Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Minnesota Comprehensive Program Integrity Review

Final Report

June 2012

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Introduction

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Minnesota Medicaid program. The MIG conducted the onsite portion of the review at the Minnesota Department of Human Services (DHS) offices. The review team also visited the office of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Surveillance and Integrity Review Section (SIRS) within the Performance Measurement and Quality Improvement (PMQI) Division of the DHS. The SIRS is responsible for implementing program integrity activities. This report describes one noteworthy practice, four effective practices, five regulatory compliance issues, and six 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 Minnesota improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Minnesota's Medicaid Program

The DHS administers the Minnesota Medicaid program. As of January 1, 2011, the program served approximately 705,994 beneficiaries. Minnesota has a comprehensive managed care program which served 558,489 beneficiaries, or 79 percent of Minnesota's Medicaid population as of January 1, 2011.

At the time of the review, the Minnesota Medicaid program had 120,000 participating fee-for-service (FFS) providers. As of February 25, 2011, Minnesota's eight managed care organizations (MCOs) reported a total of 59,295 providers enrolled in the State's managed care program. Medicaid expenditures for the State fiscal year (SFY) ending June 30, 2010 totaled $7,907,213,519. Approximately $4.9 billion of these outlays, or 62 percent, went to the FFS Medicaid program.

Surveillance and Integrity Review Section

The SIRS is an organizational component of DHS located within PMQI. It is responsible for the prevention and detection of fraud, abuse and improper payments within the Minnesota Medicaid Program. At the time of the review, SIRS had 21.5 full-time equivalent staff including one supervisor and one section manager. There were two vacant positions.

The table below represents the total number of preliminary and full investigations and the

amount of identified and recouped overpayments in the past four SFYs as a result of program integrity activities. The numbers do not reflect data on managed care program integrity activities, but the figures on overpayments collected include dollars recouped from global settlements.

Table 1

SFY	Number of Preliminary & Full Investigations*	Number of Investigations Referred to MFCU	Amount of Overpayments Identified	Amount of Overpayments Collected
2007	507	16	$,5,221,947.68	$4,130,448.26
2008	546	45	$8,607,768.79	$6,183,073.86
2009	684	39	$5,669,947.49	$5,321,163.14
2010	848	74	$11,358,168.64	$10,230,284.92

*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 though administrative action, a referral to the MFCU or other legal disposition. Minnesota's case tracking system does not distinguish between preliminary and full investigations.

Methodology of the Review

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

During the week of June 13-17, 2011, the MIG review team visited DHS offices and also met with the MFCU director. The review team conducted interviews with numerous officials from DHS. To assess MCO compliance with State requirements and Federal regulations on program integrity, the MIG team reviewed the State-MCO contracts and interviewed representatives from four of the MCOs. In addition, the review team met with staff from the DHS division that oversees MCO contracting and program performance. 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 DHS as they relate to program integrity but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, managed care, personal care services, waiver programs and non-emergency medical transportation (NEMT).

Minnesota operates its Children's Health Insurance Program (CHIP) both as a stand alone Title XXI program and a Title XIX Medicaid expansion program. The expansion program operates under the same billing and provider enrollment policies as Minnesota's Title XIX program. The same effective practices, findings and vulnerabilities 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, Minnesota provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information provided by the State.

Results of the Review

Noteworthy Practices

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

Innovative practices in Minnesota's personal care attendant (PCA) program

The MIG's 2008 program integrity review identified Minnesota's management of PCAs as an effective practice. Elements of the program singled out for special merit included the requirement that PCAs have individual provider numbers, that they establish affiliations with home health agencies or personal care provider organizations (PCPOs), and that they undergo required provider training. Building on these practices, DHS currently requires every PCA to be enrolled in Medicaid as an individual provider and to bill services through an affiliated agency. The DHS also requires all PCAs to pass a background check before they are enrolled and eligible to bill for services.

Further, SIRS collaborates with the Department of Employment and Economic Development to review information on wages earned and hours worked to determine if PCAs have alternate employment. This information is often useful in investigations of suspect billing or conduct. The SIRS has implemented a variety of system edits that impose daily and monthly service limits, identify conflicting claims and check that claims are billed through an affiliated agency before they can be paid. Minnesota's training requirements have also evolved into a three day program called "Steps to Success" for PCPO providers and an online training for individual PCAs. Altogether, these practices have enabled Minnesota to exercise more oversight of its personal care services programs than is currently possible in most States.

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. Minnesota reported a beneficiary lock-in program, a high degree of integration in program integrity practices across units of DHS, a strong working relationship between the State agency and the MFCU, and the design of provider agreements that contain live hyperlinks to State and Federal regulations.

Beneficiary lock-in program

During the 2008 program integrity review, CMS noted that Medicaid Recipient Restriction Program (MRRP) staff worked closely with MCOs to bring about universal

restriction. Universal restriction means that regardless of whether beneficiaries are initially restricted by an MCO or the FFS Medicaid program, the restriction will follow the beneficiaries if they change plans, move from FFS to managed care, or vice versa. The MRRP staff enters such restrictions into the Medicaid Management Information System (MMIS) so that tracking edits can be created. These edits automatically prevent payment to all providers who are not the beneficiaries' designated providers. The 2011 MIG review team observed that Minnesota has continued this practice. The MRRP program has continued to reduce the abuse of services by beneficiaries and unnecessary costs to the program by decreasing the amount of unnecessary services used.

According to SIRS, the MRRP program had 1,933 active beneficiaries in the program in 2010 and had generated $9,352,848 in savings from SFY 2007 through 2010. Of this total, DHS estimated that it saved an average of $8,730 per restricted beneficiary. Approximately 55 percent of this figure ($4,626) was due to the impact of reduced utilization under the MRRP. Roughly 45 percent ($4,104) resulted from the denial of unallowable claims for services rendered by providers other than those assigned to MRRP participants.

Notwithstanding Minnesota's achievements in this area, the team found other issues related to the reporting of beneficiary fraud. These are discussed in the Findings section of this report.

Integrated program integrity practices and effective communications throughout DHS

The DHS has successfully maintained an organizational culture which emphasizes that program integrity is everyone's responsibility and utilizes practices that support communication, collaboration, and the integration of program integrity practices throughout the agency. This is achieved by ensuring that SIRS effectively interacts with other components within DHS that impact program integrity. Examples of how DHS has integrated program integrity functions into daily operations and policy setting functions include the collaboration of SIRS in prepayment reviews with the Office of Data Integrity and the development of coverage and benefit policy, service limits and system edits. These types of collaboration have made program integrity considerations a factor in most agency policy discussions and have led DHS to stress prevention as the most effective program integrity tool.

Collaborative and strong working relationship with the MFCU

The SIRS has a cooperative and strong relationship with Minnesota's MFCU. The MFCU actively communicates with, and conducts training for, a range of State programs. The MFCU's close relationship with State agency programs has resulted in an increased volume of quality referrals to the MFCU. This is due to the ongoing communication between the two areas. For instance, if SIRS is unsure about a referral, it will consistently contact the MFCU to seek input about the appropriateness of a referral. The collaborative relationship has also enabled DHS to implement payment withholding from providers referred for fraud. Minnesota's MFCU has consistently supported SIRS' practice of withholding payments based on reliable or credible evidence of fraud. The MFCU director also serves as an instructor in the State's training program for personal care provider

organizations. Further, the MFCU has a Memorandum of Understanding with each of the four largest Medicaid MCO contractors. The State agency was recognized for its collaborative relationship with the MFCU during the 2008 program integrity review.

Provider agreement hyperlinks to relevant laws and regulations.
The Minnesota Medical Assistance Provider Agreement form, available on the web, includes live hyperlinks to all relevant State and Federal regulations. This facilitates provider awareness of their legal obligations and enables applicants to read the pertinent regulations in full. In this way, the agreement expressly incorporates such regulations, promotes transparency and clarity, and provides effective and convenient information about the obligations of enrollment to all providers.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to disclosures of ownership and control, business transactions and health care-related criminal convictions, required exclusion searches and notification procedures that must be taken when the State agency excludes providers.

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

Minnesota does not require the collection of SSNs and DOBs in its MCO contract or procurement specifications. At the time of the review, the State agency indicated that it had not yet collected this information from MCOs per the new requirements of 42 CFR § 455.104. In addition, one MCO did not make clear to the State whether or not it has subcontractors in which it holds a direct or indirect ownership interest of 5 percent or more and did not list the name and

address of each person (individual or corporation) with such an interest as required by the regulation.

During the review, the State acknowledged its awareness of the addition of new disclosure items added by amendments to Federal regulations effective March 25, 2011 and said that it included the requirement to collect this additional information in its 2012 MCO contracts.

Recommendations: Develop policies and procedures for the appropriate collection of disclosures from MCEs regarding persons with an ownership or control interest, or who are managing employees of the MCEs. Modify disclosure forms as necessary to capture all disclosures required under the regulation.

The State does not adequately address business transaction disclosure requirements in its provider agreements or contracts.

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or the U.S. Department of Health and Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors.

Minnesota's contracts with the MCOs do not contain either language referring to the requirement in 42 CFR 455.105 subpart B or language that fully tracks the regulation, stipulating that upon request by the State agency or HHS Secretary, the MCO agrees to submit the business transaction information required by the regulation at 42 CFR § 455.105.[1]

Recommendation: Revise the State-MCO contracts to require disclosure upon request of the information identified in 42 CFR § 455.105(b).

The State does not capture criminal conviction disclosures from providers or contractors.

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify the U. S. Department of Health and Human Services-Office of Inspector General (HHS-OIG) whenever such disclosures are made. In addition, pursuant to 42 CFR § 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

Minnesota's Organizational Provider Enrollment Application requires criminal history disclosures

[1]During the review, the MIG team learned that there was a discrepancy with regard to whether the appropriate language was contained in the State's MCO contracts. The MIG team reviewed redlined drafts of four 2010 model managed care contracts provided by the State. Three of the four contracts appeared to have had § 455.105 language deleted from them; however, the language lacked reference to the Secretary.

from all relevant parties cited in the regulation. Further, the State's provider agreement expressly references the obligation to disclose criminal history convictions pursuant to 42 CFR § 455.106 (with the Federal regulation hyperlinked in its entirety). The State noted that it has received such disclosures in the past and reported them to the HHS-OIG. However, the State's Individual Practitioner Provider Enrollment Application does not request or provide space for health care-related criminal conviction disclosures. The review team also found no evidence of criminal history disclosures in the provider enrollment files sampled.

Recommendations: Develop policies and procedures for the appropriate collection of disclosures from providers regarding persons with an ownership or control interest, or persons who are agents or managing employees of the providers, who have been convicted of a criminal offense related to Medicare, Medicaid or Title XX since the inception of the programs. Modify disclosure forms as necessary to capture all disclosures required under the regulation.

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid.

The Federal regulation at 42 CFR § 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System (EPLS) no less frequently than monthly.

Prior to implementation of this new regulation, 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.

Although Minnesota's FFS program has a robust system of checking for excluded parties at enrollment and re-enrollment and the State checks the LEIE monthly, the State only checks the EPLS upon initial credentialing. It does not check for debarments on a monthly basis as required after March 25, 2011.

Further, although Minnesota's model MCO contract requires that the entities conduct monthly checks of the LEIE or the Medicare Exclusion Database (MED), at the time of the review, the contract did not require MCOs to check key personnel against the EPLS on a monthly basis. While several MCOs said they were making an effort to comply with the new baseline requirements on exclusion searches, not all appeared aware of them. For example, one of the four MCOs interviewed indicated that it conducts a search of the required databases for names of its employees only at the time of hire and for its board of directors only at initial appointment to the board, not monthly thereafter as required. The EPLS monthly database search was added to the requirements in the 2012 MCO contracts.

Recommendations: Develop policies and procedures for appropriate collection and maintenance of disclosure information about the provider, any person with an ownership or control interest, or who is an agent or managing employee of the provider. 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 persons or entities. Modify the managed care contract to require MCEs to search the LEIE and EPLS upon contract execution and monthly thereafter by the names of any person with an ownership or control interest in the MCE, or who is an agent or managing employee of the MCE.

The State does not provide notice of exclusion consistent with the regulation.
Under the regulation at 42 CFR § 1002.212, if a State agency initiates exclusion pursuant to the regulation at 42 CFR § 1002.210, it must provide notice to the individual or entity subject to the exclusion, as well as other State agencies; the State medical licensing board, as applicable; the public; beneficiaries; and others as provided in §§ 1001.2005 and 1001.2006.

When initiating permissive exclusions, Minnesota does not provide public notice as required by the regulation. Although the State's administrative rules (9505.2240) describe a notification policy that is consistent with Federal rules and mandates public notice, in practice Minnesota only consistently provides notice to the provider. The State sends notice to a limited number of other State agencies, licensing boards, employers and impacted beneficiaries at its discretion but does not consistently notify all parties. Further, the State informed the review team that it does not provide notice to the general public.

Recommendation: Develop policies and procedures to provide required public notice and institute more consistent and broad notification practices in conformance with 42 CFR 1002.212 when excluding a provider.

Vulnerabilities

The review team identified six areas of vulnerability in Minnesota's Medicaid practices. These include not capturing ownership and control, business transactions, and criminal conviction disclosures from network providers, and not verifying with MCO beneficiaries that billed services were received. Also included are the failure to perform complete exclusion searches and not reporting adverse actions taken against providers.

Not capturing ownership and control disclosures from network providers. (Uncorrected Partial Repeat Issue)
Minnesota's managed care and NEMT programs are not collecting the full range of ownership and control disclosures that Federal regulations at 42 CFR § 455.104 would otherwise require from FFS providers.

One of the four MCOs interviewed acknowledged that it did not collect information on persons with ownership and control interests from its network providers. This issue remains uncorrected from the 2008 MIG review. In addition, as of the date of the review, none of the MCOs were capturing SSNs and DOBs from persons with ownership and control interests in network

providers, as would have been required of disclosing entities in the FFS Medicaid program after March 25, 2011.

Under 42 CFR § 455.101, a managing employee is defined as "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency." The review team found that MCOs were not soliciting managing employee information as part of the provider enrollment and credentialing process.

In Minnesota, there are two levels of transportation services offered by the Medicaid program: access level or routine services and special transportation services (STS), such as those requiring a specialized medical vehicle. Access level services are managed by the counties, while STS are managed by the State. While STS providers are enrolled by the State and are required to provide the same disclosures and assurances as other FFS providers, no evidence was provided that the counties collect full ownership and control disclosures from vendors and drivers participating in the access level program. The State does not expressly require the counties to do so as part of their formal NEMT plans.

Thus, the State would have no way of knowing if excluded individuals are working for individual, group or institutional service providers participating in the managed care or county administered NEMT programs in such positions as billing managers and department heads.

Recommendations: Modify the managed care and NEMT contracts to require, or ensure that managed care and NEMT provider enrollment forms require, the disclosure of complete ownership, control, and relationship information from all MCE and NEMT network providers. Include contract language requiring MCEs and the counties to notify the State of such disclosures on a timely basis. The MIG made a similar recommendation regarding MCEs in its 2008 review report.

Not adequately addressing business transaction disclosures in network provider contracts. (Uncorrected Partial Repeat Issue)

Minnesota's MCO provider participation agreements do not include language requiring network providers to submit the specified business transaction information upon request that would otherwise be required of FFS providers under 42 CFR § 455.105. This issue remains uncorrected from the 2008 MIG review. In addition, the counties have not required transportation vendors and providers to furnish the equivalent information in response to State agency or HHS Secretary requests within 35 days as part of the county NEMT plans.[2]

[2]During the review, the MIG team learned there was a discrepancy with regard to whether the MCO network provider participation agreements contained appropriate language. The MIG team reviewed the 21 network provider participation agreements the State provided, and found that 5 of those agreements contained the relevant § 455.105 language, although only 1 of the network provider agreements was compliant.

Recommendation: Modify the managed care and NEMT contracts to require disclosure upon request of the information identified in 42 CFR § 455.105(b). The MIG made a similar recommendation regarding managed care in its 2008 review report.

Not capturing criminal conviction disclosures from network providers. (Uncorrected Partial Repeat Issue)

Three of the four MCOs interviewed do not collect full health care-related criminal conviction information from their network providers that would otherwise be required in the FFS program under 42 CFR § 455.106. Also, MCOs do not ask for criminal history disclosures on persons with ownership or control interests in network providers or agents and managing employees. This prevents DHS from complying with the regulation at 42 CFR § 455.106(b)(1) requiring that the State notify HHS-OIG of such disclosures within a 20 day timeframe. This issue remains uncorrected from the 2008 MIG review.

Likewise, the State provided no evidence that counties are collecting healthcare-related criminal conviction disclosures on NEMT vendors or drivers and related parties where applicable, such as persons with ownership or control interests, agents, and managing employees. The State has not expressly required the counties to do so as part of their NEMT transportation plans.

Recommendations: Modify the managed care contract and NEMT transportation plan to require, or ensure that managed care and NEMT provider enrollment forms require, the disclosure of health care-related criminal convictions on the part of persons with an ownership or control interest, or persons who are agents or managing employees of network providers. Include in the contract language requiring MCEs and counties to notify the State of such disclosures on a timely basis. The MIG made a similar recommendation regarding MCEs in its 2008 review report.

Not verifying with managed care enrollees whether services billed were received.

Minnesota sends out Explanation of Medical Benefits forms to verify service delivery with beneficiaries for every claim submitted by FFS providers. Verification of service delivery was a new managed care contract requirement for the 2011 contract. The 2011 contract also provides a detailed list of verification methodologies. However, one of the four MCOs has not implemented a process for verification of services.

Recommendation: Develop and implement procedures to verify with MCO enrollees whether services billed by providers were received.

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 MMIS, then the State cannot conduct adequate searches of the LEIE or the 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 EPLS on a monthly basis.

The DHS-MCO contract does not require MCOs to conduct monthly checks of the EPLS for network providers. The contract requires MCOs to search the LEIE or the MED on a monthly basis for excluded network providers. It also states that MCOs must "require all subcontractors to search the MED or the LEIE for any federally excluded persons with an ownership or control interests, agents, or managing employees." However, there is no contract language or policy in effect requiring subcontractors or network providers to search the EPLS on a monthly basis for excluded parties among their staffs.

Additionally, no evidence was provided that counties collect all the related party disclosures necessary for complete exclusion searches or that they search either the LEIE or EPLS for excluded vendors, drivers, or related parties in the access level NEMT program. The State has not expressly required the counties to do so as part of their formal ACCESS transportation plans.

Recommendations: Amend the FFS NEMT contract to require the 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. Require FFS NEMT providers and MCEs to search the LEIE and the EPLS upon enrollment, reenrollment, credentialing or recredentialing of network providers, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

Not reporting all adverse actions taken on provider participation to HHS-OIG. (Uncorrected Partial Repeat Issue)

The State Medicaid agency does not have clear policies and procedures or contract requirements directing the MCOs to report to it any program integrity-related adverse actions the MCO takes on a provider's participation in the network, e.g., denials of credentials, enrollment, or contracts, or terminations of credentials, enrollment, or contracts. Program integrity reasons include fraud, integrity, or quality.

Minnesota reported that its MCO contract language mandates the reporting of adverse actions taken against network providers as would be required in the FFS program under 42 CFR § 1002.3(b)(3). However, a review of the contract revealed that it does not require MCO reporting to the State agency when a provider has been denied enrollment or credentialing. The contract refers to "not renew" and "terminate" only as reportable situations. Moreover, the contract does not require that all actions the MCO takes on providers, including actions which limit the ability of providers to participate in the program, be reported to DHS. While two of the four MCOs interviewed appeared to be reporting relevant adverse actions in practice, the other two MCOs reported that they notify neither the State agency nor HHS-OIG when denying the credentialing or enrollment of a provider due to the concerns about provider fraud, integrity, or quality. This issue remains uncorrected from the 2008 MIG review.

In addition, no evidence was provided to the review team to indicate that the counties report any actions they take to limit a transportation provider's ability to participate in the Medicaid program or deny a vendor application. The State has not expressly required the counties to do so as part of their NEMT transportation plans. This prevents the State from reporting adverse actions taken for program integrity reasons to HHS-OIG as it is required to do by the regulation at 42 CFR § 1002.3(b)(3).

During the review, the State informed the review team that HHS-OIG has indicated interest in receiving notice of only limited types of adverse actions. For example, HHS-OIG did not want Minnesota to submit notices of adverse actions related to disqualifications of caregivers based on past criminal conduct.

Recommendations: Require contracted MCOs and NEMT programs to notify the State when they take adverse action against a network provider for program integrity-related reasons. Develop and implement procedures for reporting these actions to HHS-OIG. The MIG made this recommendation regarding MCOs in its 2008 review report.

Conclusion

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

- innovative practices in the PCA program,
- beneficiary lock-in program,
- highly integrated program integrity practices within the single State agency,
- collaborative and strong working relationship with the MFCU, and
- provider agreements with live hyperlinks to 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 five areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, six areas of vulnerability were identified. The CMS encourages DHS 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 Minnesota 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 Minnesota 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 Minnesota 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 Minnesota on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

Official Response from Minnesota
August 2012

Minnesota Department of **Human Services**

August 10, 2012

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

Re: Response to Medicaid Integrity Program Minnesota Comprehensive Review Final Report, June 2012 and Corrective Action Plan

Dear Mr. Miller:

Thank you for the thorough review of the Minnesota Medicaid program integrity processes and procedures. We appreciate the oversight provided by the Medicaid Integrity Group review team, the identification of strengths and vulnerabilities in our program, and the recommendations for improvement.

I have attached to this letter a description of the corrective action for the issues identified by the review team. Minnesota completed corrective action to address a number of the identified areas soon after the review team's visit, and will actively work to implement the remaining corrective actions. Please contact Ron Nail, Manager of the Surveillance and Integrity Review Section, in the Office of Inspector General, at 651-431-2619, if you have any questions.
Sincerely,

David Godfrey
Medicaid Director