing or actions taken to limit an MCO provider's network participation based on program integrity concerns.

CONCLUSION

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

- use of additional State staff in certain provider reviews, and
- involvement of program integrity staff in Medicaid agency discussions, especially on systems issues.

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

However, the identification of four areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, nine areas of vulnerability were identified. The CMS encourages West Virginia to closely examine each area of vulnerability that was identified in this review. This particularly applies to the State's SUR operation.

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