Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Michigan Comprehensive Program Integrity Review

Final Report

July 2008

Reviewers:
Todd Chandler, Review Team Leader
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INTRODUCTION

CMS' Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Michigan Medicaid Program. The onsite portion of the review was conducted in March 2007 at the Michigan Department of Community Health (MDCH) offices. The MIG review team also visited the State's Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Program Investigation Section, which is responsible for Medicaid program integrity. The report addresses regulatory compliance issues, vulnerabilities, and noteworthy practices. The review team identified five areas of non-compliance with Federal regulations during its review. One of these areas was previously identified in CMS' 2003 program integrity review.

- 42 CFR §§ 455.104(a)(1) and 455.104(a)(2), requiring that enrollment forms include the name and address of each person with an ownership or control interest of five percent or more in the disclosing entity, as well as the relationship of each owner to any other owner of the disclosing entity or its subcontractors.
- 42 CFR § 455.105(b)(2), requiring States to include in the provider agreement that the provider agrees to furnish to the State Agency or the Secretary of the U.S. Department of Health and Human Services (HHS) information related to certain business transactions with wholly owned suppliers or any subcontractors.
- 42 CFR § 455.106(a), requiring provider disclosure of criminal conviction information.
- 42 CFR § 455.106(b)(1), requiring States to report criminal conviction information to the U.S. Department of Health and Human Services, Office of the Inspector General (HHS-OIG) within 20 working days.
- 42 CFR § 1002.3(b), requiring the Medicaid agency to notify the HHS-OIG of action taken on a provider's application for participation in the program.

The State of Michigan took exception to six issues raised in the draft report. Its response has been included in its entirety as Attachment A of this report. In general, CMS stands by its conclusions. This report reflects technical corrections suggested by the State. If the State provided a comment on a finding or area of vulnerability, the response has been included in the body of this report, along with the CMS response to those comments, where appropriate.

THE REVIEW

Objectives of the Review

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

Overview of Michigan's Medicaid Program

The MDCH administers the Michigan Medicaid program. As of June 2006, the program served 1,526,159 recipients. Medicaid expenditures in Michigan for State fiscal year (SFY) ending September 30, 2006 totaled $8.5 billion. The Federal medical assistance percentage for Michigan for SFY 2006 was 56.59 percent.

Approximately 61 percent of Michigan Medicaid recipients were enrolled in 13 Medicaid managed care plans for physical health. The 13 managed care organizations (MCOs) contracted with 34,622 providers. Managed care enrollees in both the Comprehensive Health Care Program (CHCP) for physical health and the Specialty Services and Supports program for mental health and substance abuse services accounted for 51 percent of the total Medicaid expenditures. The remaining 49 percent of Medicaid expenditures were for recipients in the fee-for-service (FFS) program. At the time of our review, MDCH had enrolled 38,452 FFS providers. The MDCH processed an average of 27,831,823 FFS claims annually for the past three State fiscal years.

Program Investigation Section

In Michigan, the organizational component dedicated to fraud and abuse activities is the Program Investigation Section of the Medical Services Administration (MSA), the designated State Medicaid agency within MDCH. The Program Investigation Section has 23 FTEs. Several positions were vacant, but expected to be filled soon. Field audits are conducted by State contractors, such as ACS-Heritage, Inc., which audits pharmacy providers. The Michigan Peer Review Organization (MPRO) audits hospitals and performs long term care reviews. The table below presents the total number of audits and amounts collected in the past three SFYs as a result of program integrity activities.

Table 1

SFY	Number of Audits	Recoveries
2004	24	not available
2005	35	$6,614,285
2006	15	$2,659,678

Methodology of the Review

In advance of an onsite visit, the review team requested that Michigan complete a comprehensive review guide and supply documentation to support its answers to the review guide. The review guide included such areas as provider enrollment, claims payment and post-payment review, managed care, Surveillance and Utilization Review Subsystem, and the MFCU. A four-person team reviewed the answers and materials that the State provided in advance of the onsite visit.

During the week of March 26, 2007, the MIG review team visited the MDCH offices and the MFCU. The team conducted interviews with numerous MDCH officials as well as the MFCU director. To determine whether managed care plans were complying with the contract provisions and other Federal regulations relating to program integrity, the CMS team reviewed the contract provisions and gathered information from the MCOs directly by means of a questionnaire. The team also conducted an in-depth interview with representatives of one of the largest MCOs and

met separately with MDCH's Managed Care Division and Program Investigation Section staff to discuss the Department's managed care oversight and monitoring efforts.

Scope and Limitations of the Review

This review focused on the activities of the Program Investigation Section. Michigan's State Children's Health Insurance Program operates under Title XXI of the Social Security Act, and was therefore not included in this review. Unless otherwise noted, MDCH provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing, financial, or collections information that MDCH provided.

RESULTS OF THE REVIEW

Noteworthy Practices

Michigan generally complies with Federal regulations related to Medicaid program integrity. Two noteworthy practices include:

Summary Provider Suspensions

In high-dollar or otherwise egregious cases of fraud, the Program Investigation Section can impose a summary suspension that temporarily abrogates the existing Medicaid provider agreement and freezes all Medicaid payments until a provider has exhausted all administrative remedies or has been convicted in a court of law. The passage of a State Whistleblower Law in 2005, which offers incentives to the public to report serious cases of fraud and abuse directly to the MFCU, has enhanced MDCH's ability to combat fraud, waste, and abuse.

Managed Care Program Integrity Checklist

MDCH has developed a desk audit tool, including a comprehensive fraud and abuse component, to assess overall MCO contract compliance. The checklist permits MDCH staff to assess ongoing MCO compliance and progress towards compliance or corrective action in virtually all program integrity areas.

Regulatory Compliance Issues

The State does not comply with Federal regulations related to required disclosure and notification activities and monitoring of provider enrollment and eligibility. One of these findings was identified during a CMS program integrity review in 2003.

Michigan does not identify ownership or control interest of subcontractors (Repeat Issue)

Federal regulations at 42 CFR §§ 455.104(a)(1) and 455.104(a)(2) require that enrollment forms include the name and address of each person with an ownership or control interest of five percent or more in the disclosing entity or in a subcontractor the disclosing entity partially owns (with an ownership or control interest also of five percent or greater), as well as the relationship of each owner to any other owner (with greater than a five percent share) of the disclosing entity or its

subcontractors. In a 2003 review of Michigan's FFS program integrity policies and procedures, the review team determined that Michigan did not comply with these regulations. While the Provider Enrollment Unit (PEU) presently captures some ownership information, it still does not capture the necessary subcontractor or related owner information. Michigan's Specialty Services and Supports program, which operates under concurrent Section 1915(b) and (c) waiver authority, has contracts with 18 prepaid inpatient health plans (PIHPs) that reflect similar problems. The PIHP contracts do not stipulate that PIHPs require their contracted service providers capture information about ownership or control interests of subcontractors, or relationships among owners during provider enrollment. Sample PIHP agreements with providers that the team reviewed also do not contain this requirement, and there is no evidence that PIHPs were collecting this information.

Recommendation: Modify FFS enrollment packages to include required ownership and subcontractor information. Also, modify PIHP contracts to require that PIHPs gather and consider such information when enrolling providers.

State Response: General – In the first finding and throughout the review report, reference is made to a review of Michigan's Specialty Services and Supports Waiver which operates concurrently under Sections 1915(b) and (c) of the Social Security Act. At no time prior to, during or after the CMS review did CMS request information on this portion of Michigan's Medicaid program. Accordingly no one from the Program Integrity Division or the Federal Liaison Unit provided information or documentation on the program integrity activities of the Specialty Services and Supports Waiver. Given the lack of documentation and/or records of interviews, we disagree with CMS' inclusion of comments dealing with our Specialty Services and Supports Waiver, and/or contracts with prepaid hospital health plans (PIHPs) in this report. Without having been provided documentation or scheduled interviews, the comments must be considered groundless and should be removed completely.

We agree with the reported finding. We would, however, like to see the recommendation modified to reflect that this issue is being corrected by way of Michigan's new MMIS system (CHAMPS) which is currently under development. Additionally, for the reasons indicated above, we believe the reference to PIHPs needs to be removed.

CMS Response: The MIG review team did not interview State staff responsible for oversight of the Specialty Services and Supports program during the onsite review. Recognizing the importance of this program, the team requested additional information after the onsite portion of the review was completed. The finding is based on documentation received from MDCH after the onsite review and on a subsequent interview with staff from the Department's Mental Health and Substance Abuse Administration, which oversees the Specialty Services and Supports waiver program. The language of the original draft report has been slightly modified based on additional clarifications from State staff.

The State's comments about the proposed new Medicaid Management Information System (MMIS) are duly noted.

Provider Enrollment Agreements Lack Required Disclosures of Business Transactions
The Federal regulation at 42 CFR § 455.105(b)(2) requires that providers furnish information about certain business transactions with wholly owned suppliers or any subcontractor to MDCH or HHS upon request. Michigan's FFS provider enrollment agreements do not require such disclosures. Also, Michigan's PIHP contract does not stipulate that PIHPs require their contracted providers to furnish information about certain business transactions with wholly owned suppliers or any subcontractor upon request.

Recommendation: Modify FFS enrollment packages and PIHP contracts and enrollment packages to incorporate the appropriate business transaction language.

State Response: Provider Enrollment Agreements Lack Required Disclosures of Business Transactions – The MSA does not disagree with this finding, but would like to see the recommendation modified to include a statement that this situation will be corrected with the implementation of the new MMIS system.

CMS Response: The State's comments about the proposed new MMIS are duly noted. Regarding the reference to PIHPs, and this waiver program, please see the above CMS response.

Michigan's managed care plans do not routinely capture required information on agents or managing employees in the provider enrollment process
Pursuant to Federal regulations at 42 CFR § 455.106(a), States must require the disclosure of information regarding the identity of persons with ownership or control in the disclosing entity or agents or managing employees of the disclosing entity who have criminal convictions related to Federal health care programs. While States may delegate the function of enrolling or credentialing providers to MCOs and PIHPs for the managed care programs, the State remains responsible for ensuring that it does not pay an excluded provider for Medicaid health care items or services.

Based on responses to the review team's questionnaire for managed care plans, nine of the 13 MCOs in CHCP captured the required information about owners, operators, and managing employees, but two did not capture such information at all, one only performed a partial check, and one had not confirmed with the review team whether it complies. Several PIHPs did not request any information on managing employees in their provider enrollment and credentialing process. As a result, these MCOs and PIHPs cannot determine whether providers or entities billing the MCOs and PIHPs employ individuals who may be excluded or precluded from participation in the program.

Recommendations: Require all MCOs and PIHPs to solicit disclosure information on criminal convictions from owners, officers, and managing employees. In addition, MDCH should develop monitoring policies to ensure that all managed care plans in CHCP and the Specialty Services and Supports program perform these checks.

Michigan does not notify HHS-OIG of actions taken on provider applications

The Federal regulation at 42 CFR § 1002.3 requires reporting to HHS-OIG any actions a State takes on provider applications for participation in the program. Under that regulation, actions to deny or terminate participation include when an owner or managing employee has been convicted of a criminal offense related to the Medicare, Medicaid, or Title XX programs, or when the provider did not fully or accurately make certain disclosures. While MDCH does notify HHS-OIG when it has terminated a provider agreement, MDCH does not report to HHS-OIG any other actions it takes on provider applications. These actions include suspensions, settlement agreements, and situations when the provider withdraws from the program to avoid a formal sanction.

Recommendation: Submit appropriate reports to the HHS-OIG regarding adverse actions taken on a provider's application for participation.

Michigan does not notify HHS-OIG of criminal conviction information

Pursuant to 42 CFR § 455.106(b)(1), States must report provider disclosures of health care-related criminal conviction information to HHS-OIG within 20 working days. MDCH does not report the required information to HHS-OIG.

Recommendation: Submit appropriate reports to the HHS-OIG on provider disclosures of health care-related criminal convictions involving providers, providers' managing employees, and persons with controlling interests in the provider entity. Ensure that reports are made in a timely fashion as required by regulation.

State Response: Michigan does not notify HHS-OIG of criminal conviction information – CMS is technically correct in its statement that MDCH does not directly notify HHS-OIG of criminal convictions. However, the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General of the State of Michigan does provide criminal conviction information to HHS-OIG. Additionally, once all the information required by CMS is received from the court, it is sent to CMS within 20 days. We are requesting this finding and recommendation be changed to correctly reflect this activity.

CMS Response: The regulation stipulates that it is the State's responsibility to notify HHS-OIG of any health care-related criminal conviction disclosures within the specified time frames. When offered during the provider enrollment or reenrollment process, such disclosures will likely come to MDCH or a provider enrollment contractor rather than the MFCU. In response to the State's comments, CMS has changed the language of the finding and recommendation to reflect that they refer to provider disclosures of health care-related criminal conviction information, as opposed to conviction information furnished by a court.

Areas of Vulnerability

The review team also identified five areas of vulnerability in Michigan's practices. They specifically include concerns about provider enrollment and MCO reporting of suspected fraud and abuse.

Not capturing information on agents or managing employees in the managed care provider enrollment process

While the provider application solicits information on persons with ownership and control in the disclosing entity, and contains regulatory language requiring disclosure of the identity of persons with criminal convictions related to Federal health care programs, the application does not solicit identity information on agents or managing employees. Therefore, PEU is unable to search for exclusions or criminal convictions for managing employees or agents. In addition, Michigan's pharmacy benefits manager and enrollment contractor enrolls pharmacies, but not individual pharmacists, into Medicaid. Neither the State nor its contractor captures pharmacist information in the enrollment package.

Recommendations: Include managing employee information on all FFS and managed care enrollment forms. This information should also be captured in the application database for routine comparison during and after the enrollment process. Include the identity of all pharmacists in applications for pharmacy providers. Require MCOs and PHIPs to gather information about managing employees as part of the provider enrollment and credentialing process, so that the MCOs and PIHPs can check these individuals for excluded status.

Inadequate information for effective exclusion searches

The PEU searches for provider exclusions and General Services Administration (GSA) debarments on-line by using the HHS-OIG and GSA web-sites during the enrollment process. Both the provider applicant and the owners disclosed in the application should be searched against these databases. However, when the review team observed a demonstration of a provider enrollment, the corporate owner of a group practice was not searched. In addition, the PEU does not capture information on the owners of subcontractors, officers, and managing employees in the enrollment package. The review team noted that the PEU did not have a detailed policy and procedure manual.

Recommendation: Develop specific policies and procedures to ensure that the owners of provider practices and individual pharmacists are searched for exclusions and debarments. Furthermore, PEU should capture information on subcontractors, officers, and managing employees in order that PEU can search them for exclusions and debarments at the front end of the enrollment process.

Not initiating provider exclusions

The Federal 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.

MDCH indicated that it has procedures and uses its exclusion authority, but does not initiate exclusion of providers. MDCH only excludes providers in instances when other authorities, such as the HHS-OIG or the State's medical licensing board, have already sanctioned providers or in instances where the provider has been convicted of a criminal offense. MDCH stated that it does not attempt exclusions on its own in the absence of such prior sanctions because past attempts to exclude providers whose license and Medicare certification are in good standing have always failed on appeal.

Recommendation: MDCH should use the authority provided by 42 CFR § 1002.210 to exclude providers who, in its judgment, threaten the integrity of Michigan's Medicaid program.

Inconsistent reporting of suspected provider fraud and abuse to the State by MCOs
Michigan's CHCP contract clearly requires that MCOs report all suspected cases of provider fraud and abuse directly to the Program Investigation Section. The Program Investigation Section staff noted that MCOs generally report suspected provider fraud or abuse to MDCH so that cases can be investigated further and referred to the MFCU when appropriate. However, the number of reported cases is relatively small, accounting for 10 of the 45 referrals in 2004, four of the 26 referrals in 2005, and eight of the 61 referrals in 2006. The MFCU Director expressed concern that many plans were only beginning to appreciate the many ways in which provider fraud could be committed within managed care networks. The representatives of one of the MCOs interviewed onsite also indicated that the plan prefers to handle complaints internally rather than reporting them to MDCH to avoid exposing weaknesses to competitors.

Recommendation: MDCH should closely monitor the MCOs to ensure that suspected cases of provider fraud and abuse are reported directly to the Program Investigation Section for further evaluation.

State Response: Inconsistent reporting of suspected provider fraud and abuse to the State by MCOs – The MDCH, MSA strongly disagrees with both the statement as written and the inclusion of such an inaccurate conclusion as is presented in the final sentence of this paragraph.

To present a more accurate reflection of the activities of the health plans in this area the report would indicate that the plans prefer to perform the initial investigation internally and then turn the information over to the MDCH if the suspicion is substantiated. The State requests CMS modify the language in order to provide a correct representation of the activity.

CMS Response: CMS has modified the text to specify that one plan indicated during an interview that it was reluctant to report complaints about suspected fraud and abuse. However, the implication that MCOs generally have been reluctant to report possible fraudulent activity in their networks was corroborated by the MFCU Director and remains a concern. The MFCU Director did indicate that more MCOs were beginning to reach out to his office on program integrity issues.

Inadequate EOMB Practices by MCOs
While MDCH meets the requirements of 42 CFR § 455.20 by sending explanations of medical benefits (EOMBs) to a five percent sample of FFS recipients, the MCO responses to the review team's questionnaire indicated that 11 of the 13 MCOs in CHCP use no type of EOMB for service verification purposes, nor was there any indication that encounter data is systematically used for the purpose of verifying the provision of specific services to enrollees.

Recommendation: Modify the CHCP contracts to require that MCOs verify the receipt of services by enrollees.

CONCLUSION

The State of Michigan has some effective program integrity practices. The State's ability to impose summary suspensions, the passage of a State Whistleblower Law in 2005, and the managed care program integrity checklist are all noteworthy. CMS encourages MDCH to continue its noteworthy practices and look for additional opportunities to improve the overall program integrity of the program.

However, the identification of five areas of non-compliance with Federal regulations is of concern. That one of those issues is repeated from CMS' last review almost five years ago is particularly troubling. In addition, five areas of vulnerability were identified in this review. CMS encourages MDCH to closely examine each identified area of vulnerability.

It is important that these issues be rectified as soon as possible. To that end, we will require MDCH to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how they will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Michigan will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps you expect will occur. If correcting any of the findings or vulnerabilities will take more than 90 calendar days from the date of the letter, please provide an explanation for that. If MDCH 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 Michigan on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its noteworthy practices.

ATTACHMENT A

Response from State of Michigan / Department of Community Health

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
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February 11, 2008

Mr. Robb Miller, Director
Division of Field Operations
Medicaid Integrity Group
Centers for Medicare and Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Dear Mr. Miller:

This is in response to your January, 2008 invitation for comments on the draft report resulting from the Centers for Medicare and Medicaid Services' (CMS) review of the Michigan Department of Community Health (MDCH), Medical Services Administration's (MSA) Program Integrity activities.

In reviewing the draft report, we find areas which we believe need to be clarified and/or corrected. Specifically, they include:

Overview of Michigan's Medicaid Program – Under the Program Investigation Section (page 3) the report indicates that the Michigan Peer Review Organization audits hospitals and long term care facilities. This should be changed to indicate that the Michigan Peer Review Organization (MPRO) audits hospitals and performs long term care reviews.

Regulatory Compliance Issues

General – In the first finding and throughout the review report, reference is made to a review of Michigan's Specialty Services and Supports Waiver which operates concurrently under Sections 1915(b) and (c) of the Social Security Act. At no time prior to, during or after the CMS review did CMS request information on this portion of Michigan's Medicaid program. Accordingly no one from the Program Integrity Division or the Federal Liaison Unit provided information or documentation on the program integrity activities of the Specialty Services and Supports Waiver.

Given the lack of documentation and/or records of interviews, we disagree with CMS' inclusion of comments dealing with our Specialty Services and Supports Waiver, and/or contracts with prepaid hospital health plans (PIHPs) in this report. Without having been provided documentation or scheduled interviews, the comments must be considered groundless and should be removed completely.

Michigan does not identify ownership or control interest of subcontractors – We agree with the reported finding. We would, however, like to see the recommendation modified to reflect that this issue is being corrected by way of Michigan's new MMIS system (CHAMPS) which is currently under development. Additionally, for the reasons indicated above, we believe the reference to PIHPs needs to be removed.

Provider Enrollment Agreements Lack Required Disclosures of Business Transactions – The MSA does not disagree with this finding, but would like to see the recommendation modified to include a statement that this situation will be corrected with the implementation of the new MMIS system.

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Michigan does not notify HHS-OIG of criminal conviction information – CMS is technically correct in its statement that MDCH does not directly notify HHS-OIG of criminal convictions. However, the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General of the State of Michigan does provide criminal conviction information to HHS-OIG. Additionally, once all the information required by CMS is received from the court, it is sent to CMS within 20 days. We are requesting this finding and recommendation be changed to correctly reflect this activity.

Areas of Vulnerability

Inconsistent reporting of suspected provider fraud and abuse to the State by MCOs – The MDCH, MSA strongly disagrees with both the statement as written and the inclusion of such an inaccurate conclusion as is presented in the final sentence of this paragraph. The use of terms such as 'collusion' and/or 'blackballing' when, in the recollection of all MDCH staff present at the interview, are not terms used by the health plans, presents an inaccurate impression. If, on the other hand, the health plans provided the review team with a written statement, not shared with the State, which is being presented in the report, the entire statement should be in quotes and the author identified.

To present a more accurate reflection of the activities of the health plans in this area the report would indicate that the plans prefer to perform the initial investigation internally and then turn the information over to the MDCH if the suspicion is substantiated. The State requests CMS modify the language in order to provide a correct representation of the activity.

We appreciate the opportunity to comment on the conclusions identified in this draft report. Please advise if you would like clarification on any of the points included in this response. Should you have questions, please contact Nancy Bishop, of my staff, at 517/335-5303.

Sincerely,

Paul Reinhart, Director
Medical Services Administration