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Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Vermont 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 Vermont Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Office of Vermont Health Access (OVHA). The MIG team also visited the offices of the Medicaid Fraud & Residential Abuse Unit (MFRAU), which is Vermont's Medicaid Fraud Control Unit (MFCU).

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

THE REVIEW

Objectives of the Review

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

Overview of Vermont's Medicaid Program

The OVHA, within the Agency for Human Services (AHS), administers the Vermont Medicaid Program. As of the State Fiscal Year (SFY) ending June 30, 2007, the program served 134,588 recipients and Medicaid expenditures totaled $1,100,276,965. At the time of the review, OVHA had 10,495 enrolled providers.

The State processed an average of 8.7 million claims annually in the past three SFYs with 84 percent received electronically and 99.4 percent of all claims processed within 30 days. The Federal medical assistance percentage for Vermont during SFY 2007 was 59 percent.

The AHS currently contracts with OVHA, which is organized as a publicly run, statewide managed care organization (MCO), the first of its kind in the country. The OVHA is required to enroll all managed care providers as well as provide all managed care services under two Section 1115 waivers: 1) The Global Commitment, through which it provides health care primarily to women and children and in which providers are paid fee-for-service (FFS) or by diagnostic related group, with an additional fee paid to providers who choose to be gatekeepers, and 2) Choices for Care, primarily aimed at serving the disabled and elderly.

Because OVHA is both the Medicaid agency and an MCO, its centralized PI Unit shoulders the responsibilities of both State agency oversight and statewide MCO program integrity operation for purposes of this review.

Program Integrity Section

The PI Unit, a division within OVHA, is the organizational component dedicated to the prevention and detection of provider fraud, abuse and overpayments. At the time of the review, the PI Unit had nine full-time equivalent staff, one division director reporting to the OVHA director, and one vacant position. Vermont's PI Unit maintains an array of responsibilities that include, but are not limited to: (1) budget projections and utilization analysis, (2) rate setting, (3) timely filing and denied claims appeals, (4) mapping provider demographics, (5) payment error rate measurement, (6) lock-in drug diversion, (7) health care effectiveness data and information set analysis, (8) enrollment reporting, (9) disproportionate share hospital provider assessment, (10) data collection and analysis, (11) claims check and correct coding, and (12) billing accuracy.

The PI Unit is also involved in Vermont's present and future initiatives, which include the Public Assistance Reporting Information System initiative, a contract with a private contractor for algorithm development and data mining, and a post-payment review contract.

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

SFY	Number of Preliminary & Full Investigations	Number of State Administrative Actions or Sanctions (Approximation)	Amount of Overpayments Identified	Amount of Overpayments Collected
2006	2	11	$ 4,788	$ 2,410
2007	7	13	$ 409,483	$ 51,483
2008	2	20	$ 498,398	$ 403,295

Methodology of the Review

In advance of the onsite visit, the review team requested that Vermont complete a comprehensive review guide and supply documentation to support its answers to the review guide. The review guide included such areas as provider enrollment, claims payment and post-payment review, managed care, surveillance and utilization review subsystem, 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 September 8, 2008, the MIG review team visited the OVHA and the MFRAU offices. The team conducted interviews with numerous OVHA officials, as well

as with the MFRAU director. Because OVHA is both the Medicaid agency and the MCO, the findings and vulnerabilities discussed in this report apply to both FFS and managed care.

Scope and Limitations of the Review

This review focused on the activities of the OVHA PI Unit, but also considered the work of other components and contractors responsible for a range of program integrity functions including provider enrollment, contract management, and provider training. Vermont operates the Children's Health Insurance Program (CHIP) as an expansion program under Title XIX of the Social Security Act and it is subject to the same billing and provider enrollment practices as Medicaid. Therefore, the same findings and vulnerabilities discussed in relation to the Medicaid program apply to CHIP.

Unless otherwise noted, OVHA 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, financial, or collections information that OVHA provided.

RESULTS OF THE REVIEW

Effective Practices

The State has highlighted several practices that demonstrate its commitment to program integrity. These practices include a public MCO, criminal background checks, a link between the program integrity function and policy and operations, technological tools to combat fraud, a Fraud and Abuse Control Team (FACT), and the amount of claims data captured in the Medicaid Management Information System (MMIS).

The first statewide public MCO

States that delegate delivery of medical services to MCOs often lack sufficient oversight of the providers serving managed care enrollees, and sometimes do not even know the identity of the MCOs' providers. The OVHA is a public sector MCO and, by definition, directly contracts with all Medicaid/MCO providers. Accordingly, the State is able to maintain centralized control over the screening and credentialing process and better ensure the integrity of its programs under both FFS and managed care.

Background checks on transportation drivers and personal care assistants (PCAs)

Criminal background checks are obtained for all PCAs and transportation drivers. The Vermont Transportation Authority (within the Agency of Transportation) annually samples driver records to ensure that drivers have updated motor vehicle licenses and insurance, and that criminal history checks were done at enrollment. PCAs are checked against adult and child abuse registries.

A highly integrated PI Unit
Vermont has a highly integrated PI Unit which closely links the program integrity function with policy and operations within the Vermont Medicaid program. The PI Unit is involved in all areas of the State agency's operations such as data analysis (quality and performance measures), coverage decisions, budgeting, claims processing and rate setting. The PI Unit is also called upon to adjudicate and develop specific claims edits, conduct audits, and review specific claims areas.

Technological tools to combat fraud, waste and abuse
The OVHA's PI Unit utilizes various database and analytic tools to review providers and identify fraud, waste, and abuse. The State uses multiple products in tandem to review claims and support the MMIS. These products combine to produce a more effective approach to identifying potentially problematic payments. The OVHA also utilizes desk audits to verify problem areas. The OVHA has contracted with a private contractor to create new algorithms based on Vermont's State Plan, policies and procedures.

Fraud and Abuse Control Team
The FACT has established various goals that address and resolve findings related to fraud, waste and abuse of Medicaid resources in a collaborative manner across all sister sub-agencies of AHS. Goals include: develop a core agency program integrity plan to provide education, training and consultation to providers; identify ways to address and refer fraud, waste and abuse programmatically via monthly meetings; improve regular fraud, waste and abuse reporting; establish guidelines for developing provider corrective action interventions; and establish a process for monitoring sustained corrective actions.

MMIS captures 97% of all claims data
The State's MMIS currently captures 97% of all claims. MMIS captures all data except the individual lines of a claim that come from a sister agency, such as services managed through Vermont's Department of Health (VDH), Department of Disability, or Department of Mental Health. The OVHA is also able to drill down into sister agency databases for access to full encounter data.

Additionally, the MIG review team identified three practices that are particularly noteworthy. The MIG recognizes provider re-enrollment, verification of licensure, and a date of death information feed as further evidence of the State's program strengths.

Provider re-enrollment and recertification
Vermont re-enrolls licensed providers at the term date of their license (every two years) for licensed professionals and licensed facilities (e.g., hospitals and nursing homes). The State re-enrolls unlicensed providers (e.g., home health, mental health, counselors, mental health agencies, assisted living facilities) annually.

Inactive and unresponsive providers are dropped if they do not respond to re-enrollment materials within specified timeframes. Re-enrollment involves a complete recertification by the fiscal agent and OVHA, including the completion of all disclosures.

Verification of provider licenses
The State verifies all provider licenses at the time of enrollment, including out-of-state providers. The OVHA uses state websites to verify the validity and status of all out-of-state licenses.

VDH direct information feed
The OVHA collaborated with VDH to develop a direct and timely date of death information feed from vital records to avoid paying claims after a Medicaid recipient's date of death.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to required disclosures of ownership and control information, business transaction information, criminal conviction information and notification activities, and provider attestations.

The State's provider enrollment process does not capture some required ownership, control, and relationship information.
Under 42 CFR § 455.104(a)(1), a provider, or "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.

Vermont's provider enrollment applications do not capture all of the required disclosures. The State's disclosure forms do not capture the addresses of the specified subcontractors or those persons with ownership or controlling interests, nor do they capture information clearly on family or business relationships between disclosing entities as is required by § 455.104(a)(2) and (a)(3). Therefore, the inter-relationships of entities, related organizations, and subcontractors cannot be easily established, and OVHA cannot always determine when a provider seeking to enroll in Medicaid has an ownership or control interest in excluded related organizations or subcontractors.

Recommendation: Modify provider enrollment applications to capture appropriate ownership and control information required to be disclosed under 42 CFR § 455.104.

The State's provider enrollment agreements do not require disclosure of business transactions.

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or U.S. Department of Health and Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors. Vermont's provider enrollment agreements do not require provision of this information upon request.

Recommendation: Modify provider agreements to require disclosure upon request of the information identified in 42 CFR § 455.105.

The State's provider enrollment applications do not capture required criminal conviction information.

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS Office of Inspector General (HHS-OIG) within 20 working days whenever such disclosures are made.

Vermont's provider enrollment application asks, "whether (i) providers, (ii) any employee or person in whom the provider has a controlling interest, or (iii) any person having a controlling interest in the provider has been convicted of a crime related to, or terminated from federal or state medical assistance programs." "*Federal or state medical assistance programs*" is not sufficiently precise and the application should include the language "*related to or terminated from Medicare, Medicaid or Title XX.*" Although the provider is asked to explain a relevant conviction, the provider is not directly asked to supply the identity of the convicted person as required by the regulation. Vermont also does not have a process for forwarding information on providers, owners, agents and managing employees to HHS-OIG within 20 working days, as is required by the regulation.

Recommendations: Modify provider enrollment applications to meet the full criminal conviction disclosure requirements under 42 CFR § 455.106. Refer that information to HHS-OIG as required by the regulation.

The State does not ensure that providers attest that information provided on claims is accurate.

The regulation at 42 CFR § 455.18 requires that providers attest to the accuracy of information on all claim forms. The regulation at 42 CFR § 455.19 permits an alternative to attestations on claim forms; the State may print attestation language above the claimant's endorsement on checks or warrants payable to providers.

Vermont utilizes the CMS-1450 (UB-04) form for billing purposes. The form does not provide an area for the provider's signature certifying that the information on the form is true, accurate, and complete. Additionally, the language used on this claim form is not exact and precise to the regulation and, as such, requires approval from the CMS Region I Administrator. In addition, the State's checks payable do not use the exact wording as required by 42 CFR § 455.19.

Recommendation: Utilize claim forms that meet the full requirements of 42 CFR § 455.18 or modify the language on checks payable to include the language specified in 42 CFR § 455.19.

Vulnerabilities

The review team identified five areas of vulnerability in Vermont's program integrity practices. They include notification procedures, checking for exclusions, disclosures, exclusion notification, and the relationship between the PI Unit and MFRAU.

Not having written policies and procedures for reporting adverse actions to HHS-OIG.
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 OVHA has never received a criminal conviction disclosure in regards to 42 CFR §1002.3; however, the State agency does not have a protocol in place to notify the OIG of any actions the State takes to limit the ability of a person or entity to participate in the program consistent with §1002.3(b).

Recommendation: Develop and implement procedures to notify the regional HHS-OIG of any actions that OVHA takes to limit a provider's participation in the program.

Not checking for provider exclusions.
During interviews, both OVHA and its fiscal agent reported that the fiscal agent does a standard check against the List of Excluded Individuals/Entities (LEIE) at enrollment for all providers. A sample printout, used as proof of the LEIE check, was provided to the review team. However, only one of seven provider enrollment application files reviewed included this documentation.

Recommendation: Develop and implement procedures to ensure the LEIE is being checked at enrollment and that the check is properly documented in all completed provider enrollment application files.

Not capturing managing employee information on enrollment and 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." The State does not solicit managing employee information in provider enrollment and credentialing forms. Thus, the State would have no way of knowing if excluded individuals are working for providers or health care entities in such positions as billing managers and department heads.

Recommendation: Modify provider enrollment applications to require disclosure of managing employee information.

Not notifying 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 Sections 1001.2005 and 1001.2006.

The OVHA indicated during the review that it has never initiated an exclusion. However, the scope of Vermont's notifications is limited because current procedures include notification only to the provider, beneficiaries, and licensing authority.

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

Not maintaining an effective relationship between the PI Unit and MFRAU. Despite positive intent and a good collegial relationship, there was evidence that the PI Unit and MFRAU are not yet working effectively together. The review illustrated that coordination of efforts between the PI Unit and the MFRAU could be improved. For example, since April, monthly scheduled meetings were not held because of competing priorities and work pressures. In addition, the two units do not have clear procedures for assigning or sharing the workload for preliminary and full investigations. Furthermore, few cases are being referred to the MFRAU. In the past year, the MFRAU has only received three referrals from the PI Unit. The MFRAU conveyed that it had not adequately shared ideas with the PI Unit regarding how the two units might collectively focus their attention.

Recommendation: Work with MFRAU to develop and implement policies and procedures that clearly delineate each agency's responsibilities. The MIG recently published a document titled "Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units" which provides guidance for interactions between the State Program Integrity Unit and its MFCU. This document can be used as a reference.

CONCLUSION

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

- the first statewide public MCO,
- background checks on transportation drivers and PCAs,
- a highly integrated PI Unit which links the program integrity function with policy and operations,
- various technological tools to combat fraud, waste and abuse,
- a Fraud and Abuse Control Team,
- MMIS capture of 97% of all claims data,
- annual or bi-annual provider re-enrollment and recertification,
- verification of all provider licenses, and
- a direct date of death information feed to OVHA.

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

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

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