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SOCIAL SERVICES

Medicaid Provider Monitoring

April 2009

Report No. 2009-39

auditor.mo.gov

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YELLOW SHEET

Medicaid Provider Monitoring Can Be Improved

Medicaid is a jointly funded state and federal partnership providing health coverage for selected categories of people with low incomes who might otherwise go without medical care. The state's Medicaid Program spent between $6.7 and $7.2 billion (approximately split 60 percent federal and 40 percent state) annually over the last several years. The Program Integrity Unit (PIU) of the Department of Social Services, MO HealthNet Division (division) is responsible for monitoring the utilization of Medicaid services in the state. The audit objectives included determining whether the Missouri Medicaid Program has an effective system for (1) preventing improper payments to service providers, and (2) identifying and recouping any improper payments that occur.

Staffing levels and resources limit productivity

PIU analysts told us heavy workloads impacted the timeliness of case reviews and the extent of work performed. An analysis of case assignments showed (1) PIU analysts responsible for provider reviews opened cases, but did not begin working the cases for several months or longer, (2) PIU provider reviews are not always expanded to additional time periods outside the initial review period or to similar providers when concerns are identified, (3) PIU management had inadequate procedures to identify and track open cases, (4) staff primarily conducted desk reviews instead of on-site visits of providers due to a limited or no travel budget, and (5) staff limited record requests from providers due to concern over potential charges for copies. (See page 9)

Problem providers need to be better monitored

The division does not effectively monitor known problem providers or use available sanctions. Concerns identified include (1) there are no established follow-up procedures for providers sent education letters, cited for over billings, or with a previous history of abusive billing practices, (2) re-enrolled providers with past billing problems are not monitored more closely, and (3) few providers are put on prepayment review. (See page 13)

Disqualified Medicaid provider paid $669,000

In 2004, division staff approved a Medicaid provider that was on the federal Department of Health and Human Services (DHHS) - Office of Inspector General (OIG) disqualified list. The provider remained an active Missouri Medicaid provider until a federal DHHS employee contacted the division in March 2006. The provider was paid a total of $669,000.

The provider had pleaded guilty to mail fraud related to a federal health program in 1994 and had been placed on the federal OIG disqualified list for 5 years beginning November 1995. The provider had not applied for removal from the disqualified list at the end of the disqualification period. A division official said the provider's approval in 2004 was a mistake and could provide no explanation why the approval occurred. Division officials are seeking reimbursement for payments made to the provider. As of January 2009, the Administrative Hearing Commission case remained open. (See page 23)

Missouri's False Claims Act does not mirror federal act

The 2007 Missouri General Assembly enacted legislation modifying existing state Medicaid fraud laws to include false claims act provisions. However, state law does not include required provisions to allow Missouri to retain an additional 10 percent of funds recovered under the act. To encourage states to pass false claims act legislation, the Federal Deficit Reduction Act of 2005 included provisions allowing states which pass laws that mirror the Federal False Claims Act to keep 10 percent more than the Medicaid matching rate of monies recovered from cases that are settled or prosecuted under the state act. (See page 27)

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Abbreviations

AGO	Attorney General's Office
AHC	Administrative Hearing Commission
AIDS	Acquired Immune Deficiency Syndrome
CFR	Code of Federal Regulations
CMS	Center for Medicare and Medicaid Services
CSR	Code of State Regulations
DHHS	Department of Health and Human Services
DLS	Division of Legal Services
FAD	Fraud and Abuse Detection
GAO	Government Accountability Office
MFCU	Medicaid Fraud Control Unit
MMIS	Medicaid Management Information System
OIG	Office of Inspector General
PDW	Physical Disability Waiver
PIU	Program Integrity Unit
PO	Program Operations
ROI	Return on Investment
RSMo	Missouri Revised Statutes
SAO	State Auditor's Office
SPAR	System Problem Assistance Requests

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Missouri State Auditor

Honorable Jeremiah W. (Jay) Nixon, Governor
and
Members of the General Assembly
and
Ronald J. Levy, Director
Department of Social Services
Jefferson City, Missouri

Missouri spends more than $6.5 billion annually on Medicaid services. The Program Integrity Unit (PIU) of the Department of Social Services, MO HealthNet Division (division) is responsible for monitoring the utilization of Medicaid services in the state. The audit objectives included determining whether the Missouri Medicaid Program has an effective system for (1) preventing improper payments to service providers, and (2) identifying and recouping any improper payments that occur.

PIU decisions and results could be improved through (1) use of return on investment analysis, (2) evaluating and addressing staffing level and resource needs, (3) more fraud training, (4) better monitoring of problem providers, and (5) requiring re-enrollment of providers. In addition, collection procedures on overpayment amounts past due from providers need improvement to ensure monies are appropriately recovered. Various management and control weaknesses have resulted in (1) a disqualified provider being approved and paid as an eligible provider, (2) exception reports not being reviewed and system changes not being made timely, and (3) managed care claims activity not being reviewed. Further, the state's False Claims Act does not meet criteria set by the federal government to allow additional state reimbursement, and implementation of the state's fraud and abuse detection system took longer than planned with the division exchanging original contract items for other services.

We conducted our audit in accordance with the standards applicable to performance audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform our audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides such a basis. This report was prepared under the direction of John Luetkemeyer. Key contributors to this report were Jon Halwes, Norma Payne, Kelly Davis, and Dana Wansing.

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Introduction

Medicaid is a jointly funded state and federal partnership providing health coverage for selected categories of people with low incomes who might otherwise go without medical care. The state's Medicaid Program spent between $6.7 and $7.2 billion (approximately split 60 percent federal and 40 percent state) annually over the last several years.

Title XIX of the Social Security Act requires states to offer certain basic services to the needy population in order to receive federal matching funds. States may receive additional federal Medicaid matching funds if they elect to provide other optional services. Pursuant to 42 Code of Federal Regulations (CFR) Part 455.13, a state Medicaid agency is required to have (1) methods and criteria for identifying suspected fraud cases, (2) methods for investigating these cases, and (3) procedures, developed in cooperation with state legal authorities, for referring suspected fraud cases to law enforcement officials. The U.S. Department of Health and Human Services (DHHS) - Centers for Medicare and Medicaid Services (CMS) oversees the Medicaid Program for the federal government. The Department of Social Services, MO HealthNet Division[1] (division) has state responsibility for the program.

Claim Submission and Review

Providers submit Medicaid claims requesting payment in one of three forms:

- Point of Sale System - claims are submitted electronically by pharmacies using an on-line system with real time processing.

- Electronically - claims are submitted through the state contractor, or by entering claim information into the Medicaid Management Information System (MMIS).

- Paper - claims are submitted using standardized paper forms applicable to the type of claim. Claims submitted on paper forms are keyed manually into the MMIS. Pharmacies are not allowed to submit paper claims.

Prior to payment, Medicaid claims go through various system edits in the MMIS to identify potential incomplete or invalid program billings. Each edit is assigned a status code that determines whether a claim is to be paid, denied, or suspended.[2] Division management determines the status code assigned to the edits. The modification of edits occurs upon formal request

[1] Effective September 1, 2007, the Division of Medical Services was renamed the MO HealthNet Division as part of the Missouri Health Improvement Act of 2007.

[2] This process is referred to as claim disposition.

from division employees. Requests to research an MMIS processing issue (for example payment errors, denied claims, etc.) are submitted on System Problem Assistance Requests (SPARs).

PIU Responsible for Monitoring Utilization

The division's Program Integrity Unit (PIU) is responsible for monitoring the utilization of Medicaid services in the state. As described in 42 CFR Parts 456.1 through 456.23, the PIU is to determine the propriety of claims reimbursed by the Medicaid Program. At January 2008, the PIU consisted of 24 staff with 14 staff dedicated to provider reviews.

Medicaid providers are selected for review based upon referrals, exception reports, and/or other system generated reports. Referrals concerning possible misutilization may be received from providers, recipients, consultants, division employees, and staff from other agencies. Exception reports are produced on providers that have unusual patterns of utilization, or deviate from established norms. The PIU uses exception reports from a fraud and abuse detection (FAD) system and the MMIS to evaluate providers for potential overpayments.

Post-payment review process

A post-payment review of Medicaid claims is performed on selected providers or projects to determine program compliance. These reviews are completed by either a desk or field review.

Evaluation criteria are based on the specific requirements stated in each program's Missouri Medicaid Manual and updated by Missouri Medicaid Bulletins. All programs are evaluated for adequate documentation as defined in 13 Code of State Regulations (CSR) 70-3.030, Section (2)(A), which defines adequate documentation (in part) as, "…documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty. Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnosis, treatments, prognosis, and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty."

Fraud[3] is an intentional deception, false statement or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or another person. Waste and abuse[3] are practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that constitute an over-utilization of services, resulting in unnecessary costs.

[3] As defined by various CMS sources.

The PIU is responsible for ensuring the appropriateness and quality of service are also considered for the claims being reviewed. If a question regarding the quality of service, medical necessity or medical interpretation exists, the case is referred to the division's contracted medical consultant(s) for review. The division also has a doctor on staff for medical referrals. Improper payments include inadvertent errors, such as duplicate payments and miscalculations; payments for unsupported or inadequately supported claims; payments for services not rendered; and payments to ineligible beneficiaries.

Post-payment review may result in administrative action

The outcome of a post-payment provider review may include one or more administrative actions or sanctions including (1) determination of overpayment, (2) withholding of future payments, (3) transfer to closed-end agreement, (4) provider education, (5) placement on prepayment review status, (6) referral to another state or federal agency, and (7) suspension or termination of the provider's Medicaid participation agreement.

If the review findings question the provider's license or certification, an appropriate referral is made to the state's Department of Insurance, Financial Institutions and Professional Registration. If the review findings question the practitioner’s Bureau of Narcotic and Dangerous Drugs prescribing privileges, the appropriate referral is made to that state agency. If a question of potential fraud exists, the case is referred to the Attorney General's office (AGO), Medicaid Fraud Control Unit (MFCU). The PIU regularly meets with the MFCU to discuss providers suspected of fraud. The MFCU accepts 20 to 25 cases per year from the PIU.

Overpayment collection and reporting procedures

If an overpayment is identified, a certified mailing is sent to the provider outlining the error(s) noted in the review and informing the provider of the total amount overpaid. The provider is also notified of repayment options available, as outlined in 13 CSR 70-3.030, Section (6).

Upon receipt of the overpayment notification, the provider has 45 days to remit payment to the division. If, after 45 days, the provider has not remitted payment, the overpayment due is to be established in the MMIS system and withheld from current payments due the provider. If, after 3 months, the provider has discontinued billing, the overpayment is to be forwarded to the department's Division of Legal Services (DLS) for further referral to the AGO for collection or possible litigation, and the provider is terminated from participation in the program.

When an overpayment is identified, the overpayment amount must be reported as an offset to expenditures. States are required by 42 CFR Parts 433.312, 433.316, and 433.320, to refund the federal share of overpayments

within 60 days of discovery even if the state has not recovered the overpayment from the provider. Under federal guidelines, the state does not have to return the federal portion of an overpayment if during the 60-day period, the overpaid provider filed for bankruptcy or went out of business and the state followed required efforts to collect the overpayment.

Pre-payment reviews of claims

Prepayment review, as authorized in 13 CSR 70-3.030, Section (4) (J), is a means by which a specific provider's claims are reviewed by a division contracted consultant prior to payment to determine the reasonableness and appropriateness of services and charges. In such cases, division consultants monitor all claims submitted and payment is denied for all incorrectly billed services. Whether a provider is placed on prepayment review depends on the type of error and the benefit to the division in initiating the procedure.

Other Review Responsibilities

The division has separate units (Pharmacy, Managed Care, Nursing Home Policy and Reimbursement, and Hospital Policy and Reimbursement) that handle some expenditure review activity outside of the responsibilities of the PIU. The division's Provider Enrollment Unit is responsible for determining and monitoring provider eligibility. During fiscal year 2008, the program had about 39,000 enrolled providers. Some providers are approved for a specific period of eligibility while others have open-ended eligibility. Providers with open-ended enrollment are not required to be re-enrolled at a future date.

The division contracts with vendors for inpatient hospital utilization reviews and approvals and pharmacy prescription drug claim evaluation.

Managed care

Approximately half of Missouri's Medicaid recipients receive services through managed cared. The division plans to transition more recipients to managed care over the next several years. Under managed care, recipients select a health plan and a primary care provider within the plan to access healthcare services. The state pays the health plans an amount per person each month to cover all health benefits (capitation payment); as such, the state is not at risk for healthcare costs beyond the monthly capitation payment. Health plans must ensure each enrollee has access to a comprehensive benefits package and 24-hour access to necessary covered services. The health plans contract with doctors, hospitals, pharmacies and other providers. The managed care providers submit encounter data to the division for services provided to recipients.

Scope and Methodology

We reviewed state and federal regulations related to provider enrollment and PIU operations. We performed research to identify fraudulent practices occurring in the healthcare industry. We obtained audit reports prepared by other state auditors and federal agencies covering Medicaid provider issues and used the findings in those reports to identify possible review areas. We reviewed the contracts and division procedures for the post-payment analysis software, inpatient hospital approval and pharmacy claims, and spoke with representatives of the vendors. We obtained selected expenditure data for calendar years 2004 to 2007 to analyze for trends or potential problem providers.

To analyze the procedures and records of the PIU, we interviewed all PIU staff and reviewed the logs and other documents maintained by the unit. We contacted Medicaid PIU representatives in Arkansas, Florida, Georgia, Illinois, Iowa, Kansas, Kentucky, Nebraska, North Carolina, Ohio, Oklahoma, Tennessee, and Texas to determine their staff sizes, budgets, procedures, and annual recoveries.

To evaluate overpayment collection procedures, we discussed procedures with department and PIU staff and reviewed documentation. We also reviewed collection procedures for Medicaid overpayments with the DLS and the AGO. We reviewed records covering 2005 to 2007.

To evaluate provider enrollment procedures, we interviewed PIU staff and compared Missouri's procedures to those used in other states.

To analyze MMIS edits, we reviewed the default status of all edits as of specific dates in 2006 and 2008 and reviewed edit change and review procedures and policies. We obtained a database of SPARs from June 2004 to October 2006 to identify requests that remained uncompleted for extended periods and the potential impact of those delays.

To evaluate managed care claims analysis, we discussed procedures with applicable division staff, and reviewed external quality review reports and the completeness of encounter claim data.

To evaluate Missouri's False Claims Act, we compared it to the federal government's act and similar acts established in other states. We contacted officials in 16 states (Arkansas, California, Delaware, Florida, Illinois, Indiana, Louisiana, Massachusetts, Michigan, Montana, Nevada, New Mexico, New Hampshire, Tennessee, Texas, and Virginia) with false claims acts as part of this analysis.

More Effective Use of Resources and Improved Prioritization Could Benefit PIU Efforts

Identification of fraud and overpayments could be improved through (1) the use of return on investment (ROI) analysis in operational decisions, (2) evaluating and addressing staffing level and resource needs, (3) more fraud training, and (4) better monitoring of problem providers. Requiring providers to periodically re-enroll could also benefit the program.

Management Decisions Not Supported by Cost-Benefit Analysis

PIU and division officials have based operational decisions upon costs without considering savings, benefits, or calculating the ROI to determine if the benefit produced outweighs the associated costs. Division officials could not provide cost-benefit analyses supporting several decisions made including:

- Elimination of most on-site provider visits
- Not participating in the National Association of Medicaid Program Integrity[4]
- Limited use of prepayment review before paying providers

Division officials said budget concerns resulted in these areas being reduced or eliminated. When a division official was asked to support a reported PIU calculation of $500,000 for ROI of adding each new PIU employee, the official responded, "We have no actuarially sound formula for calculating or reporting ROI..." The Government Accountability Office (GAO) has reported that calculating a ROI can determine the effectiveness of program integrity activities.[5] ROI identifies the dollars saved for each dollar spent. It will also ensure management decisions are supported by the benefit. ROI is one of six major strategies the CMS Medicaid Integrity Group reported using for the Comprehensive Medicaid Integrity Plan.[6]

Staffing Levels and Resources Limit Productivity

PIU analysts told us heavy workloads impacted the timeliness of case reviews and the extent of work performed. An analysis of case assignments showed (1) PIU analysts responsible for provider reviews opened cases, but did not begin working the cases for several months or longer, (2) PIU provider reviews are not always expanded to additional time periods outside the initial review period or to similar providers when concerns are

[4] The purpose of the association is to assist states in providing the greatest control of fraud or abuse for the Medicaid Program. Annual dues per member are included in the cost of attending the organization's annual conference or $25 per year.

[5] GAO, *Medicaid Integrity, Implementation of New Program Provides Opportunities for Federal Leadership to Combat Fraud, Waste, and Abuse*, GAO-06-578T, March 28, 2006.

[6] Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations Medicaid Integrity Group, *Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program*, FY 2006-2010, July 2006.

identified, (3) PIU management had inadequate procedures to identify and track open cases, (4) staff primarily conducted desk reviews instead of on-site visits of providers due to a limited or no travel budget, and (5) staff limited record requests from providers due to concern over potential charges for copies.

Provider reviews not always timely

Supervisors have instructed PIU analysts to open approximately 3 cases per month. Our analysis showed analysts frequently opened cases, but did not actively work them for months. Case records showed post-payment review time for cases frequently exceeded 180 days. A PIU supervisor said the general expectation was for cases to be opened and closed within 3 months and no longer than 6 months. Analysts said they opened cases because it was expected, but heavy workloads, extended leave and other assignments did not allow for some cases to be processed in a timely manner.

Examples of untimely program reviews include:

Hospital Outpatient Expenditures

Staff said outpatient hospital charges were not regularly reviewed by the PIU from January 2004 through May 2006. An analyst conducted a review of one outpatient code resulting in overpayments of $87,142. The review started May 22, 2006 and completed January 30, 2007, determined all providers reviewed had a billing error. The scope of the review included billings from September 1, 2003 through March 10, 2006. The review was not expanded to cover more current time periods, or additional outpatient codes (see page 11 for further discussion of expanding reviews).

Waiver Reviews

The fiscal year 2004 and 2005 Physical Disability Waiver (PDW) reviews were not completed until fiscal years 2007 and 2008, respectively. The fiscal year 2004 acquired immune deficiency syndrome (AIDS) waiver review was not completed until fiscal year 2007. The state's waiver agreements with the federal government require the division to monitor compliance with requirements of each waiver.

A PIU official said these reviews were not a priority and due to limited resources the PIU focused on reviews which yielded the highest returns. The fiscal year 2005 PDW review identified overpayments of $56,305. The fiscal year 2004 AIDS waiver and PDW reviews identified overpayments of $33,268 and $36,018, respectively. In March 2008, PIU staff said the fiscal year 2005 AIDS waiver review began in July 2007 but was not yet complete and the 2006 review had not been started.

Reviews not expanded

Identified errors were not always expanded to other time periods for that provider or like providers. When PIU analysts identified errors during a provider review, the analysts told us they did not always expand the review on that provider to other time periods or review other providers for the same error because of a lack of time to complete their current workloads. Four of 12 analysts told us they had expanded the review period for a provider after errors had been identified.

Examples of reviews not being expanded include:

- In February 2007, the PIU began a review of payments to nursing home providers when recipients were hospitalized and not in the home. The review started after a nursing home self reported a problem and included all nursing home providers. As of early 2008, the review was still open with identified overpayments of $806,000. PIU staff said the review was not expanded to periods after December 2005 because of the time consuming case review process.

- In February 2007, the PIU completed a review of a durable medical equipment provider resulting in an overpayment of $45,436 for improperly billed services. Although the review did not begin until August 2006, the review only included billings for July 1, 2005 through December 31, 2005. The PIU analyst said the review had been limited to the original billing period selected for review.

Procedures to identify open cases need improvement

The PIU lacked a process to track open cases by analyst and to identify cases that remained open when analysts ended their employment. PIU staff relied upon pre-set system reports that showed cases opened, closed, and remaining open during the month, but did not identify individual cases. A PIU supervisor said it is her personal practice to get a summary of pending cases from staff who terminate and reassign the case. However, the supervisor said there is no written policy or procedure to identify the open cases.

We identified cases remaining open after analysts left and these cases were not included on the PIU monthly report. PIU staff closed the majority of these cases without further action after we discussed the issue with PIU supervisors. PIU officials said since October 2008 a report is now run quarterly to enhance tracking of cases.

On-site provider reviews infrequent

Provider reviews are impacted due to limited on-site reviews. PIU analysts said they primarily perform desk reviews of providers instead of on-site reviews because of little or no travel budget. In April 2002, division administration directed that all on-site reviews be cancelled or delayed until

notified to proceed. The PIU received a similar notification again in February 2003. During fiscal year 2005 through fiscal year 2007, PIU analysts told us they could do on-site reviews only if the review did not involve an overnight stay and could be performed in less than 12 hours for one day. Division officials could not provide documentation of a cost-benefit analysis to support the decision to reduce travel funding.

The analysts said more overpayments were identified when records were reviewed on-site. In September 2007, a PIU official said a small amount of funding was made available for increasing field reviews, but funding is not sufficient for providing this function on a full-time basis. The PIU official said the fiscal year 2009 budget did not include requests for funding on-site visits.

Copy costs a concern

The number of records reviewed on provider cases is limited. PIU analysts said supervisors have instructed them to limit most record requests to 25 or 30 items over concern providers will charge the state for copy costs.

The state's agreement with Medicaid providers requires them to furnish, on request, information regarding payments claimed. Section 191.227.2, RSMo, allows healthcare providers to condition the furnishing of a patient's health care records to the patient, the patient's authorized representative, or any other person or entity authorized by law to obtain or reproduce such records upon payment of a fee to cover copy or other costs associated with providing the information. During fiscal years 2005 and 2006[7] the division paid a total of about $5,300 for medical record copies.

Arkansas has addressed this cost concern through a provision in its Medicaid Fairness Act which requires providers to supply records at their own cost during a review.[8] An Iowa Medicaid employee told us providers are not allowed to charge the program for copy costs; however, he indicated this provision is not in the provider contracts or specifically covered by a state law. A division official said provider agreements could be amended to limit the ability of providers to charge for copies.

[7] Division officials did not provide copy cost information for fiscal years 2007 and 2008.

[8] The law allows the provider to bill for copy costs if records are requested more than once on the same review.

More Fraud Training Would Be Beneficial

PIU staff lack training on identification of specific fraudulent activity. A December 2004 report[9] by the General Assembly's Joint Committee on Legislative Research, Oversight Division reported staff training received was based on the capabilities of the new FAD system and the PIU lacked training to identify potential fraudulent activity. The report recommended division staff receive training from the Attorney General's MFCU. Our analysis of training logs for 2005 to 2007 and part of 2008 showed while training was provided by the state contractor for the state's FAD system as a part of weekly meetings, limited outside fraud training was obtained and no training had been provided by the MFCU. Minutes from PIU and MFCU joint meetings show PIU officials requested fraud training on two occasions. MCFU staff told us no training took place because PIU staff did not identify specific training requests. A PIU official said outside fraud training is provided based on funding availability. The official said since March 2008, PIU staff has begun to receive training through the federal government's newly established Medicaid Integrity Institute.

Problem Providers Need to Be Better Monitored

The division does not effectively monitor known problem providers or use available sanctions. Concerns identified include:

- There are no established follow-up procedures for providers sent education letters, cited for over billings, or with a previous history of abusive billing practices.
- Re-enrolled providers with past billing problems are not monitored more closely.
- Few providers are put on prepayment review.

The GAO[10] has reported some state Medicaid agencies increase the monitoring and review of providers that have been identified as having significant billing problems if they remain in the program.

No established follow-up policy

The PIU did not have specific written guidelines for determining the extent and comprehensiveness of follow-up reviews and identifying which providers require a follow-up review. A PIU official said analysts are to follow-up on cases as much as time allows. However, no tracking process is in place to evaluate if follow-up reviews are occurring. Our analysis showed 5 of 12 analysts regularly or occasionally performed follow-up reviews on

[9] Oversight Division, Joint Committee on Legislative Research, Program Evaluation, *Medicaid Fraud Program Follow-up*, December 2004.

[10] GAO, Medicaid Program Integrity, *State and Federal Efforts to Prevent and Detect Improper Payments*, GAO-04-707, July 2004.

problem providers. PIU analysts said time spent on current cases prevented the review of old cases and/or ongoing monitoring to ensure problem providers had corrected billing practices.

A representative from the PIU in Ohio said providers under indictment or that have had previous billing problems are more closely monitored in that state. The official said it is too difficult to recoup money once the provider is paid. Providers under indictment are subject to prepayment review which could require the provider to submit documentation that services were rendered. The official said the concern was not the cost of monitoring, but how much it would have cost the Medicaid Program if the problem providers were not monitored.

Re-enrolling providers with past billing problems not monitored

The PIU has no procedures to monitor providers with prior billing problems that re-enroll in the Medicaid Program once prior overpayment debts are resolved. A PIU analyst said former providers that had previous overpayments can easily re-enroll once overpayments are paid. Analysts also said these providers will be monitored like any other provider with no additional scrutiny.

Prepayment review is limited

Few providers are placed on prepayment review. PIU staff said prepayment reviews are infrequently established because of the contracted consultant costs for handling the reviews. Division officials said a cost-benefit analysis has not been prepared to support the limited use of prepayment review. The PIU staff said they placed only 2 providers on prepayment review in 2006 and 8 in 2007.

In September 2004, the MFCU recommended the PIU place a psychology services provider on prepayment review. Documentation in the PIU's file on the provider showed a PIU supervisor concluded the division needed to limit expenditures to the psychology consultant and therefore did not place the provider on prepayment review status. In March 2006, the provider pleaded guilty to 3 counts of health care fraud following a MFCU investigation, and was terminated from the Medicaid Program for 5 years and ordered to pay restitution of $3,356.

Division officials said as of early 2009, 55 providers were on prepayment review, including 43 ambulance services, 7 physicians and 5 psychologists. Hired consultants handle the psychology reviews while division employees or the MMIS contractor staff handle the ambulance and physician reviews.

Providers Are Not Required to Re-Enroll

Missouri Medicaid providers with open-ended eligibility dates are not required to periodically re-enroll. Re-enrollment allows states to periodically verify provider information such as medical specialty credentials, addresses, and ownership and licensure status.

A 2004 report[11] by the GAO reported 25 states require at least some Medicaid providers to re-enroll or re-certify. We contacted Medicaid staff in Missouri's contiguous states about their provider enrollment procedures. Medicaid staff from 3 (Illinois, Kentucky, and Oklahoma) of 7 states contacted said their programs limit the length of time certain providers are enrolled. Illinois uses a 180 day probationary period for high-risk providers, while Kentucky and Oklahoma require re-enrollment or re-certification at least every 3 years.

A PIU analyst said as part of sending letters to psychology service providers on a review project, 25 of about 560 letters were returned as undeliverable by the post office. A division employee said the provider enrollment unit does not have enough staff to require providers to periodically re-enroll.

Conclusions

PIU and division officials have based operational decisions on costs without considering potential savings or calculating the ROI.

Staffing and funding limitations have negatively impacted the timeliness of case reviews, the ability to perform on-site work at providers, the ability to expand reviews when overpayments are detected, and potential recoveries.

Poor tracking of cases has resulted in cases remaining open for extended periods when analysts leave the PIU. Unit staffing levels may limit the number of cases the PIU can work at one time, but timely identification and tracking of open cases would allow unit management to prioritize which cases will be reviewed.

Limiting record requests from providers due to concerns over potential copy costs is unnecessary. Other states have taken either legislative or administrative actions to eliminate or limit copy costs.

Specific fraud training enhances PIU analysts' ability to detect and identify provider fraud or abuse. The training analysts are now receiving through the Medicaid Integrity Institute should benefit the state's program integrity efforts.

[11] GAO, *Medicaid Provider Integrity - State and Federal Efforts to Prevent and Detect Improper Payments*, GAO-04-707, July 2004.

The PIU had not developed increased monitoring procedures for providers with past billing problems. These providers are a higher risk for potential fraud or abuse and need additional scrutiny from division staff.

Other states periodically re-enroll providers to obtain up-to-date provider information.

Recommendations

We recommend the Director of the Department of Social Services:

2.1 Evaluate the ROI when making decisions on the operation of the PIU.

2.2 Evaluate the staffing and funding needs of the PIU which would include:

- The need for more staffing and/or specialized staffing
- Funding to perform on-site provider reviews
- Work redistribution and prioritization
- Increased in-house and external (from MCFU and others) fraud identification training

2.3 Improve case tracking to ensure provider reviews are reassigned and prioritized when analysts leave employment.

2.4 Seek legislative change or amend the provider participation agreement, as necessary, to require providers to supply copies of records at no cost to the PIU.

2.5 Improve monitoring of problem providers by:

- Establishing specific follow-up procedures on providers with identified overpayments
- Establishing specific monitoring procedures for re-enrolled providers with past billing problems
- Expanding the use of prepayment reviews

2.6 Evaluate implementing a periodic provider re-enrollment process for at least high-risk providers.

Agency Comments

2.1 We partially agree with this recommendation. The department agrees that calculating a return on investment is a wise strategy to ensure best use of limited resources available for expenditure. The PIU routinely evaluates and focuses efforts toward projects yielding the greatest return. As recently as December 2008, PIU analyzed work

distribution based on return on investment, trend analysis, and referrals.

The report indicated operational decisions were made based upon costs without considering savings, benefits, or calculating the return on investment (ROI) to determine if the benefit produced outweighs the associated costs. Specific instances cited in the report included reduction of on-site provider visits, not participating in a national association for Program Integrity, and limited use of prepayment review of providers. These are all items that are paid from the division's operating budget for administration of the program.

The operation of the PIU is reliant upon appropriation of funds from the Missouri General Assembly. The funds available for PIU are included in the Administration appropriation. The department cannot redirect funds from other appropriation lines for administration of the program. When fewer administrative dollars are available as was the case in past fiscal years, the department must make tough decisions and reduce expenditures and live within its budget authority. Those items cited in the report were ways the department reduced expenditures during tough economic times while maintaining core operations within the PIU.

The division did not eliminate travel for on-site provider visits but looked at ways that would not require the expense of overnight stays. Staff could and did do on-site reviews of providers that did not require an overnight stay. In some instances, PIU was able to use staff from other divisions within the Department of Social Services to collect records in other locations that would have required an overnight stay by PIU staff.

The sanction of a prepayment review was not eliminated in its entirety, but was used strategically because of the cost associated with hiring a consultant as a peer reviewer of the provider's claims.

2.2 We partially agree with this recommendation. In the state fiscal year 2010 budget, the department requested and the Governor recommended funding for four new positions to increase the capabilities of the unit to detect and eliminate waste, fraud and abuse in the MO HealthNet Program. The request funds two auditors and two investigators to expand on site reviews and increase recoveries by approximately $1.6 million annually. The department is hopeful that this budget request will be funded by the General Assembly.

The PIU routinely reassesses workloads and priorities. As recently as December 2008, PIU analyzed work distribution based on return on investment, trend analysis, and referrals. As this report recommended in 2.1, return on investment is a critical tool for prioritizing work load. Delay in completion of low return projects will occur as staff is redirected to higher return projects. By taking this very pragmatic approach, the impact to the program increased steadily over time as demonstrated in the following chart.

DSS MO HealthNet Program Integrity and Cost Recovery

Fiscal Year	*Cost Avoidance*	*Cost Recovery*	*Total*
2004	*$84,708,463*	*$38,035,986*	*$122,744,449*
2005	*$90,904,620*	*$41,084,920*	*$131,989,540*
2006	*$123,377,373*	*$63,289,433*	*$186,666,806*
2007	*$142,884,088*	*$54,060,109*	*$196,944,197*
2008	*$162,255,546*	*$47,689,870*	*$209,945,416*

In addition to the training PIU staff are taking advantage of through the Medicaid Integrity Institute, PIU is coordinating a fraud training session for staff to be provided by MFCU.

2.3 We agree with this recommendation and it has been implemented. The reporting system used by PIU now generates reports by analyst. In October 2008, PIU implemented a process to generate an open case report on a quarterly basis to enhance tracking of cases. At the time an analyst terminates employment with PIU, the supervisor identifies the analyst's open cases by running the open case report to reassign to another analyst.

2.4 We disagree with this recommendation. Within the last year, the PIU has obtained two scanners for on-site audits which are no cost to PIU for copying records and PIU does not limit record requests based on the number of pages. While the department does recognize the cost to providers, not all providers charge for copies. Since January 1, 2009, PIU has received 10 provider reimbursement requests for supplying copies of records for a total of $225.

2.5 We partially agree with this recommendation. Providers with past problems have always been included in the regular reporting of suspicious claims. If a provider continued past billing behaviors that resulted in an overpayment, any problem claims would again be identified in the reports generated from the Fraud and Abuse Detection System. Generally, the identification of suspicious claims

through the Fraud and Abuse Detection System was how the provider was originally targeted.

In total there are almost 40,000 enrolled providers. In state fiscal year 2008, the PIU conducted 337 provider review projects that encompassed 4,653 providers. PIU has 17 full-time equivalent employees to conduct those activities. As was indicated in recommendations 2.1, 2.2 and 2.3, the work of PIU is targeted to those activities with the highest return. We are concerned that including providers without indication of continuing problems as identified through the Fraud and Abuse Detection System would have diminishing returns. Typically, overpayments are not the result of providers intending to defraud the program. Once an error is identified and brought to attention, providers generally correct their billing practices and there is no need for further follow-up.

The PIU will evaluate its policies to determine if there are instances in which a further review of a provider is warranted even though their on-going claims are not appearing in suspicious activity reports.

2.6 We agree with this recommendation. The department will evaluate implementing a periodic provider re-enrollment process for at least high-risk providers.

Weaknesses in Collection Process Impacts Recoveries

Collection procedures for overpayment amounts due from providers need improvement to ensure monies are appropriately recovered.

Collection Process Needs Improvement

Bad debt referrals have not always been timely, the overpayment tracking process lacks key reconciliations and controls, and available resources have not always been used.

Action taken for collection not always timely

Our review of outstanding receivables indicated PIU analysts did not always follow collection referral guidelines and did not refer cases for collection timely. The PIU's system did not automatically notify analysts when it was time to take the next step in the collection process. Instead, the unit has relied on analysts to identify those cases that should be referred for collection. PIU analysts said unit procedures had required them to monitor cases for collections and attributed the delays to their work loads and higher priority assignments.

Providers receive an overpayment letter when PIU analysts identify an overpayment. If a provider fails to respond to the overpayment letter after 45 days, PIU staff is supposed to recoup the receivable from payments that may be due the provider for other claims. If the provider is no longer billing, the analyst notifies the provider to pay by certified check or money order. The PIU allows 3 months[12] to lapse before referring the debt to the DLS for collection.

PIU supervisors said beginning April 2007, and fully implemented in early 2008, receivable and collection functions were consolidated with two unit staff (an analyst and account clerk) to improve the collection process. In addition beginning in March 2008, once collection efforts have been determined unsuccessful, a letter is sent giving the provider 30 days to pay any balance due.

System lacks controls

PIU receivable and collection information is tracked in both the MMIS and PIU case tracking database. However these systems are not linked and had not been reconciled to identify errors. Our review of the case tracking database indicated:

- The system design made it difficult to track individual collection amounts and the method of collection (actual payments or withholding from subsequent claims).

[12] Prior to late 2007, the time period allowed was 6 months.

- The system formula logic did not always result in accurate receivable balances or alert staff to incorrectly entered dates or amounts outside of reasonable field parameters.

- The system could not provide an aging of receivables.

As a result, receivable information in the database had inaccuracies. PIU analysts said they tracked some payment information in manual case files due to system limitations. A PIU official said staff has now begun a process to regularly reconcile information in the two systems.

PIU does not use resources available

The PIU does not use the MMIS system to automatically generate letters to providers with outstanding receivable balances. The letters could help the PIU meet federal regulations for documentation of collection efforts in the first 60 days. PIU officials said they did not use these letters because of concern about sending letters to providers with an Administrative Hearing Case (AHC) case that had an active stay order. Staff in the department's Division of Finance and Administrative Services told us the MMIS system can be set to block sending individual letters to vendors that have received a stay. PIU officials also said the changes made in early 2008 to the collection process would improve collections.

Conclusions

Weaknesses in receivable tracking and collection procedures impact recoveries. Changes made in 2008 to consolidate responsibility for collection activity between two PIU staff should help address some of the weaknesses.

Recommendation

We recommend the Director of the Department of Social Services:

3.1 Evaluate the procedures being used for collection of overpayments identified by PIU. Issues to be evaluated include:

- Monitoring the collection process changes to evaluate their effectiveness
- Improvements to the functionality of the case tracking database
- Reconciliation of data between the tracking system and the MMIS
- Use of the automatic letters in the MMIS

Agency Comments

3.1 We partially agree with this recommendation. Procedures were implemented in early 2008 to improve the collection process and have proven to be effective. Specifically, the PIU reporting system now contains the date the overpayment was established and tracks the date payments are applied to the account. This allows staff to calculate the age of PIU receivables.

The PIU has performed a reconciliation of the MMIS and the PIU database. PIU procedures include a quarterly reconciliation. In addition, the PIU check log is reconciled monthly with the MMIS. System recoupment of payments is reconciled with the MMIS after each financial cycle.

The use of the automatic letters in the MMIS is not feasible for PIU because of the variation in the verbiage of the overpayment letters.

Other Management and Statutory Weaknesses

Various management and control weaknesses have resulted in (1) a disqualified provider being approved as an eligible provider, (2) MMIS exception reports not reviewed and system changes not made timely, and (3) managed care claims activity not reviewed. The state's False Claims Act does not meet criteria set by the federal government to allow additional state retention of recovered monies. Implementation of the state's FAD system took longer than planned with the division exchanging original contract items for other services.

Disqualified Medicaid Provider Paid $669,000

In 2004, division staff approved a Medicaid provider that was on the federal DHHS - Office of Inspector General's (OIG) disqualified list. The provider remained an active Missouri Medicaid provider until a federal DHHS employee contacted the division in March 2006. The provider was paid a total of $669,000.

The provider had pleaded guilty to mail fraud related to a federal health program in 1994 and had been placed on the federal OIG disqualified list for 5 years beginning November 1995.[13] The 2004 provider application submitted by the provider disclosed the conviction and disqualification information. Division officials said approval procedures include checking the OIG disqualification list, and following identification of this situation the Provider Enrollment Unit made changes to address any weaknesses in approval procedures. A division official said the provider's approval in 2004 was a mistake and could provide no explanation why the approval occurred.

Department officials are seeking reimbursement for payments made to the provider. As of January 2009, the AHC case remained open. An AHC hearing official said the department and provider have waived their hearing and submitted a joint stipulation of facts and asked the AHC for permission to submit a joint brief.

MMIS Edit Weaknesses

System reports for certain edit dispositions have not been regularly reviewed, edits identifying transactions having a high likelihood of fraud or abuse were set to force the payment of claims, and requested system changes have not been tracked for timely completion.

Edits compare the data submitted on a claim to a series of tests to determine whether the data is valid, and whether billing of the services complies with department policy. Through this process, the claims are subjected to various

[13] Providers must apply for reinstatement with the OIG to be removed from the exclusion list once exclusion periods end. The provider had not done this at the time he was approved as a Missouri Medicaid provider in 2004.

edits, including duplicate payment edits, provider and recipient eligibility edits, coverage edits and various other edits that are specific to provider types and specialties.

The MMIS status codes and dispositions are as follows:

- Status 1 - Super Suspend - Claims are not paid but are suspended regardless of any other exceptions or status codes.
- Status 2 - Deny - Claims are not paid.
- Status 3 - Suspend - Claims are not paid but are posted to a suspended claim file for resolution.
- Status 4 - Pay, but report - claims are paid and posted to an exception report which division staff is to evaluate later to determine the appropriateness of the payment.
- Status 5 - Pay - Claims are paid and not posted to an exception report for staff review (in limited situations the claim benefit information may be reported to the provider).

Reports not reviewed

The status 4 exception report had not been reviewed for years prior to our audit inquiries. This daily report can be in excess of 1,000 pages. The reports should have been reviewed by applicable division staff to ensure the propriety of claims paid. Discussions with agency officials in the PIU, Program Operations (PO), and MMIS sections determined no one had reviewed the daily reports for approximately 6 years prior to our inquiries in June 2007. According to division employees, the division discontinued printing most exception reports (including the status 4 exception report) between 2000 and 2001. A PO supervisor and PIU official could not provide a reason why exception report reviews were discontinued once the report became an electronic document.

In June 2007, PIU staff performed an analysis of the report. The summary report of the analysis showed:

- After July 2005 when many edit codes changed to status 4, PO ran exception reports comparing billing by code before and after the change, but did not analyze the status 4 exception report.
- PO staff identified codes related to circumcisions being billed more frequently after the change, but department officials denied changing the

edit for these codes. PIU staff performed a separate review on these codes.

- Drug claim codes had been essentially inactivated in the MMIS system because those claims are now analyzed by a state contractor.
- For some codes the staff person suggested consideration of an exception report to monitor the code.
- For some codes the staff person suggested the PIU consider the area for a medical review.

Potential abuse edits changed

Edits having a high potential for identifying fraud and abuse were changed to status 4. We reviewed a November 2000 Medicaid fraud risk review report[14] contracted for by the state. This report identified 23 edits as having a potential for identifying fraud or abuse. Our analysis of 14 of these edits determined the system status for 10 edits had changed by 2006 to status 4 or 5 (for paper and/or electronic claims) from deny or suspend.

A PIU analyst said many of the edits changed due to the division's transition to a paperless claim submission process. A MMIS official also said some edits also changed for drug claims because those claims are now reviewed under a separate state contract.

We obtained paid claim detail for the period April 2005 to January 2008 for expenditures that hit these edits. Seven of the edits showed little or no activity but three had activity as detailed below:

- Edit 005 - Provider name and number do not match - 657 claims paid for $50,878.
- Edit 564 - Visit billed within 30 days of procedure - 801 claims paid for $31,010.
- Edit 476 - Global prenatal billed after 2 prenatal consultations -14 claims paid for $13,650.

Division officials could not provide documentation to show any of these transactions or the providers associated with the transactions had been reviewed for propriety.

[14] The Medstat Group Inc., *Medicaid, Fraud, Waste and Abuse Risk Review*, November 21, 2000.

SPARs requests not always completed timely

SPAR processing lacked monitoring and tracking procedures which resulted in some SPARs prioritized as high risk not being promptly processed. A SPAR is completed when there is a request for MMIS staff to research a problem with the MMIS.

We reviewed 75 SPARs made from June 2004 to October 2006. Twenty of the SPARs had been prioritized for completion as high or as soon as possible. Reports showed 8 of the SPARs took more than a year for completion with 4 taking more than 2 years to complete.

An MMIS official attributed the delays to lack of staff assigned to the SPAR review and resolution process. The official said the SPAR priority ranking is assigned using her judgment. During fiscal year 2008, MMIS officials assigned a PIU employee to track the status of the SPARs in a database and periodically inquire on their completion status, according to the official.

Managed Care Encounter Data Not Reviewed

PIU staff does not perform fraud detection activities on encounter claim[15] data in the managed care program. Federal regulations require states to perform fraud detection work on Medicaid claims which would include both fee-for-service and managed care activity. PIU officials told us unit staff perform fraud detection activities in the Medicaid fee-for-service program. However, the officials said no fraud detection work is performed in the managed care program because of a lack of resources and reliance on the fraud detection programs the managed care companies are required to have, and the encounter claim data is not reliably complete. A similar problem was reported in a report issued by the SAO in January 2004.[16] A federal official involved in the Medicaid Program told us by not monitoring the managed care program for fraudulent activity, the division cannot be sure if the levels of capitation payments reflect the true cost of services, which could eventually result in higher costs to the state.

Encounter claims data still not complete

Encounter data submitted by managed care organizations is not complete. In December 2007, the state's Managed Care External Quality Review for fiscal year 2006 reported weaknesses with encounter data still existed. The report said analysis performed was impacted because only paid encounter claims were available and other claims submitted and rejected through system edits were unavailable. The report said contractor staff could not conclude on the extent to which the encounter claims database reflected the

[15] Encounter data is used for managed care organization rate setting and quality improvement evaluations.

[16] SAO, *Oversight Controls and Management in the State's Managed Care Program*, 2004-01, January 2004.

accuracy and completeness of rejected claims. In January 2004, the SAO reported similar weaknesses in encounter data.

Missouri's False Claims Act Does Not Mirror Federal Act

The 2007 Missouri General Assembly enacted legislation modifying existing state Medicaid fraud laws to include false claims act provisions. However, state law does not include required provisions to allow Missouri to retain an additional 10 percent of funds recovered under the act. To encourage states to pass false claims act legislation, the Federal Deficit Reduction Act of 2005 included provisions allowing states which pass laws that mirror the Federal False Claims Act[17] to keep 10 percent more than the Medicaid matching rate of monies recovered from cases that are settled or prosecuted under the state act.[18]

Guidelines[19] state that for a state's act to mirror the federal act and be eligible for the enhanced recoveries, the state act must include provisions that (1) the suit will remain under seal for at least 60 days, and (2) cases not accepted by the Attorney General can proceed at the discretion of the citizen/whistleblower.[20] Missouri's 2007 legislation did not include either of these provisions. The legislation allows the Attorney General to proceed with a case at his discretion, but does not include a provision allowing the citizen/whistleblower to proceed with the case if the Attorney General declines to pursue it. The person providing the information for any case prosecuted by the Attorney General would be eligible to receive 10 percent of recovered monies. A person intentionally filing a false report or claim alleging a Medicaid fraud violation would be guilty of a misdemeanor under the legislation.

As of 2008, our review determined 23 other states had enacted false claims acts with some states limiting the provision to the Medicaid Program. Texas

[17] 31 U.S.C. sections 3729-3733. A federal law which allows people who are not affiliated with the government to file actions against federal contractors claiming fraud against the government. The act of filing such actions is informally called "whistleblowing." Persons filing under the act stand to receive a portion of any recovered damages. The act provides a legal tool to counteract fraudulent billings turned in to the federal government. Claims under the law have been filed by persons with insider knowledge of false claims which have typically involved health care, military, or other government spending programs.

[18] The federal portion of Medicaid monies recovered from over billings or fraud must be reimbursed to the federal government. Effective October 1, 2007, Missouri's Medicaid federal matching rate was 62.42 percent. As a result, with an eligible state False Claims Act, Missouri would only have to reimburse the federal government 52.42 percent for recoveries or settlement resulting from cases filed under the act. The matching rate increased to 63.19 percent effective October 1, 2008.

[19] Federal Register, Vol. 71, No. 161 issued August 21, 2006.

[20] Referred to as Qui tam provision.

established its act in 1995 and New Jersey did so in 2008. The state acts generally mirrored the Federal False Claims Act which includes whistleblower provisions allowing citizens with evidence of fraud against government contracts and programs to sue, on behalf of the government, to recover the funds. In compensation for the risk and effort of filing such cases, the citizen/whistleblower may be awarded a portion of the funds recovered, typically between 15 and 25 percent. Such federal suits initially remain under seal for at least 60 days during which time the Department of Justice can investigate and decide whether to join the action. At the state level, a state's Attorney General evaluates the merits of a case. An Indiana official said he believed a false claims act helped identify more fraud and abuse because even if a state Medicaid Fraud Unit investigates a provider, it may not be able to get as much information as an insider would. At least 15 states with false claims acts allow the cases to continue if the Attorney General decides not to proceed with the case.

Other states with false claims acts did not experience a reduction in provider enrollment

To discuss the impact of these acts on the Medicaid Program, we contacted Medicaid staff in 17 states[21] with false claims acts. Officials from these states said a false claims act should not adversely affect current Medicaid providers. A Michigan official said frivolous lawsuits are limited in that state because of the extensive vetting process the state's Attorney General uses before choosing to prosecute a case. He also said Medicaid providers are already subject to suit under the Federal False Claims Act, and if they have not been charged under that act, it is unlikely they will face a suit under a state's false claims act. Another official in Virginia, who handles false claims act cases, said small dollar cases, which are feared by providers, would not be filed under the law because they would not be worth the time and money of the private citizen and his/her legal counsel. The same official in Virginia and an official from Massachusetts said suits normally involve large providers, often in the pharmaceutical industry.

None of the Medicaid staff from other states reported a decrease in provider enrollment after passage of a False Claims Act. Medicaid officials from 6 states told us Medicaid provider enrollment had not decreased in their state for several years.

Representatives from 4 states reported total recoveries under false claims acts of greater than $10 million, with one state reporting over $79 million in recoveries. Two other states reported total recoveries in excess of $1 million.

[21] States contacted had their False Claims Acts in place by early 2007. Officials from three states did not respond to our requests for information. We did not contact Hawaii.

FAD System Contract Included Items Not Used

The division requested functionality elements for its FAD system in the original contract that were not implemented. Through December 2007, the division spent about $10.5 million on the system and exchanged original contract components for additional consulting hours and software. In 2002, the division contracted to build and support a FAD system to assist the PIU in identifying abnormal billing patterns by providers and provide information for identifying potential overpayments. The initial 5 year contract required the contractor to provide functionality including, among other things, 80 data processing algorithms[22] over the life of the contract; a case tracking system; a mapping system; and advanced FAD system software for data mining. None of this functionality has been provided as originally required.

Only 48 of the 80 data processing algorithms were produced. PIU staff told us the approved algorithms required many hours of work to provide useful results and additional algorithms would increase this workload. Contractor officials said the 80 algorithms originally requested by Missouri were more than any of the other 7 states with which the company had contracts. An official from Nebraska[23] with a similar system told us that state only has a few algorithms and plans to contract for more incrementally. In 2005, the division exchanged the other 32 contracted algorithms for consulting hours that were provided by the contractor. Division officials said the contractor used the hours for additional projects which included a rebuild of the FAD system and an analysis project.

The division substituted the contractual mapping, case tracking, and advanced fraud and abuse system for other hardware and software. The mapping software was exchanged for hardware needed to maintain the FAD system. Both the case tracking software and advanced FAD system were exchanged for another data analysis tool and licenses for that tool. The case tracking software was developed by the contractor, but never approved by the division. Records show division officials notified the contractor in March 2006 that the FAD system provided was sufficient to meet the needs of the PIU, and the advanced system was more complex than the unit could effectively use at the time. The records also stated the contractor was not obligated to deliver or support the case tracking software under the contract, and did not request any compensation for forgoing this portion of the

[22] A step-by-step problem-solving procedure, especially an established, recursive computational procedure for solving a problem in a finite number of steps.

[23] Seven states other than Missouri (Georgia, Nebraska, Nevada, New Hampshire, Ohio, South Carolina, and Tennessee) contract with this contractor for a FAD system. Only Medicaid staff from two states, Nebraska and New Hampshire, responded to questions regarding their system.

contract. Division officials subsequently contacted the contractor in the summer 2006, to obtain the software licenses discussed on the previous page.

FAD system implemented behind schedule

Implementation of the FAD system did not meet the timeframe requirements specified in the contract. The contract required initial implementation of the system within the first 9-10 months of the contract period. By the end of the first contract year the software was to be installed, customized and tested, including 50 algorithms to be implemented by the end of phase two of the contract. The initial contract also called for phase three, including advanced software implementation, to be completed by the 15th month of the contract. The remainder of the contract term was to include additional algorithm implementation and general training and support.

Missouri completed year five of the contract in March 2007. The contract was scheduled to move to the support phase out of the testing phase at the beginning of 2007 but was not completed until December 2007. In November 2005, PIU officials approved 38 algorithms for use. An additional 10 algorithms were also tested for final use. Case management systems and advanced FAD software were not complete when they were exchanged for other software in year five of the contract.

Both division and contractor officials cite the lengthy algorithm approval process as a reason for the delay in system implementation. Per division officials, the "canned" algorithms the contractor had previously designed for other states required a lot of work and review before they were useful for Missouri. PIU staff and supervisors reviewed algorithms extensively to ensure results having the most potential information and resulting ROI. PIU staff said the algorithms produced a lot of "false positives[24]" which led to additional work requiring the contractor programmers to redefine the algorithm logic.

Two contractor officials agreed the algorithm approval process took longer than expected. One official said other states used fewer algorithms but, moved into the actual process of finding fraud faster. The contractor officials said it is difficult to compare the work done with other states to Missouri because of the unique needs of the state. One official said she felt PIU staff wanted reports that produce no "false positives." She also stated the review process in Missouri was more intense than in other states, possibly due to an effort to prevent these "false positives."

[24] The potential exceptions in the algorithm result turn out to be proper transactions.

Contract amended in fiscal year 2008

Effective August 1, 2007, the division amended the contract with the FAD system contractor to include analytical consulting services for $41,042 per month, for the 11 month contract period. The contract required the contractor to hold back billing 10 percent or $4,104 per month until the division validates that program savings from recoveries and cost avoidance totaled a minimum of $25 million for the fiscal year ending June 30, 2008. If the minimum savings threshold was not met, the hold back would not be invoiced by the contractor.

The deliverables to be provided for the monthly fee include:

- New algorithms and modifications to existing algorithms
- Reports and documentation relevant to case development
- Procedures for providing division administration with documentation of barriers to recovery including Medicaid policy issues
- Preparation of relevant portions of reports on PIU activities as requested by the division
- Providing 2 full-time contractor staff to fulfill the deliverables

Division officials said the FAD system contractor provides PIU analysts with reports which allow them to review a specific provider for various infractions. The official said recoveries and cost avoidance identified for the period ended June 30, 2008, totaled $25.3 million (approximately 80 percent cost avoidance) and the contract had been extended.

Conclusions

An error in provider enrollment resulted in a disqualified provider being paid $669,000 in Medicaid funding. Division officials reported making procedural changes to better identify excluded providers following this situation. These procedures need to be periodically evaluated and improved where necessary to prevent similar errors in the future.

Limited review of transactions hitting the status 4 report, especially for edits with a higher risk for fraud or abuse, increases the risk that abusive billing practices will not be detected.

High priority SPAR changes have not always been performed timely due to the lack of a completion tracking process. Such a process is needed to ensure staff identified system critical concerns are corrected.

Division staff does not perform fraud detection work on managed care encounter data and managed care organizations are still not submitting complete and accurate encounter data. These areas, while already critical to Medicaid Program oversight, will become even more important as the division transitions Medicaid recipients to managed care from fee-for service over the next few years. Incomplete or inaccurate encounter claim data can led to higher future capitation rates.

A state's False Claims Acts must meet guidelines established by the DHHS – OIG to be eligible for retaining 10 percent more of recoveries under the act. Missouri law fails to meet those requirements resulting in the state being able to retain less recovered funding than possible.

The division contracted for a system PIU staff could not effectively use. A FAD system is a useful tool for identifying potential overpayments. However, the division spent almost four of the five contract years implementing rather than using the system. This problem led to the contract being behind schedule and the division exchanging original contract elements for other services.

Recommendations

We recommend the Director of the Department of Social Services:

4.1 Periodically reevaluate provider enrollment procedures to ensure disqualified providers are not approved as active Medicaid providers.

4.2 Improve procedures regarding MMIS edits that would include:

- Reviewing the status 4 report on a routine basis for transaction propriety and trends.
- Evaluating edits set at status 4 to ensure the edits offer the payment safeguard designed to protect Medicaid funds. In addition, the department should ensure timely transaction review or other compensating controls are in place for edits set at that status.
- Establishing procedures to track SPAR completion status to ensure high priority requests are timely completed.

4.3 Develop and implement fraud detection activities for encounter claim data.

4.4 Continue working with managed care organizations to improve the accuracy of encounter claim submissions.

4.5 Work with the General Assembly to pass False Claims Act legislation that allows the state to retain a larger share of recovered monies.

4.6 Ensure FAD system features are needed for future contracts and evaluate the needs of the unit when considering future FAD system contract changes.

Agency Comments

4.1 We agree with this recommendation. At the time the provider was identified, the Provider Enrollment Unit (PEU) immediately made procedural changes to ensure that the provider is not enrolled if his/her name remains on the exclusion list even after the expiration of the exclusion period.

The provider in question was excluded beginning in November 1995 for a period of five years. The provider was eligible to have his name removed from the exclusion list in late 2000, but failed to complete the necessary paperwork. The division erroneously enrolled the provider in 2004 due to that technical oversight. Once it was brought to the provider's attention, he completed the necessary paperwork to have his name removed from the exclusion list.

*4.2 We partially agree with this recommendation. Many of the claims in question had been set to a status 4 (pay but report) prior to the implementation of the Fraud and Abuse Detection System. Prior to the enhancement of the ability of the division to systematically detect suspicious claims, a tool was to identify an edit to manually monitor. It is a laborious and staff intensive process to go through every claim that may hit an edit. With staffing cuts in 2003 and 2005, the division relied more upon the Fraud and Abuse Detection System to identify suspicious claims in an effort to direct s*taff *to more probable cases for a better return on investment.*

The PIU will evaluate the status 4 report. The evaluation each month will focus on several edits at a time. Based upon the review, a determination will be made for the appropriate action to be taken. If an issue arises with a particular edit during the month, priority will be given to the issue.

Fiscal agent staff have been made aware that high priority SPARs need to be resolved as soon as possible. A MMIS staff person has been assigned the task of monitoring SPARs for completion time and will notify the fiscal agent and supervisor when resolution is not timely. A new view has been created in the SPAR database that will give staff the ability to monitor requests by priority and handle accordingly.

4.3 We partially agree with this recommendation. Currently, the Managed Care Organizations (MCOs) have an approved fraud and abuse detection plan and are required to monitor their contracted providers' billing practices. The MCOs have a vested interest in protecting against fraud and abuse since they are at full risk for the financial loss.

The MCOs report their identified suspected fraud and abuse cases and activities to the MO HealthNet Division on a quarterly basis. PIU does notify the MCOs of problem providers that are also in the MCO network to see if the questionable practices are affecting the MCO billings as well. PIU is not staffed to monitor the MCO network providers as well as the MO HealthNet fee-for-service network.

The PIU will evaluate whether there is a non-duplicative monitoring process for encounter data that has a high return on investment.

4.4 We agree with this recommendation. In December 2007, the Managed Care Unit began conducting monthly Encounter Data Technical Assistance calls with the Managed Care Organizations (MCOs) and Infocrossing Healthcare Services, Inc. to improve the accuracy of encounter data and use for managed care rate development. The monthly technical assistance calls will continue until all outstanding encounter submission issues are resolved.

Once all outstanding issues are resolved, the Managed Care Unit will move to quarterly Encounter Data Technical Assistance calls with Infocrossing and the MCOs to address new issues as they arise.

Current evaluation has determined that the hospital and pharmacy encounters are reliable. Other encounter data claim types are nearing being able to be rated as valid. New contract requirements regarding encounter submission requirements will help improve the reliability and accuracy of encounter data.

4.5 We agree with this recommendation. There was such a bill filed in 2006 (Senate Bill 1210). The bill was not passed by the General Assembly at that time. The department will cooperate and provide supporting documentation as requested by the General Assembly.

4.6 We disagree with this recommendation. The FAD system is operational and fully functional. Although not all 50 algorithms were in place, 38 algorithms and other system capabilities were fully functional and were producing results as evidenced by the increasing

savings over time. It would not be wise to simply insert canned reports into a system without modification to reflect a state's unique billing rules. Without that critical step, you would get a report that would have lower yield. By taking the time necessary to ensure that the algorithms produce the correct result, the resulting yield and return on investment is greatly enhanced. Fraud and Abuse Detection is not a static environment where you implement a detection report and expect the same level of results over time. As you work a report over time, providers learn the correct billing procedures and the detection report has diminishing returns. In fact, the division and contractor continue to review and refine algorithms that reflect the changing billing patterns of providers over time and the discovery of new schemes that have potential for recovery.

SAO Comment

The point of recommendation 4.6 is not to criticize the number of algorithms, but to recommend that planning for similar future contracts or FAD system improvements be better coordinated since many of the original items in the contract including a case tracking system, a mapping system, and advanced FAD system software for data mining were not delivered.