Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Louisiana Comprehensive Program Integrity Review

Final Report

December 2013

Reviewers:
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Executive Summary and Introduction

The Centers for Medicare & Medicaid Services (CMS) regularly conducts reviews of each state's Medicaid program integrity activities to assess the state's effectiveness in combating Medicaid fraud, waste, and abuse. Through state comprehensive program integrity reviews, the CMS Medicaid Integrity Group (MIG) identifies program integrity related risks in state operations and, in turn, helps states improve program integrity efforts. In addition, CMS uses the reviews to identify noteworthy program integrity practices worthy of being emulated by other states. Each year, CMS prepares and publishes a compendium of findings, vulnerabilities, and noteworthy practices culled from the state comprehensive review reports issued during the previous year in the *Program Integrity Review Annual Summary Report*.

The purpose of this review was to determine whether Louisiana's program integrity procedures satisfy the requirements of federal regulations and applicable provisions of the Social Security Act. A related purpose of the review was to learn how the State Medicaid Agency receives and uses information about potential fraud and abuse involving Medicaid providers and how the state works with the Medicaid Fraud Control Unit (MFCU) in coordinating efforts related to fraud and abuse issues. Other major focuses of the review include but are not limited to: provider enrollment, disclosures, and reporting; program integrity activities including pre-payment and post-payment review, methods for identifying, investigating, and referring fraud, appropriate use of payment suspensions, and False Claims Act education and monitoring; managed care oversight at the state level; and program integrity activities conducted by managed care organizations.

During 2012, Louisiana implemented a statewide physical and behavioral health Medicaid managed care program. Medicaid recipients have access to physical health care services with Bayou Health plans and access to behavioral health services through a Statewide Management Organization (SMO). The review of Louisiana's program integrity activities found the state to be in compliance with many of the program integrity requirements. However, the review team did note the state's Medicaid program is at risk because it has a number of vulnerabilities in its program integrity activities for fee-for service (FFS) and managed care. Ranked below in order of risk to the program these are:

1) Inadequate oversight of managed care operations in the first year of statewide implementation, including not having methods and criteria for oversight of Bayou Health plans and the SMO, and failing to verify services received directly with behavioral health beneficiaries.
2) Ineffective provider enrollment practices and reporting for FFS and managed care, including but not limited to, failing to properly search for excluded providers, properly capture necessary information for enrollment, or properly handle the termination of providers being removed from the program.

These risks include instances of regulatory non-compliance by the state as well as areas where the state does not have adequate program safeguards, creating a risk to the Medicaid program. These issues and CMS's recommendations for improvement are described in detail in this report.

CMS is concerned that two of the issues described in this review were also identified in CMS's 2009 review and are still uncorrected. CMS will work closely with the state to ensure that all issues, particularly those that remain from the earlier review are satisfactorily resolved as soon as possible.

Methodology of the Review

In advance of the onsite visit, the review team requested that Louisiana complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity infrastructure, provider enrollment and disclosure, fraud and abuse detection, interagency and intra-agency relationships, oversight of managed care, and relationship with the MFCU. A four-person team reviewed the responses and materials that the state provided in advance of the onsite visit. The review team also conducted in-depth telephone interviews with representatives from the MFCU, two Bayou Health plans and the SMO.

During the week of September 11, 2012, the MIG review team visited the Department of Health and Hospitals (DHH) Office of the Secretary and the fiscal agent offices. The team conducted interviews with numerous DHH officials as well as with staff from the fiscal agent. To determine whether the Bayou Health plans and the SMO 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 met separately with the DHH and contracted 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 Louisiana's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the Program Integrity Unit (PIU) within the DHH, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment and contract management. Louisiana operates its Children's Health Insurance Program (CHIP) as both a Title XIX Medicaid expansion program and a stand-alone Title XXI program. The expansion program operates under the same billing and provider enrollment policies as Louisiana's Title XIX program. The same effective practices and risks discussed in relation to the Medicaid program also apply to the CHIP expansion program. The stand-alone CHIP program operates under the authority of Title XXI and is beyond the scope of this review. Unless otherwise noted, Louisiana provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that the DHH provided.

Medicaid Program Integrity Unit

In Louisiana, the PIU is the organizational component dedicated to fraud and abuse activities. At the time of the review, the DHH had 12 full-time equivalent positions allocated to Medicaid program integrity functions and a new PIU director as of August 2012. Most surveillance and utilization review activities are contracted to the fiscal agent who supports core functions for state program integrity staff. The table below presents the total number of preliminary and full

investigations, and the amount of identified and recouped overpayments related to program integrity activities in the last four complete state fiscal years (SFYs).

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified	Amounts Recouped as a Result of State Imposed Administrative Sanctions ***
2009	442	912	$6,240,578	$5,856,659
2010	198	748	$5,632,691	$4,466,303
2011	288	987	$8,793,220	$8,462,409
2012	144	1220	$5,713,758	$5,340,600

* Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition. In Louisiana, many investigations originate as full investigations, bypassing the preliminary stage.
***The increase in overpayments identified and collected in SFY 2011 is due to special projects case work. This also explains the variations in preliminary and full investigations.

Result of the Review

The CMS review team found a considerable number of regulatory compliance issues and vulnerabilities related to program integrity in Louisiana's Medicaid program. Several of the issues are significant and represent risks to the integrity of the state's Medicaid program. These issues fall into two major categories of risk as outlined and discussed below. To address them, Louisiana should improve oversight and build more robust program safeguards.

RISK 1: Inadequate oversight of managed care operations in the first year of statewide implementation, including not having methods and criteria for oversight of the Bayou Health plans and the SMO, and failing to verify services received directly with behavioral health beneficiaries.

Oversight of Bayou Health plans and the SMO

The state had not adequately incorporated program integrity principles and policies in its newly implemented managed care program. The state began providing Medicaid services through a managed care delivery system in 2012. Neither the Office of Bayou Health, the Office of Behavioral Health, nor the PIU had developed written policies and procedures or had methods to effectively monitor program integrity activities to ensure that the baseline standards outlined at 42 CFR 438 Subpart H-*Certifications and Program Integrity* and 42 CFR 455 Subpart A–*Medicaid Agency Fraud Detection and Investigation Program* were actually being met.

Louisiana uses an External Quality Review Organization (EQRO) to perform some oversight functions in the managed care program. The review team was told by the state that the EQRO oversight includes program integrity. However, a review of the contract shows the work is only related to access and quality of care and does not include any program integrity oversight or ongoing monitoring of program integrity activities in its scope of work. The state also relied upon

the EQRO to perform a readiness review of the Bayou Health plans' managed care activities. With the SMO, the state relied on its Quality Management Strategy (QMS) and the SMO's Fraud Waste and Abuse Compliance Program for program integrity policies and procedures instead of using the EQRO. A review of the QMS showed that it did not encompass the monitoring of program integrity activities. Moreover, the state did not have an explicit plan to monitor the SMO's compliance plan or internal policies for effective implementation and operation.

In addition, in the startup of its managed care program, the state had inadequate processes to monitor provider enrollment activities to ensure that essential provider enrollment standards are being met and safeguards are in place. Risk 2 contains a more detailed discussion of provider enrollment and disclosure issues affecting managed care.

Verification of Services

A vulnerability was identified related to verification of services with beneficiaries. 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 Medicaid FFS program. While not legally mandated for managed care, CMS considers this to be a program safeguard that would generally be considered prudent to apply to managed care settings.

The Bayou Health Prepaid Managed Care Request for Proposal at section 17.3 required the plans within forty-five days of payment of claims to provide individual notices to a sample group of the members who received services. However, there was no contractual requirement for the SMO to verify the receipt of services, and there was no evidence that the SMO was doing this.

Recommendations: Develop and implement policies and procedures to facilitate stronger DHH oversight of Bayou Health and the SMO program integrity activities. Ensure at a minimum that managed care oversight staff in DHH continue to meet with Bayou Health plans and the SMO as well as the PIU to discuss program integrity issues and provide fraud and abuse prevention and detection training. Require Bayou Health plans and the SMO to verify with enrollees whether services by providers were received.

RISK 2: Ineffective provider enrollment practices and reporting for FFS and managed care, including but not limited to, failing to properly search for excluded providers, properly capture necessary information for enrollment, or properly handle the termination of providers being removed from the program.

Exclusion Searches

Upon enrollment and monthly thereafter, all providers as well as persons with ownership and control interests in, and agents and managing employees of, the provider must be checked against

the General Services Administration's Excluded Parties List System (EPLS)[1] and the U.S. Department of Health and Human Services – Office of Inspector General's (HHS-OIG's) List of Excluded Individual and Entities (LEIE) to ensure that programs are free from excluded and debarred providers and individuals in accordance with 42 CFR 455.436.

In the 2009 CMS review, the state was not maintaining complete information on owners, officers and managing employees in its Medicaid Management Information System (MMIS); therefore it could not conduct adequate checks of federal databases for exclusions and debarments. The state improved in this review, but was still not fully compliant as described in the section on ownership and control disclosures discussed below. During the provider enrollment demonstration, the review team noted that the state was not in compliance with 42 CFR 455.436 because only the practitioner and entity names were checked against the Medicare Exclusion Database (MED) on a monthly basis. The names of managing employees and agents of enrolling individual providers were not checked at enrollment for exclusions and debarments. In addition, there were no monthly checks conducted against the EPLS for debarments.

In the managed care program, one of the two Bayou Health plans interviewed was checking only practitioners and entity names at enrollment, re-credentialing and monthly in the LEIE. In addition, the EPLS was checked only at enrollment and re-credentialing for practitioner and entity names with no ongoing monthly checks for debarments. On the other hand, the SMO's Fraud, Waste, and Abuse Compliance Program required the plan to check the LEIE and EPLS for contractors and providers barred from participation and to perform these checks during credentialing, re-credentialing, contracting and monthly thereafter. However, during the interview, the SMO was not able to describe procedures used for exclusion and debarment searches. In addition, the plan used enrollment forms that did not capture persons with an ownership and control interest or agents and managing employees, which would prevent them from checking these individuals against federal databases. While not legally mandated for managed care entities, CMS considers this to be a program safeguard that would generally be considered prudent to apply to managed care settings.

Ownership and Control Disclosures

The state was also cited during the 2009 CMS review for not capturing all the disclosures as required in 42 CFR 455.104. While the state improved in this review, it was still not fully compliant in capturing disclosures for FFS providers. For corporate ownership, the Disclosure of Ownership Information Form and the basic Provider Enrollment form (PE-50) did not capture every business location and P.O. Box address, which is required in section (b)(1)(i) of the regulation. In addition, the language intended to capture the relationship of persons with an ownership or controlling interest in the disclosing entity and any subcontractors that the disclosing entity may own does not fully do so. The language asks for the relationship of such persons with the subcontractor rather than with the owners of the subcontractor.

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[1] On July 31, 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.

The state's Disclosure of Ownership and Control Interest Statement collected from the Bayou Health plans failed to capture the full range of disclosures for managing employees and other disclosing entities required by the regulation. Additionally, the state was unaware who received the disclosure forms completed by the SMO, so the review team could not determine if they were in compliance with the regulation.

Furthermore, a review of the managed care network providers applications showed that one of the Bayou Health plan's enrollment forms and the SMO network provider entity application did not require several parts of information that federal regulations at 42 CFR 455.104 (b)(1) would otherwise require from FFS providers. While not legally mandated for managed care network providers, CMS considers this to be a program safeguard that would generally be considered prudent to apply to managed care settings. Specifically, the forms did not capture:

- the name, address, date of birth and Social Security Number for individuals, or the tax identification number of persons with an ownership or control interest in the provider or subcontractor;
- relationship information about persons with an ownership or controlling interest in both the primary disclosing entity and subcontractor; and
- information on managing employees.

Additionally, the standard Ownership and Control Interest Statement completed by the fiscal intermediary for consumer directed personal care services was lacking the same requirements described above. Further, the state did not provide the MMIS fiscal agent's contract or disclosure form to determine if they were in compliance with the regulation.

Criminal Offense Disclosures

One of the Bayou Health plans along with the SMO did not require network providers to disclose the health care-related criminal conviction information that is required from FFS providers at 42 CFR 455.106. While not legally mandated for managed care network providers, CMS considers this to be a program safeguard that would generally be considered prudent to apply to managed care settings. The Bayou Health plan's individual application asks if the applicant had been found guilty of a misdemeanor in the past 10 years, but did not ask for owners, agents and managing employees. The Standard Credentialing Application and entity applications did not ask for criminal convictions related to Title XX and did not solicit disclosures for owners, agents or managing employees.

In addition, the SMO's provider application included a section to indicate whether the organization, program or staff members had any legal actions brought against them in the last 5 years. This section was not required if the provider location is Joint Commission certified.

Business Transaction Disclosures

The SMO contract did not contain the appropriate language for supplying business transaction information upon request as required by 42 CFR 455.105. The credentialing forms and provider agreements used by the Bayou Health plans and the SMO did not obligate network providers to

disclose certain business transactions with wholly owned suppliers or any subcontractors upon request. Additionally, only one of the Bayou Health plan's provider agreements required the submission of business transaction disclosures, so this information could be forwarded to the Medicaid Agency or the U.S. Department of Health and Human Services (HHS) Secretary, as required for FFS providers. While not legally mandated for managed care network providers, CMS considers this to be a program safeguard that would generally be considered prudent to apply to managed care settings.

Notifications to HHS-OIG and State Agency Exclusion Notifications

The state was not reporting fraud and abuse-related denials of provider enrollment for FFS to the HHS-OIG according to 42 CFR 1002.3. In the managed care program the state did not have clear 7guidance or contract requirements directing the Bayou Health plans or the SMO to report to the state any program integrity-related (fraud, integrity, or quality) adverse action taken on provider participation in their network. These reportable actions include denial of credentials, enrollment, or contracts. While managed care is not required by federal regulations to report directly to HHS-OIG, reporting these actions to the state is critical for timely reporting to the HHS-OIG along with FFS adverse actions.

Additionally, when the state executed permissive exclusions to terminate[2] a provider for program integrity issues, the public was not notified as required by the regulation at 42 CFR 1002.212.

Recommendations: Revise enrollment and disclosure forms and contracts used for FFS providers, the fiscal agent, managed care entities, and for managed care network providers to ensure the collection of complete and accurate disclosure information. Ensure that any person with an ownership or control interest or who is an agent or managing employee of the provider is checked against the EPLS and the LEIE during the enrollment process and monthly thereafter and that adverse action reporting and provider notification requirements are met when terminating and reinstating providers.

Effective Practices

As part of its comprehensive review process, CMS also 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. The state reported that its statutes help promote program integrity in its Medicaid program and that it has an effective working relationship with the MFCU.

State statutes help promote integrity in Medicaid program

Louisiana enacted a law on Unauthorized Participation in Medical Assistance Programs in July 2009. The law adds language to the statute making it a felony to attempt to participate in the Medicaid program while in an excluded status. Based on the law, an excluded person would

[2] For reporting purposes, CMS refers to state actions in accordance with this regulation as "terminations" whether the state calls them "terminations" or "exclusions".

commit a crime by seeking or obtaining employment with a provider or enrolling as a provider. It is also a crime to seek or obtain payment from any state or federal assistance program or to contract with, have ownership of, or provide management for a provider while excluded from participation. This statute is actively enforced by both the Medicaid agency and the MFCU. The statute helps ensure that funds are recovered from a provider who may have hired a person inappropriately and facilitates prosecution of the excluded individual for attempting to subvert the process by which he/she was excluded. Previously, only the enrolled provider was held responsible. Now the excluded individual is personally responsible, even if he/she is not an enrolled provider.

Louisiana's Medical Assistance Programs Integrity Law (MAPIL) was enacted in 1999 to combat fraud and abuse and to negate the adverse effects that such activities have on fiscal and programmatic integrity. The statute is applicable not only to Medicaid, but to all other health care programs funded by the state. Provisions of the statute include: specific provider enrollment requirements; requiring pre and post-claims review; and allowing for the withholding of payments to protect the fiscal integrity of the program. The MAPIL also allows for the forfeiture of property for payment recovery. It contains a look-back provision for the transfer of assets and delineates a more expansive list of provider misconduct. In addition, the MAPIL allows the state to impose stricter fines and civil money penalties and to file civil suit actions for recovery from providers that violate its provisions. Moreover, it authorizes the state to place a lien on the property of a practitioner while civil collection suits are pending. The inclusion of program integrity and provider enrollment requirements in the state statute gives these provisions the highest form of legal sanction in the state other than the State's Constitution. This shows a strong state commitment to program integrity by both the legislative and executive branches of state government.

Working relationship with the MFCU

Both the PIU and the MFCU indicated in separate interviews that they have a close and effective working relationship. This collaboration was also highlighted during the 2009 CMS review and continues to make each unit more effective in its various roles. This is demonstrated by the MFCU's observation that it always receives well-documented cases from the PIU. The MFCU staff meets with the PIU staff on a regular basis to discuss the status of active and pending cases. The PIU works collaboratively with the MFCU and now with the Bayou Health plans and the SMO to help the program integrity activities of the managed care program be more effective. Both the PIU and the MFCU host bi-monthly meetings with Bayou Health plans and the SMO to cross-train staff and discuss current fraud and abuse schemes. Although both components have established some regular communications with Bayou Health plans and the SMO, the team found issues with the oversight of the managed care programs in Louisiana. These were discussed earlier in the results section of this report.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Louisiana to consider utilizing:

- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in RISS for information provided by other states including best practices and managed care contracts.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and assistance as needed to conduct exclusion searches and training of managed care staff in program integrity issues.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. There is an upcoming class on Medicaid managed care in early 2014. More information can be found at http://www.justice.gov/usao/eousa/ole/mii/mii.courses.html.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Work with the assigned CMS MIG State Liaison to discuss program integrity issues and request technical assistance as needed.
- Access the MIG's website at www.cms.gov/medicaidintegrityprogram. The website is frequently updated and contains resources for states including annual program integrity review summary reports, best practices reports, and educational toolkits developed by CMS for training purposes.

Conclusion

The identification of significant areas of risk and numerous instances of non-compliance with federal regulations is of great concern and should be addressed immediately. CMS is also particularly concerned about uncorrected, repeat problems that remain from the time of the agency's last comprehensive program integrity review.

To that end, we will require the state to provide a CAP for each of the areas of concern within 30 calendar days from the date of the final report letter. The CAP should address all specific problems identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will occur and identify which area of the state is responsible for correcting the issue. The state should provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. Please provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state 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 Louisiana to build an effective and strengthened program integrity function.

Official Response from Louisiana
February 2014

Bobby Jindal
GOVERNOR

Kathy Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

February 27, 2014

Mark Majestic, Acting Director
Medicaid Integrity Group
Department of Health & Human Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Mail Stop AR-18-50
Baltimore, Maryland 21244-1850

Dear Mr. Majestic

In response to your correspondence dated December 23, 2013 we have reviewed the findings from your September 2012 review of Louisiana Medicaid's program integrity procedures and processes and provide this formal response.

As requested in the Medicaid Integrity Program's Louisiana Comprehensive Program Integrity Review Final Report, we have prepared the attached consolidated corrective action plan, which focused upon the two (2) areas of non-compliance which were cited. The State's corrective action plan also addresses the area of vulnerability related to verification of services, which was also identified in the final report.

Should you have any questions, please do not hesitate to contact me. In addition, you may contact John Korduner Program Integrity Section Chief for the Louisiana Department of Health and Hospitals (DHH) at 225-219-4150, or by e-mail at john.korduner@la.gov, should you need any additional information about Louisiana's response or the state's corrective action plan.

On behalf of the Louisiana Department of Health and Hospitals, I would like to thank the Medicaid Integrity Program's site visit team that conducted the review and CMS for providing the final report that will help us to strengthen our Medicaid program integrity function and ensure deficiencies do not recur.

Sincerely,

J. Ruth Kennedy
Medicaid Director

JRK:JS:BB