Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Oklahoma Comprehensive Program Integrity Review

Final Report

July 2008

Reviewers:
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INTRODUCTION

CMS' Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Oklahoma Medicaid program. The onsite portion of the review was conducted at the offices of the Oklahoma Health Care Authority (OHCA). The MIG review team also visited the offices of the Patient Abuse and Medicaid Fraud Control Unit (PAMFCU).

This review focused on the activities of the Program Integrity and Planning Division (PIPD), which is responsible for Medicaid program integrity oversight. The report addresses regulatory compliance issues and noteworthy practices. The review team identified two areas of non-compliance with Federal regulations during its review.

- 42 CFR § 455.104(c) provides that the Medicaid agency shall not approve a provider agreement or a contract with a fiscal agent, and must terminate an existing agreement or contract, if the provider or fiscal agent fails to disclose specific ownership and control information as required in another paragraph of this section.

- 42 CFR § 1002.3(b)(2) and (b)(3) requires the Medicaid agency to notify the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) of action taken on a provider's application for participation in the program.

The State of Oklahoma had an opportunity to review and respond to this report prior to release. CMS made minor modifications in the text in response to technical corrections suggested by the State. Oklahoma indicated that it would initiate corrective action on the findings identified in the report. These comments are included in the text following each finding. Oklahoma's complete response to the draft report is also included as Attachment A.

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 Oklahoma improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Oklahoma's Medicaid Program

The OHCA administers the Medicaid program through SoonerCare. As of January 30, 2008, the SoonerCare program served 763,565 recipients. Medicaid expenditures for the State fiscal year (SFY) ending June 30, 2007 totaled $3,420,671,434. The Federal medical assistance percentage for Oklahoma in SFY 2007 varied from 67.91 to 68.14 percent. OHCA processed an average of 30 million claims annually for the past three SFYs. Of those claims, approximately 92 percent

were submitted electronically. As of January 30, 2008, OHCA had 25,565 enrolled providers and required providers to re-enroll every three years.

More than 80 percent of the State's recipients are enrolled in a primary care case management (PCCM) program. The State contracts directly with primary care providers throughout the State to provide basic health care services.

All claims in the PCCM program are processed by OHCA's fiscal agent, Electronic Data Systems, Inc. (EDS). Providers' claims in SoonerRide, the State's Non-Emergency Transportation (NET) program, are paid by OHCA's NET broker. LogistiCare Solutions, is responsible for subcontracting with and managing third party local transportation companies. OHCA pays LogistiCare Solutions on a per member per month basis.

Program Integrity and Planning Division

In Oklahoma, the organizational component dedicated to fraud and abuse detection activities is Program Integrity and Accountability (PIA) located within the PIPD. The PIA has the position authority for 29 staff including four managers. At the time of the review, two of the non-managerial positions in the section were vacant. The audit management unit within PIA performs compliance, financial, and control audits of providers. The Surveillance and Utilization Review Subsystem (SURS) Unit conducts preliminary investigations and post-payment utilization reviews. OHCA contracts with APS Healthcare Midwest, Inc. to perform post-payment reviews of inpatient services. The SURS Unit uses EDS SUR for exception processing. EDS Business Objects is used by SURS and Audit Management for data mining activities. The EDS SURS Case Tracking, a different application from EDS SUR, is used for case tracking.

The OHCA data warehouse contains ten years of claims history and provides direct user access to the Medicaid Management Information System and external sources for the creation of ad hoc and canned reports. The table below presents the total number of reviews, identified overpayments, and amounts collected for the last three SFYs as a result of program integrity activities.

Table 1

SFY/ PI Unit	Reviews Opened / Closed	Overpayments Identified	Overpayments Collected
SURS	139/126	$925,304	$867,969
Audit	784/784	$2,377,086	$2,334,054
2005 Total	923/910	$3,302,390	$3,211,024
SURS	107/165	$3,899,141	$1,041,093
Audit	1,572/1,572	$3,199,578	$2,327,669
2006 Total	1,679/1,737	$7,098,719	$3,368,761
SURS	154/122	$2,394,321	$1,879,968
Audit	1,347/1,347	$5,983,319	$4,481,125
2007 Total	1,501/1,469	$8,377,640	$6,361,093

Methodology of the Review

In advance of the onsite visit, the review team requested that OHCA 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, claims payment and post-payment review, managed care, SURS, and the MFCU. A five-person review team reviewed the responses and materials that the State provided in advance of the onsite visit. During the week of February 10, 2008, the MIG review team visited the PIPD and the PAMFCU offices.

Scope and Limitations of the Review

This review focused on the activities of the PIPD, but also considered the work of other components and contractors responsible for a range of complementary functions, including provider enrollment, data mining, and legal support.

Oklahoma operates an expansion State Children's Health Insurance Program (SCHIP) under Title XIX of the Social Security Act. SCHIP operates under the same PCCM model and fee-for-service (FFS) billing and provider enrollment policies as Oklahoma's SoonerCare Program. The same findings, vulnerability, and noteworthy practices discussed in relation to the Medicaid program also apply to SCHIP.

Unless otherwise noted, PIPD 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 PIPD provided.

RESULTS OF THE REVIEW

Noteworthy Practices

The team identified three noteworthy practices related to quality assurance, reduction in payment error rates and periodic provider re-enrollment.

Quality Assurance (QA) Committee

The OHCA QA committee formulates organizational quality improvement policy and oversees the overall coordination and management of OHCA's quality assurance activities, including those of PIPD. PIPD utilizes the QA committee, which is composed of representatives from all components of the Medicaid agency, as a cross-check on its core activities. The QA committee reviews SURS findings and audits and recommends actions such as referrals, provider education, or termination to the State Medicaid Director for final decision. Referral actions against providers can be sent to the PAMFCU or the appropriate licensing board.

Payment Error Rate Reduction

PIPD has incorporated a State-initiated payment error rate measure, with a targeted error rate of no more than five percent, with an objective of changing provider behavior to improve health care quality. Because payment error rate reduction is a national priority, PIPD's effort at improving payment error rates within the State is a proactive measure that helps to improve the

economy and efficiency of the program. Oklahoma is currently scheduled for the CMS Payment Error Rate Measurement review in Federal fiscal year (FFY) 2009.

Provider Re-enrollment Process

The OHCA requires providers to re-enroll every three years. During re-enrollment, providers must complete a new application. If they do not, their contracts lapse. All contracts for a given provider type expire at the same time, regardless of when the contract began.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to obtaining disclosures from its fiscal agent and providing required notification to HHS-OIG.

OHCA does not require disclosure by the fiscal agent of ownership or control information.

Under 42 CFR § 455.104(a)(1), a provider, or "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 five 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. Finally, under § 455.104(c), the Medicaid agency may not approve a provider agreement or a contract with a fiscal agent, and must terminate an existing agreement or contract, if the provider or fiscal agent fails to disclose required ownership or control information.

The PIPD was unable to document that the State's contract with EDS required the disclosures mandated by the regulation, including the owners of the fiscal agent or subcontractors and their relationships or the identity of other disclosing entities in which there is an ownership or controlling interest. While State staff provided the review team with an EDS affidavit of non-collusion, State staff could not identify an instrument used by the State to capture disclosure information from fiscal agents.

***Recommendations*:** Modify the contract with the fiscal agent to mandate submission of required ownership and control information. Collect required disclosures or terminate the contract.

***State Response*:** The Legal Division will review the fiscal agent contract to ensure that appropriate disclosure requirements are included. EDS, the agency's fiscal agent, has had a change in ownership. We will request the new ownership information and provide it to you upon receipt.

OHCA does not report to HHS-OIG adverse actions it takes on provider applications.

Federal regulations at 42 CFR § 1002.3(b)(2) and (b)(3) require 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. Provider contracting staff was unable to document that the State reported to HHS-OIG any actions taken in the enrollment process to deny or limit provider participation in the program.

***Recommendation*:** Develop and implement procedures to report to HHS-OIG all adverse actions taken against and limits placed on providers applying to participate in the program.

***State Response*:** OHCA is not an "any willing provider state"; therefore not all providers applying will be selected to participate in the program. The agency may choose not to contract with a provider for reasons other than contractual or quality issues, such as lack of need for a particular provider type in a service area.

The Legal Division will put in place procedures to notify the HHS-OIG when a provider is denied enrollment due to criminal or quality issues. They will also notify HHS-OIG when the Quality Assurance Committee takes an adverse action against a provider due to criminal behavior, lack of or inaccurate disclosures or quality issue(s) deemed cause for termination.

CONCLUSION

The State of Oklahoma has some effective program integrity practices: specifically, the creation of a quality assurance committee, its efforts at reducing payment error rates and its periodic re-enrollment of providers. CMS encourages OHCA to look for additional opportunities to improve overall program integrity.

However, the identification of two areas of non-compliance with Federal regulations is of concern and should be addressed immediately. To that end, we will require OHCA to provide a corrective action plan for each area of non-compliance within 30 calendar days of the date of the final report letter.

The corrective action plan should address how the State of Oklahoma 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. It should also include an explanation if correcting any of the findings will take more than 90 calendar days from the date of the letter. If OHCA has already taken action to correct compliance deficiencies, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Oklahoma on correcting its areas of non-compliance, eliminating vulnerabilities and building on its noteworthy practices.

Attachment A

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

BRAD HENRY
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

June 11, 2008

Robb Miller, Director
Medicaid Integrity Group
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Chicago, IL 60601

RE: Review of Program Integrity Procedures for Oklahoma, May 2008

Mr. Miller,

Following is our response to the recommendations made by the Medicaid Integrity Group regarding the report, Review of Program Integrity Procedures for Oklahoma, dated May 2008. We have addressed both findings as well as making additional comments regarding the content of the report.

1. Modify the contract with the fiscal agent to mandate submission of required ownership and control information. Collect required disclosures or terminate the contract.

   The Legal Division will review the fiscal agent contract to ensure that appropriate disclosure requirements are included. EDS, the agency's fiscal agent, has had a change in ownership. We will request the new ownership information and provide it to you upon receipt.

2. Develop and implement procedures to report to HHS-OIG all adverse actions taken against and limits placed on providers applying to participate in the program.

   OHCA is not an "any willing provider state"; therefore not all providers applying will be selected to participate in the program. The agency may choose not to contract with a provider for reasons other than contractual or quality issues, such as lack of need for a particular provider type in a service area.

   The Legal Division will put in place procedures to notify the HHS-OIG when a provider is denied enrollment due to criminal or quality issues. They will also notify HHS-OIG when the Quality Assurance Committee takes an adverse action against a provider due to criminal behavior, lack of or inaccurate disclosures or quality issue(s) deemed cause for termination.

For your information, below are clarifying comments regarding statements made in the report.

1. Page 3, Paragraph 3: "The surveillance and utilization review subsystems (SURS) unit conducts preliminary investigations of suspected provider fraud. OHCA contracts with APS Healthcare Midwest, Inc. to perform post-payment utilization reviews…"

   To clarify: The SURS unit conducts preliminary investigations and post-payment utilization reviews. OHCA contracts with APS Healthcare Midwest, Inc. to perform post-payment reviews of inpatient services.

2. Page 3, Paragraph 3: "The SURS unit utilizes EDS Business Objects for data mining activities and EDS SURS Case Tracking System to track cases."

   To clarify: The SURS unit uses EDS SUR for exception processing. EDS Business Objects is used by SURS and Audit Management for data mining activities. The EDS SURS Case Tracking, a different application than EDS SUR, is used for case tracking.

3. Page 5, Paragraph 2: "The PIPD requires providers to re-enroll every three years."

   To clarify: The PIPD does not dictate provider enrollment rules / requirements. This function is the responsibility of Provider Contracts. A more accurate statement would be: OHCA requires providers to re-enroll every three years.

Thank you for the opportunity to respond to the report. We are in the process of collecting the required information and implementing procedures as stated. Please feel free to contact me at Carol.McFarland@okhca.org or at (405) 522-7448.

Sincerely,

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Performance and Internal Audit Manager

cc: Cindy Roberts, CPA, CGFM, Director of Program Integrity and Planning
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