Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Michigan Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Michigan Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Medical Services Administration (MSA) in the Michigan Department of Community Health (MDCH). The review team also visited the office of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Medicaid Integrity Program Section (MIPS) within MSA, which is primarily responsible for Medicaid program integrity oversight. This report describes one noteworthy practice and one effective practice, four regulatory compliance issues, and five vulnerabilities in the State's program integrity operations

THE REVIEW

Objectives of the Review

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

Overview of Michigan's Medicaid Program

The MSA administers the Michigan Medicaid Program. Based on data reported to CMS, on June 30, 2009, 1,629,959 beneficiaries were enrolled in the program. Of this total, 1,088,815 were enrolled in 14 managed care organizations (MCOs) for most of their Medicaid benefits. In addition, 1,447,373 beneficiaries were covered by 18 prepaid inpatient health plans (PIHPs). The PIHPs contract with the MDCH to serve clients with severe behavioral health and substance abuse problems.

At the time of the review, MDCH had approximately 64,000 participating Medicaid fee-for-service (FFS) providers, while the managed care program had roughly 20,000 unduplicated providers. Medicaid expenditures in Michigan for the State fiscal year (SFY) ending September 30, 2009 totaled $10,542,112,745. The SFY 2009 FFS expenditures amounted to $5,360,659,029, or almost 51 percent of the total. The Federal medical assistance percentage (FMAP) for Michigan in Federal fiscal year (FFY) 2009 was 60.27 percent. However, with adjustments attributable to the American Recovery and Reinvestment Act of 2009, the State's effective FMAP was 72.19 percent.

Program Integrity Division

The MIPS is the organizational component dedicated to fraud and abuse activities. At the time of the review, MIPS had 22 of 30 authorized full-time equivalent (FTE) employees focusing on Medicaid program integrity. From SFY 2007 through SFY 2009, MIPS staff conducted an

annual average of 465 preliminary investigations and 26 full investigations. The table below presents the total number of investigations and overpayment amounts identified and collected for the last four SFYs as a result of program integrity activities. All figures for SFY 2010 were incomplete at the time of the review. Overpayments collected do not include recoveries from global settlements or provider-initiated self-audits. These figures also are often lower than the original overpayment amounts identified because of reductions following the appeals process.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified	Amount of Overpayments Collected
2007	539	27	$4,747,277	$2,761,166
2008	526	22	$7,530,838	$2,292,415
2009	329	29	$9,179,238	$2,644,256
2010	56	6	$933,647	not available

* Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation. Figures represent cases investigated by MIPS staff.
** Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the Medicaid Fraud Control Unit or administrative or legal disposition. Figures represent cases referred to the MFCU.

Methodology of the Review

In advance of the onsite visit, the review team requested that Michigan 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, managed care, and the MFCU. A four-person team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of June 20, 2010, the MIG review team visited the MDCH and MFCU offices. The team conducted interviews with numerous MDCH officials, as well as with staff from the pharmacy benefit manager (PBM) and the MFCU. In order to determine whether managed care plans were complying with the contract provisions and Federal regulations relating to program integrity, the MIG team reviewed the State's MCO contracts. The team conducted in-depth interviews with representatives from four MCOs and met separately with MDCH staff to discuss managed care oversight and monitoring efforts. The team also conducted sampling of provider enrollment applications, case files, selected claims, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of MIPS. The Michigan Children's Health Insurance Program (CHIP) consists of a stand alone component and a Medicaid expansion component. The stand alone component operates under Title XXI of the Social Security Act and was, therefore, not included in this review. The Medicaid expansion component operates under the same billing and provider enrollment policies as the State's Title XIX program. The same

findings, vulnerabilities, and effective practices discussed in relation to the Medicaid program also apply to the expansion CHIP.

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 or financial information that MDCH provided.

RESULTS OF THE REVIEW

Noteworthy Practices

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

Provider re-enrollment system based on licensure renewal

Michigan reported 64,000 active enrolled providers in the Community Health Automated Medicaid Processing System (CHAMPS), the State's main FFS enrollment tool. The ability to remain enrolled in CHAMPS is linked to the renewal of each provider's license. For in-state providers, Michigan has a daily system feed that updates provider enrollment status when a provider's license has been renewed with the license bureau. If an update is not received, CHAMPS generates a letter to the provider. The provider then has 60 days to respond to the letter with an updated license. If the provider does not respond within 60 days, the provider's authorization to bill Medicaid is end dated in CHAMPS with the expiration date of the license and will not be renewed until the provider has renewed his/her license.

Out-of-state providers are handled manually, as Michigan does not have a file feed to update them automatically in CHAMPS. If a provider does not furnish evidence of licensure renewal, Medicaid enrollment in CHAMPS will expire upon the license expiration date. If a provider furnishes evidence of a continuing active license, provider enrollment staff update the enrollment status manually in CHAMPS.

Out-of-state hospital licenses are renewed yearly and given a business status of one year, so they must re-enroll upon license expiration.

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. Michigan reported the use of a managed care program integrity checklist that facilitates active MIPS engagement in managed care compliance reviews.

Managed care program integrity checklist

The MDCH has developed a desk audit tool to assess overall MCO contract compliance.

The tool describes numerous contract requirements and how compliance with them will be assessed. It includes a comprehensive program integrity component. The MDCH conducts compliance reviews of all MCOs annually. The checklist permits MDCH staff to assess ongoing MCO compliance and progress towards compliance or corrective action in virtually all program integrity areas. It was cited as an effective practice in the MIG's 2007 comprehensive program integrity review report.

As part of the compliance review, MCOs must submit documentation demonstrating their tools and processes for detecting both under- and overutilization of services. They must also document an internal auditing and monitoring process and a process for determining areas that are at risk for fraud, waste and abuse. In addition, the MCOs must submit documentation that they endeavored to educate providers on the detection of fraud, waste, and abuse, and they must list the number of complaints that warranted a preliminary investigation since the last desk audit or site visit.

The MDCH reported that it required MCOs to develop corrective action plans (CAPs) in SFY 2009 to address 50 criteria based on findings during compliance reviews using the checklist. These CAPS are tracked in each site tool itself, and not in a separate document. As a result, there is no document showing the total number of CAPs that were required based on program integrity concerns.

The managed care program integrity checklist is a useful tool. However the review team observed other managed care program issues which are discussed in the Vulnerabilities section of this report.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations regarding its notice of payment withholding to providers and the capture of certain required disclosures.

The State's notice of payment withholding does not include all required information.
The regulation at 42 CFR § 455.23(b) stipulates that the Medicaid agency's notice of withholding state that payments are being withheld in accordance with the Federal regulation.

The MDCH MIPS utilizes summary suspensions for all provider withholding actions related to fraud and willful misrepresentation. Summary suspensions give MDCH the ability to dissolve the provider agreement and freeze all Medicaid payments while pursuing administrative or judicial remedies against problem providers. According to the program integrity director, MIPS issued two summary suspensions in SFY 2009. However, the withholding letter that MDCH utilizes to announce the suspension of payments from providers in cases of fraud and willful misrepresentation does not meet the requirements of 42 CFR § 455.23(b) because there is no reference to the Federal regulation.

NOTE: The program integrity regulation at 42 CFR § 455.23 has been substantially revised and the amendment was effective March 25, 2011. The regulation as amended requires payment

suspension pending investigations of credible allegations of fraud and referral to the MFCU, or other law enforcement agency if there is no certified MFCU in the State.

Recommendation: Modify the withholding letter to include language that references 42 CFR § 455.23 as required by the regulation.

The MDCH does not capture all required ownership, control and relationship information from FFS and non-emergency medical transportation (NEMT) providers, fiscal agents, and MCOs. (Uncorrected Partial Repeat Finding)

Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

During MIG's 2007 program integrity review, the review team noted that Michigan's provider enrollment applications did not capture the required information on subcontractors and relationships among owners during the provider enrollment process. The team also found that the PIHPs did not capture any of the required disclosure information. The 2010 review team noted some improvement. While the FFS provider application process using CHAMPS (launched in 2008) now captures much of the required ownership and relationship information, it still does not capture information on ownership interests in subcontractors.

Moreover, the required disclosure information is not captured in the special enrollment processes for provider types enrolled outside CHAMPS. Pharmacies, personal care services (PCS) providers, and NEMT providers are enrolled separately using forms that do not fully comply with the ownership and disclosure requirements. For example, Michigan has a PBM which enrolls pharmacies and processes pharmacy claims for payment by MDCH. The PBM pharmacy provider enrollment and trading partner agreement does not ask for addresses in the ownership section, nor does it collect relevant subcontractor information. Additionally, the State does not solicit the required disclosure information from the PBM itself, although it functions as a fiscal agent.

Incomplete information is likewise collected from PCS providers. In Michigan, personal care

services are rendered under the "Home Help program." The enrollment of PCS providers is undertaken by the Department of Human Services (DHS). However, while the names of owners and individuals with a 5 percent or greater ownership interest in agencies providing personal care services are collected, again no address or subcontractor information is solicited during the enrollment process. The DHS also handles NEMT provider enrollments, for which none of the required ownership, control and relationship information is requested.

Additionally, Michigan's Medicaid MCO contracts do not require the MCOs to disclose the name and address of any subcontractor in which MCO owners have an ownership or controlling interest or to disclose whether any persons named as owners of the MCO and subcontractors are related to one another. They also do not require MCOs to furnish the name of any other disclosing entity in which there are interlocking ownership and control interests as specified in 42 CFR § 455.104(a)(2). Based on interviews and review guide responses, the team found that MDCH does not collect this required disclosure information prior to entering into contracts with MCOs. In contrast, since the 2007 program integrity review, MDCH contracts with the 18 behavioral health PIHPs in Michigan were modified to require complete disclosure information per 42 CFR § 455.104.

NOTE: The CMS team reviewed the FFS applications and NEMT, fiscal agent and managed care contracts and other provider agreements for compliance with 42 CFR § 455.104 as it was effective at the time of the review. That section of the program integrity regulations has been substantially revised and the amendment was effective on March 25, 2011. The amendment adds requirements for provision of Social Security Numbers and dates of birth as well as more complete address information regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any actions the State takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

Recommendations: Modify FFS provider enrollment packages and MCO and NEMT contracts to capture all disclosure information required under 42 CFR § 455.104. Ensure that full ownership, control, and relationship information is collected from the State's PBM prior to contracting and is periodically updated.

Provider agreements in the Home Help program and MCO contracts do not require the disclosure of business transaction information. (Uncorrected Partial Repeat Finding)
The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or U.S. Department of Health and Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors.

The 2007 review team observed that the language required by 42 CFR § 455.105 was not present in the FFS provider agreements and PIHP contracts with the State. While MDCH has addressed this issue in these two areas, the 2010 review team could not find the required language in the Home Help provider agreement.

Lastly, the review team could find no language in Michigan's MCO contracts requiring the

MCOs to furnish information about their own organizations' business transactions with wholly owned suppliers or any subcontractor upon request.

Recommendation: Modify the Home Help provider agreement and MCO contracts to require disclosure upon request of the business transaction information specified in 42 CFR § 455.105.

The State does not require disclosure of health care-related criminal convictions in its FFS, MCO, and NEMT provider applications or credentialing packages. (Uncorrected Partial Repeat Finding)

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 U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG) whenever such disclosures are made.

The 2007 MIG review revealed that the Michigan FFS provider application did not request health care-related criminal conviction information on persons with ownership or control interests in the provider or agents or managing employees. The State's current web-based FFS application (CHAMPS) solicits such information concerning the applicant, owners, and managing employees but still does not ask for health care-related criminal conviction disclosures by agents of the provider.

Likewise, the Medical Assistance Home Help Provider Agreement for Home Help agencies does not ask about health care-related criminal convictions of owners.

In the NEMT program, for which no documentation was provided to the review team, MDCH and DHS staff mentioned in interviews that NEMT providers are not asked for any criminal conviction information.

Lastly, Michigan's MCO contracts do require MCOs to disclose the identities of persons with ownership and control interests and managing employees who have health care-related criminal convictions. However, they do not request the disclosure of similar information about agents, although that is also required by the regulation.

Recommendation: Modify FFS, NEMT, and Home Help provider enrollment applications and the MCO contracts to meet the full criminal conviction disclosure requirements of 42 CFR § 455.106. Add this element to the managed care program integrity checklist discussed in the Effective Practices section of this report.

Vulnerabilities

The review team identified five areas of vulnerability in Michigan's program integrity practices. These related to ineffective program integrity oversight and operations and the failure to obtain specific disclosures from managed care network providers. They also involved the failure of

managed care plans to report certain adverse actions against provider applicants as well as the failure of the FFS and managed care programs to conduct complete exclusion searches.

Ineffective program integrity oversight and operations.
With a $10 billion Medicaid budget, Michigan ranks in the top 10 of States in terms of total Medicaid expenditures. Yet it has an unusually small program integrity staff for the range and volume of responsibilities one would expect in a program of this size. The team found that limited staffing and budgetary resources make it difficult for program integrity management to be maximally proactive in developing core MIPS functions, such as data analysis, auditing, and the development of cases for referral.

At the time of the review, MDCH had 22 FTEs devoted to program integrity functions. A review of MDCH staffing for the previous 4 SFYs reveals that MIPS had never been authorized more than 30 FTEs in any given year. Further analysis of review guide responses shows that MIPS was not staffed up to its authorized number of FTEs in any of these years and that, in fact, the vacancy rate ranged from 15 to 38 percent. During interviews, it was also noted that the division had lost experienced staff over time.

According to the MIPS director, the lack of the authority to recruit and maintain staff has been reflected in the State's audit efforts and recovery totals. A significant number of Michigan Medicaid audits are undertaken by contractors. The average annual collections in the period SFY 2007-2009 as a result of audits performed by State and contractor staff was somewhat more than $2 million per year. Typical of most States, most of Michigan's audit effort goes into desk audits. However, the range of field audit activity is unusually narrow. Based on interviews with MIPS staff and responses to the review guide, in SFY 2009, for example, only 26 field audits were conducted on hospitals, 17 on pharmacy providers, 3 on dental providers and 5 on medical suppliers and hearing aid dealers. In the same year, no NEMT providers, group practices or home health agencies were audited at all. During interviews, the MFCU director also expressed concern that the State was not looking at high billers, such as long term care, managed care and pharmacy. In a financial audit report covering the period October 1, 2007 through September 30, 2009, Michigan's Office of the Auditor General similarly reported that MDCH did not use MIPS personnel to identify suspected fraud or abuse at long term care facilities, despite the fact that these accounted for roughly 14 percent of all Medicaid expenditures.

The MDCH representatives did not find the MFCU comments entirely warranted. Although MIPS did not conduct audits of long term care facilities, these facilities were audited by the Department of Community Health's Office of Audit. During SFYs 2007–2009, 392, 440, and 379 audits of nursing facilities were conducted, respectively. In addition, the Michigan Medicaid State Plan requires that an onsite audit be conducted no less than once every four years. Again, during the above referenced SFYs, the proportion of audits conducted onsite was 86, 87, and 82 percent, respectively. There are approximately 450 nursing facilities throughout Michigan.

The MDCH also noted that the Contracts Management office and MIPS performed yearly MCO visits, utilizing the managed care site tool, to all 14 MCOs. Likewise, the pharmacy contractor, under the direction of MIPS, performed numerous pharmacy audits during October 1, 2007 through September 30, 2009.

Notwithstanding the audit activity performed outside MIPS by other MDCH components and contractors, the extent of program integrity activities which MIPS can undertake is limited by factors beyond its control. Though Michigan has recovered substantial additional sums in some years through global settlements and considerable staff effort has gone into this work, overall program integrity operations appear severely drained by chronic staff and budget shortages.

The results can be seen in a comparison of Michigan with other large Medicaid programs on a number of key program integrity performance indicators. In a ranking of all States by total Medicaid expenditures in FFY 2009, Michigan had the 10th largest budget. The three States ranked 7th, 8th, and 9th were Illinois, Massachusetts and North Carolina, respectively, while New Jersey, Arizona, and Missouri were 11th, 12th, and 13th. Of these seven States, Michigan ranked as follows on a list of key program integrity effectiveness indicators reported on CMS' most recently published State Program Integrity Assessment surveys (for FFY 2008):

Table 2

Performance Indicator	Michigan's Ranking Among the Seven States
Staffing	7
Total Audits Undertaken	5
Recoveries from Provider Audits	6
Total recoveries--all program integrity activities	7

The obstacles faced by program integrity operations in Michigan can be seen in other ways as well. Interviews with MIPS staff and responses from the review guide show that MDCH has one staff person assigned to prepayment review. Although MDCH processes approximately 400,000 claims per week, this individual reviews only paper claims (about 7 percent of total billings) for completeness. No automated provider claims have been selected for manual prepayment reviews in the last four SFYs.

The limited effectiveness of program integrity operations is also reflected in MFCU referrals. According to both MIPS staff and the MFCU director, the Medicaid agency has referred to the MFCU an average of 26 cases per year over the period SFY 2007 to SFY 2009. In contrast, the two largest other programs in the same CMS Region, Illinois and Ohio, averaged over 100 and nearly 185, respectively during the same time period. The MFCU director indicated during interviews that MDCH referrals are often of low quality and reflect relatively limited financial exposure. He considered the potential return on investment low for a State with annual Medicaid expenditures of more than $10 billion. A MIPS representative noted, however, that MIPS meets monthly with a MFCU liaison to discuss whether questionable cases should be referred from MIPS to the MFCU and that this practice had been in place for many years.

The problems of oversight extend to the NEMT program. The MDCH is responsible for developing NEMT policies, but DHS is responsible for oversight of the program. Local DHS offices have transportation coordinators who are responsible for enrolling providers in the NEMT program. In Michigan, NEMT services may be provided by members of the recipient's

household, other volunteer drivers or professional transportation companies, none of which are enrolled in CHAMPS. As noted earlier, criminal conviction information is not requested of prospective NEMT providers, nor are they subjected to regular exclusion checks.

The DHS sends MDCH a monthly bill for payment of the costs incurred by NEMT providers, which comes to around $11 million per year. However, DHS does not conduct any pre-or post-payment analysis of NEMT provider claims. Based on interviews and review guide responses, cases of fraud, waste, or abuse in the NEMT program are reported to the DHS Office of Inspector General (DHS-OIG), but the DHS-OIG does not report any of these findings to MDCH or MIPS. Both MDCH and DHS staff stated that NEMT providers are not considered "providers" in Michigan. They also maintained in interviews that because of low reimbursement rates, there was little opportunity for fraud. Nevertheless, given the high incidence of NEMT issues in many States, the near absence of monitoring or controls in the program remains a concern.

In comparison with the size of the overall program, the scope of surveillance, investigative, and auditing activities performed by program integrity staff is relatively limited. The recent identification of Detroit as one of nine areas where Federal programs are subject to high levels of provider fraud and the establishment of a joint HHS-Department of Justice Health Care Fraud Prevention and Enforcement Action Team (known as HEAT) to target providers in this area is an indication of the magnitude of the tasks facing MIPS staff. Notwithstanding the diligent efforts of MIPS personnel on a day-to-day basis, effective fraud and abuse detection and monitoring in the Michigan Medicaid program will continue to face challenges without a greater commitment at the highest levels of State government to address existing resource and staffing issues.

Recommendations: Develop and implement policies and procedures for organizing program integrity operations commensurate with the size of Michigan's Medicaid program, including the investigation and auditing of provider types where Medicaid dollars are most at risk. Ensure that required pre-enrollment screenings and checks, along with post-enrollment claims reviews and audits are applied to provider types, such as NEMT providers, who are not directly overseen or enrolled by the Medicaid program.

Not collecting full ownership and control disclosure information from MCO and PIHP network providers.

Michigan has 14 MCOs and 18 behavioral health/substance abuse programs operating as PIHPs. The review team interviewed four of the MCOs and the MDCH staff responsible for administering the PIHP program. A review of the credentialing applications for the four MCOs interviewed revealed that three of the four MCOs do not capture address and relationship information on persons with ownership and control interests in the provider's business. The fourth MCO requires its network providers to enroll in FFS prior to inclusion in its network.

Although the review team did not interview PIHP staff, the team did review provider credentialing applications for 6 of the 18 PIHPs. The team found that Michigan's PIHPs use a variety of different forms to collect information during the provider enrollment process. There is

no consistency to ensure that all PIHP providers submit full disclosures. Of the six plans reviewed, none collected complete address or relationship information on persons with ownership and control interests in the enrolling provider.

NOTE: The CMS team reviewed the managed care and PIHP applications and other provider agreements for compliance with 42 CFR § 455.104 as it was effective at the time of the review. That section of the program integrity regulations has been substantially revised and the amendment was effective on March 25, 2011. The amendment adds requirements for provision of Social Security Numbers and dates of birth as well as more complete address information regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any actions the State takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

Recommendation: Modify managed care and PIHP contracts to require the full range of disclosures that FFS providers would be required to furnish under the Federal regulation at 42 CFR § 455.104.

Not requiring disclosure of business transaction information, upon request, in the managed care and PIHP network provider agreements.

All four MCOs reviewed did not include language in their provider agreements requiring network providers to submit specified business transaction information upon request. Similarly, of the six PIHP provider credentialing applications reviewed, none of the provider agreements contained any reference to this requirement, which would be mandatory for all FFS providers.

Recommendation: Modify MCO and PIHP network provider agreements to require disclosure, upon request, of the business transaction information that FFS providers would be required to furnish under the Federal regulation at 42 CFR § 455.105(b).

Not notifying the State agency or HHS-OIG when MCOs deny credentialing or enrollment to a provider.

The Michigan MCO contract does not require the MCOs to report to HHS-OIG adverse actions taken on provider applications for reasons of fraud, quality, or integrity, as would be required of the FFS Medicaid program under the Federal regulation at 42 CFR § 1002.3(b)(3).

While the State provided the review team with documentation indicating that MCOs report network provider terminations to the State for transmission to HHS-OIG, there was no indication that application denials were covered in existing policies and procedures on reportable actions. Three of the four MCOs interviewed indicated that they do not report application denials. One of the plans justified the current practice on the grounds that it was not a contractual requirement. The end result is that the MDCH is unable to report all adverse actions taken by MCOs to HHS-OIG as the regulation requires. In addition, the failure to notify MDCH of providers who are denied credentialing for program integrity reasons affords such providers a potential opportunity to enroll with other managed care plans or FFS Medicaid which might otherwise be prevented.

Recommendations: Require contracted MCOs to notify the State agency when they deny providers credentialing for program integrity reasons. Develop and implement policies and procedures for reporting these adverse actions to HHS-OIG.

Not conducting complete searches for individuals and entities excluded from participating in Medicaid.

The regulations at 42 CFR §§ 455.104 through 455.106 require States to solicit disclosure information from disclosing entities, including providers, and require that provider agreements contain language by which the provider agrees to supply disclosures upon request. If the State neither collects nor maintains complete information on owners, officers, and managing employees in the Medicaid Management Information System, then the State cannot conduct adequate searches of the List of Excluded Individuals/Entities (LEIE) or the Medicare Exclusion Database (MED).

The CMS issued a State Medicaid Director Letter (SMDL) #08-003 dated June 16, 2008 providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the MED upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties, including owners, agents, and managing employees. A new regulation at 42 CFR § 455.436, effective March 25, 2011, now requires States to check enrolled providers, persons with ownership and control interests, and managing employees for exclusions in both the LEIE and the Excluded Parties List System (EPLS) on a monthly basis.

Based on interviews and responses to the review guide, Michigan's provider enrollment staff does not search the HHS-OIG LEIE or the MED on a monthly basis for excluded providers in the FFS system. Moreover, Michigan does not conduct exclusion searches on contracted MCO personnel that are consistent with SMDL #08-003. Michigan indicated it relies upon the MCOs themselves to conduct checks on their owners and subcontractors.

In addition, the State does not have procedures in place to receive ownership and control information from the State survey agency for entities that are subject to periodic survey and certification. The State relies on survey staff to report any changes in ownership, but there are no information exchange requirements going beyond this.

The MDCH staff indicated that during annual compliance reviews, they confirm if the MCOs conducted a search of names in the EPLS, which is maintained by the General Services Administration. However, as Michigan does not collect complete information on owners and agents, EPLS checks might not identify debarred persons affiliated with the MCOs, and in any case the more current Medicare exclusion sources (LEIE or MED) are not consulted.

Lastly, Michigan does not require the MCOs to conduct exclusion searches consistent with SMDL #09-001. Managed care staff indicated to the review team that "the contract does not state how frequently the plans need to check; however, most plans are checking on an annual basis." All of the MCOs interviewed reported that they checked only providers for exclusions on a monthly basis. They did not do monthly checks on owners, agents and managing employees. One of the four MCOs reported that it did check its officers, directors, board members, and contractors in the EPLS yearly. It was not clear how often the other MCOs checked or that they solicited information on the full range of parties to be scrutinized.

Recommendation: Develop policies and procedures for appropriate collection and maintenance of disclosure information about disclosing entities, and about any person with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity. Search the LEIE (or the 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 person or entities.

CONCLUSION

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

- development of a provider re-enrollment system based on licensure renewal, and
- development and utilization of the managed care program integrity checklist to monitor MCO compliance with State and Federal regulations.

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

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

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 it 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 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 Michigan 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 effective practices.

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
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OLGA DAZZO
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September 30, 2011

Robb Miller, Director
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Baltimore, MD 21244

Dear Mr. Miller:

I am in receipt of a letter from Angela Brice-Smith dated July 22, 2011 as well as the Medicaid Integrity Program, Michigan Comprehensive Program Integrity Review Final Report dated July 2011. The Michigan Department of Community Health appreciates the two effective practices highlighted and discussed in the Final Report as well as the opportunity to submit a corrective action plan in response to the regulatory compliance issues identified in the Final Report. As requested, we are also including a description of how the identified vulnerabilities will be addressed. See the two enclosed documents.

Please contact me if you have further questions or need clarification regarding the information contained in the Regulatory Compliance Issues and Corrective Action Plan or the Vulnerabilities and How They Will be Addressed documents. Thank you.

Sincerely,

Stephen Fitton
Medicaid Director

Enclosures

CC: Angela Brice-Smith, MIG Director
Jackie Garner, CMCHO Consortium Administrator
Verlon Johnson, DMCHO Associate Regional Administrator
Kerry A. Coffman, CMS/CPI
Mary Linda Morgan, CMS/CPI
David Tanay, MFCU Director
Beau Hill, MDCH Inspector General
Michele Warstler, PI Manager