Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Alabama Comprehensive Program Integrity Review

Final Report

June 2013

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Introduction

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Alabama Medicaid Program. The MIG review team conducted the onsite portion of the review at the Alabama Medicaid Agency (AMA) offices. The MIG also conducted a telephone interview with the Alabama Medicaid Fraud Control Unit (MFCU).

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

The CMS is concerned that the review identified one partial repeat and two repeat findings from its 2009 review of Alabama. The CMS plans on working closely with the State to ensure that all issues, particularly those that remain from the previous review, are resolved as soon as possible.

The Review

Objectives of the Review

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

Overview of Alabama's Medicaid Program

The AMA administers the Alabama Medicaid program. As of January 1, 2012, the program served 939,100 beneficiaries, 59 percent of whom were enrolled in a primary care case management program. Alabama has a Prepaid Ambulatory Health Plan (PAHP) that delivers maternity services to Medicaid beneficiaries through a mandatory Maternity Care Program. These PAHPs use several managed care techniques although they are paid on a pre-determined global fee for service package rate for covered services. The State considers PAHPs as managed care entities (MCEs). Medicaid net expenditures in Alabama for the State fiscal year (SFY) ending September 30, 2011 totaled $4,793,247,547.

Medicaid Program Integrity Division

In Alabama, the PID within the AMA is the organizational component dedicated to fraud and abuse activities. At the time of the review, the PID had 27 full-time equivalent positions. The following table presents the total number of preliminary and full investigations and overpayments identified and collected in the last four SFYs.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified***	Amount of Overpayments Collected***
2008	840	830	$7,250,165	$3,807,986
2009	718	647	$8,467,567	$2,138,743
2010	568	525	$6,353,426	$4,308,331
2011	186	163	$5,088,818	$4,497,246

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation. The decrease in preliminary investigations in SFY 2011 resulted in the elimination of the pharmacy audit unit and staff. Current pharmacy audits are performed with the PID but not at the same volume as in past years.
**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved though administrative action, a referral to the MFCU or other legal disposition.
***These figures do not reflect global settlements.

Methodology of the Review

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

During the week of August 7, 2012, the MIG review team visited the PID and fiscal agent offices. The team conducted interviews with numerous PID officials, as well as with staff from the fiscal agent. The review team interviewed MFCU staff by telephone during the week prior to the onsite review. To determine whether the MCEs were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team reviewed the State's managed care contracts. The team conducted in-depth interviews with representatives from MCEs and met separately with AMA staff to discuss managed care oversight and monitoring. In addition, the team conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate Alabama's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the PID, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment and contract management. Alabama operates its Children's Health Insurance Program (CHIP) as a stand-alone Title XXI program. The stand-alone CHIP program operates under the authority of Title XXI and is beyond the scope of this review.

Unless otherwise noted, Alabama provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information provided.

Results of the Review

Noteworthy Practice

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

Mandatory enrollment of all fee-for-service (FFS) providers, MCEs, and managed care network providers

The State requires mandatory enrollment of all FFS providers, MCEs and managed care network providers into the Medicaid program. By having a single focal point of enrollment, the Medicaid agency ensures that these provider types are subject to the same enrollment processes in which required disclosures are made, license verification conducted and exclusion searches performed.

Notwithstanding Alabama's achievements in this area, the team found other issues related to the provider enrollment process. These are discussed in the Regulatory Compliance Issues section of this report.

Effective Practices

As part of its comprehensive review process CMS invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Alabama reported pre-enrollment site visits for high risk providers and effective oversight and coordination practices for their waiver programs.

Pre-enrollment site visits for high risk durable medical equipment (DME) providers

The State conducts pre-enrollment site visits for high risk providers. Since July 2009 when the State implemented this process, 196 site visits have been conducted and 21 DME provider applications have been denied for non-compliance with Medicaid requirements. Additionally, since November 2010, the State has included high-risk providers from bordering States in this process.

Enhanced oversight of and coordination among waiver program

The State's Long Term Care Division and Waiver Quality Assurance Unit oversee three sister agencies: the Department of Mental Health and Mental Retardation (DMH), the Department of Senior Services (DSS), and the Department of Rehabilitation Services (DRS). These three agencies administer six of seven home and community-based service waivers. The State's oversight of the waiver programs includes auditing 50 client records of the sister agencies annually; onsite audits of group homes and day centers; unannounced site visits; review of direct service providers and agencies billing and medical records to match claims data; review of case management records and personnel files; review requirements for nurses and level of care for personal care services; and beneficiary home visits in particular waivers. In addition, the sister agencies perform similar second tier reviews of their subcontracted providers and provider networks on a

varying monthly, quarterly or annual schedule. Finally, the State Medicaid agency and sister agencies meet quarterly to discuss waiver program issues including program integrity.

Regulatory Compliance Issues

The CMS review team found six regulatory compliance issues related to program integrity in Alabama. These issues are significant and represent risk to the Alabama Medicaid program. Ranked in order of risk to the program, these compliance issues include: not complying with Federal regulations regarding suspension of payments in cases involving credible allegations of fraud, conducting incomplete searches for excluded and debarred individuals and entities, failing to collect complete ownership and control disclosures, not verifying receipt of Medicaid services billed by providers, and not collecting complete business transaction and criminal conviction disclosures.

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

The PID is not suspending payments when there is a credible allegation of fraud before referring to the MFCU nor documenting a good cause exception not to suspend payments. The PID referred seven cases to the MFCU from March 25, 2011 through August 6, 2012. Of the seven cases sampled, four cases had documentation indicating that payment suspension was initiated after the referral to the MFCU and not at the time the referral was made nor were the cases documented with a good cause exception to not suspend provider payments. Cases sampled by the MIG review revealed that, on average, payment suspensions were delayed by 5-10 days after the referral to the MFCU. As a result, approximately $1,477,928.86 was paid to providers from January 5, 2012 through April 13, 2012 after the referral to the MFCU after the State determined there was a credible allegation of fraud, potentially putting these payments at risk. Furthermore, the State did not have policies and procedures to ensure there is a consistent process for suspending payment.

In addition, three of the seven cases sampled did not meet the minimum criteria in the referral performance standards under 42 CFR 455.23(d)(2)(ii). In the three cases identified, the State did not make reference to specific Medicaid statutes, rules, regulations, or policies violated, and in some cases there was no reference to the amount paid to the provider during the alleged misconduct or during the last three years.

Recommendations: Suspend payments to providers when an investigation determines there is a credible allegation of fraud or document a good cause exception not to suspend payments. Refer

such cases to the MFCU and comply with the documentation requirements of 42 CFR 455.23. Develop policies and procedures to ensure there is a consistent process to comply with 42 CFR 455.23.

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid.
The Federal regulation at 42 CFR 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on U.S. Department of Health and Human Services Office of Inspector General's (HHS-OIG) List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System (EPLS[1]) no less frequently than monthly.

Neither the State nor the fiscal agent checks the LEIE or EPLS during the enrollment process. The fiscal agent only checked the Medicare Exclusion Database (MED) at enrollment or re-enrollment. Monthly checks are not performed against any of the databases as required under 42 CFR 455.436. Additionally, the State's automated database, administered by the fiscal agent, includes only provider names. Owners, persons with controlling interests, and managing employees have not been keyed into this database, so the State does not have a complete list of names to use for continuous monthly exclusion checking. Furthermore, the State did not have policies and procedures for conducting searches for excluded individuals and entities.

The State agency established and disseminated policies to sister agencies requiring waiver programs to check their providers against the State Suspended Providers List and the LEIE. Chapter 7 of the Provider Manual clearly details the providers' responsibility in checking the various exclusion lists. However, a notice suggests that sister agencies encourage their providers to check employees and subcontractors, it was not confirmed that waiver program providers consistently do so or that this is a focus of the administrative audits performed by the State or sister agencies. Specifically, DMH reported that it does exclusion checking only as needed. DRS conducts exclusion checking of the provider name, Licensed Practical Nurses/Registered Nurses working in Direct Service Provider agencies and all owners names captured at enrollment. DSS reported that exclusion checking would be done at the Area Agencies on Aging level and could not confirm that exclusion checking on all parties required by the Federal rule is completed at enrollment or conducted monthly. In brief, waiver program staff discussed checking against the LEIE but not doing so monthly and it was not clear that waiver programs have consistently checked against exclusion databases at initial enrollment across all programs and for all required parties.

In addition, the AMA does not search the names of parties disclosed by the MCEs on the LEIE or the EPLS at the time of contracting or monthly for MCEs. Also, the AMA contracts have no requirements for MCEs to perform monthly exclusion checking on the LEIE or EPLS for

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[1] On July 30, 2012, the EPLS was migrated into the new System for Award Management (SAM). State Medicaid agencies should begin using the SAM database. See the guidance at http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-01-12.pdf for assistance in accessing the database at its new location.

providers regarding persons with an ownership or controlling interest, agents and managing employees.

Recommendations: Search the LEIE (or MED) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities. Develop and implement policies and procedures for appropriate collection and maintenance of disclosure information about the provider, any person with an ownership or control interest, or who is an agent or managing employee of the provider.

Modify the managed care contract to require MCEs to search the LEIE and EPLS upon contract execution and monthly thereafter by the names of any person with an ownership or control interest in the MCE, or who is an agent or managing employee of the MCE.

The State does not capture all required ownership and control disclosures from disclosing entities. (Uncorrected Partial Repeat Finding)
Under 42 CFR 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or MCE, must disclose to the State Medicaid agency the name, address, date of birth (DOB), and Social Security Number (SSN) of each person or entity with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling. Moreover, under 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

The State's provider enrollment forms for FFS and managed care network providers covers all required elements with the exception of defining and requesting the enhanced address from individual or corporate owners. In addition, the DSS and DRS enrollment processes do not capture all of the requirements under 42 CFR 455.104 about persons with ownership or controlling interests and managing employees.

In the 2009 MIG review, it was noted that the State was not collecting fiscal agent disclosures. Although, the State is currently collecting fiscal agent disclosures as part of the Request for Proposal and contracting process, individuals and entities are not required to provide DOB and SSN as mandated under 42 CFR 455.104.

In addition, a review of the 'State of Alabama Disclosure Statement' completed by MCEs as part

of the procurement process does not include information matching the requirements of 42 CFR 455.104. Specifically, this disclosure statement does not request the name, address, DOB, and SSN of each person or entity with an ownership or controlling interest in the MCE or in any subcontractor in which the MCE has a direct or indirect ownership interest of 5 percent or more. It also does not request every business location, including P.O. Box address, relationship information, nor the name of any other disclosing entity in which a person with an ownership or controlling interest in the MCE has an ownership or controlling interest. Lastly, the AMA does not require MCEs to provide the name, address, DOB, and SSN of any managing employee.

Recommendations: Modify disclosure forms as necessary to capture all disclosures required under 42 CFR 455.104. Collect the full range of disclosures from the fiscal agent during contracting as mandated by the regulation. The MIG made the same recommendations regarding fiscal agent disclosures in the 2009 review report.

The State does not verify with beneficiaries whether services billed were received. (Uncorrected Repeat Finding)
The regulation at 42 CFR 455.20 requires the State Medicaid agency to have a method for verifying with beneficiaries whether services billed by providers were received.

In the 2009 MIG review, it was noted that the State was not verifying with Medicaid beneficiaries whether services billed by providers were received. Although Alabama does send out Recipient Explanation of Medicaid Benefits Statements (REOMBs), these are used only to gain beneficiaries input on quality of care issues. The REOMBs do not verify that services billed were actually delivered. The Medicaid State agency realizes the value of issuance of beneficiary verifications, but due to budget constraints have not been able to implement notices to validate services.

Recommendation: Verify with Medicaid beneficiaries whether services were received as billed. The MIG made the same recommendation regarding verification of receipt of services in the 2009 review report.

The State does not adequately address business transaction disclosure requirements in its provider agreements or contracts. (Uncorrected Repeat Finding)
The regulation at 42 CFR 455.105(b) requires that, upon request, providers furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractors.

Provider agreements and memoranda of agreement used by sister agencies for waiver programs do not include provisions consistent with 42 CFR 455.105(b). Also, a review of Alabama’s contracts with its MCEs revealed that the AMA does not require the MCEs to furnish business transaction information to the State or HHS upon request; nor does the AMA have a provider agreement signed by the MCEs requiring them to submit business transactions as mandated under 42 CFR 455.105(b). In 2009, the AMA out-of-state provider agreement did not include a statement that the provider agreed to furnish business transaction disclosures within 35 days of a

request by AMA or HHS.

Recommendation: Revise provider agreements and managed care contracts to require disclosure upon request of the information identified in 42 CFR 455.105(b). The MIG made the same recommendation regarding MCEs in the 2009 review report.

The State does not capture required criminal conviction disclosures from contractors.
The regulation at 42 CFR 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify the HHS-OIG whenever such disclosures are made. Pursuant to 42 CFR 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

The State is not collecting criminal history disclosures in waiver programs from persons with ownership and controlling interests in the provider, agents, and managing employees. Although provider enrollment in waiver programs requires that criminal background checks are done for all direct service providers, criminal history disclosures are not collected for all required parties.

A review of the "State of Alabama Disclosure Statement" form completed by the MCEs during the procurement process revealed that the AMA does not require its MCEs to provide criminal conviction disclosures as required by 42 CFR 455.106 at the point of contracting or contract renewal. Also, a review of the AMA contracts with its MCEs indicated there are no contractual requirements for the MCEs to furnish criminal conviction disclosures to the State upon request. As a result, the AMA does not have procedures in place ensuring the reporting of MCE criminal convictions to the HHS-OIG within 20 working days.

Recommendations: Collect the appropriate criminal conviction disclosures in waiver programs from persons with ownership and controlling interest in the provider, agents, and managing employees. Revise managed care contracts to include contractual requirements for the MCEs to furnish criminal conviction disclosures to the State at any time or upon request and develop procedures to ensure HHS-OIG is notified with 20 working days when the State becomes aware of this information.

Vulnerabilities
The Alabama Medicaid program is at risk because it has two vulnerabilities in its program integrity activities. They include a lack of effective coordination and communication between the PID and MFCU and limited use of the State's own permissive exclusion authority.

Lack of effective coordination and communication with the PID and the MFCU.
Under the Federal regulation at 42 CFR 455.21, State Medicaid agencies must refer all cases of suspected provider fraud to the MFCU; promptly comply with requests for access to records or information, including computerized data, from the agency or its contractors, and from providers; and initiate administrative or judicial actions to recover improper payments from

providers.

Alabama's current Memorandum of Understanding (MOU) between the Office of the Attorney General and the AMA requires at a minimum quarterly meetings to discuss anticipated referrals of reviews pending at Medicaid, training opportunities, the status of referrals under investigation by the Fraud Unit and other items of mutual interest to Medicaid and the MFCU. However, during interviews with both PID and MFCU Directors, the team was informed that meetings do not take place once per quarter but are held on an as needed basis. In addition, both parties confirmed that little or no training has taken place from either unit over the past several years and no joint training has been provided for other units of the State agency or other stakeholders.

As a result of interviews with the PID and the MFCU, the review team noted inconsistencies in communication between the two units. Review of documents and sampled case files revealed lack of coordination between the PID and the MFCU, which showed evidence of ineffective identification of suspected fraud, lack of collaborative referral processes and inconsistent resolution of suspected fraud and abuse.

Furthermore, based on the case files sampled, the CMS review team found that the MFCU did not consistently acknowledge when it receives a referral. The review team noted that the status of a case often becomes clear only when the MFCU declines a case, which in some instances can be several months later, or when the MFCU closes a case at conviction or settlement.

Recommendations: Develop procedures to ensure that the PID and the MFCU are meeting according to the guidelines in the MOU and that necessary trainings are conducted between both parties. Incorporate the September 2008 CMS fraud referral performance standards into written policies and procedures and training materials related to fraud cases and the referral process.

Not utilizing its authority to initiate exclusions for any reason for which the HHS-OIG could exclude a provider.
The regulation at 42 CFR 1002.210 requires that the State institute administrative procedures to exclude a provider for any reason for which the HHS-OIG could exclude a provider under 42 CFR Parts 1001 and 1003.

Although the State has a permissive exclusion policy in place, this program integrity tool is not being fully utilized. Almost all permissive exclusions reported by the State are either triggered by an OIG exclusion, Medicare exclusion, criminal conviction or license revocation. The State agency has a Utilization Review Committee that reviews and approves all adverse administrative actions proposed against providers, but the committee has rarely taken action without prior actions being taken by other agencies. In addition, the permissive exclusion policy did not address the responsibilities of this committee. During case sampling, the CMS review team sampled cases where repeated billing errors, excessive charges or unnecessary services, while not rising to the level of fraud, might have triggered stronger sanctions including permissive exclusions. The team also found that Alabama aggressively uses its administrative authority to recoup dollars, but could be more proactive in taking actions to independently sanction, suspend, or terminate providers.

Recommendation: Fully utilize the State's permissive exclusion policy to exclude an individual or entity for any reason for which the Secretary could exclude such individual is as required by the regulation at 42 CFR 1002.210. Consider including the responsibilities of the Utilization Review Committee in the policy or in some type of written format so all parties are aware of their responsibilities.

Conclusion

The identification of six areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, two areas of vulnerability were identified. The CMS is particularly concerned that the review identified one partial repeat finding and two repeat findings from its 2009 review of Alabama.

To that end, we will require Alabama to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Furthermore, 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 Alabama 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 Alabama 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 Alabama on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

Official Response from Alabama
July 2013

ROBERT BENTLEY
Governor

Alabama Medicaid Agency

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STEPHANIE MCGEE AZAR
Acting Commissioner

July 17, 2013

Peter Leonis, Director
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Dear Mr. Leonis:

This letter is a formal response to the Alabama Comprehensive Program Integrity Review Final Report issued by your office on June 18, 2013. I would like to take this opportunity to thank you and your staff for working with the Alabama Medicaid Agency staff to ensure that all comments were taken into consideration prior to issuing the final report.

Enclosed with this letter are the corrective action plans for each of the six non-compliance issues and the two areas of vulnerabilities identified during the review. We appreciate the opportunity to share the corrective action plan with you and your staff and will continue to work to ensure that we are in compliance with all program integrity statues and regulations.

If you have any questions, please feel free to contact Jacqueline Thomas at (334) 242-5318 or at Jacqueline.Thomas@medicaid.alabama.gov .

Sincerely,

Stephanie McGee Azar
Acting Commissioner

SMA:JTj

Enclosure