

**Department of Health and Human Services  
Centers for Medicare & Medicaid Services**

**Medicaid Integrity Program  
Virginia Comprehensive Program Integrity Review  
Final Report  
November 2008**

**Reviewers:  
Eva Tetteyfo, Review Team Leader  
Todd Chandler  
Mark Rogers**

**Virginia Comprehensive PI Review Final Report**  
**November 2008**

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## INTRODUCTION

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CMS' Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Virginia Medicaid Program. The onsite portion of the review was conducted at the Virginia Department of Medical Assistance Services (DMAS) offices. The MIG review team also visited the State's Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Program Integrity Division (PID), which is responsible for Medicaid program integrity. This report describes six effective practices, four regulatory compliance issues, and two vulnerabilities in the State's program integrity operations.

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## THE REVIEW

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### *Objectives of the Review*

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

### *Overview of Virginia's Medicaid Program*

The DMAS administers the Virginia Medicaid program. As of June 2007, the program served approximately 694,910 recipients. Medicaid expenditures in Virginia for the State fiscal year (SFY) ending June 30, 2006 totaled \$4,772,677,271. The Federal medical assistance percentage for Virginia is 50 percent.

Approximately 45 percent of Virginia's Medicaid recipients received fee-for-service (FFS) Medicaid services. At the time of the review, DMAS had 53,038 enrolled FFS providers. DMAS processed approximately 1.7 million FFS claims per year in the last three SFYs. The remaining 55 percent of Medicaid recipients were enrolled in five Medicaid managed care plans. Those managed care enrollees accounted for just 22 percent of the Commonwealth's total Medicaid expenditures. The five managed care organizations (MCOs) contracted with 56,339 providers, some of whom are FFS-enrolled providers.

### *Program Integrity Division*

In Virginia, the organizational component dedicated to fraud and abuse activities is the PID. The PID has 47 full-time equivalent employees (FTEs) and consists of four units. Of these, the Provider Review Unit (PRU) works exclusively on provider fraud and abuse. The PRU has 14 FTEs, with one FTE dedicated solely to the Surveillance and Utilization Review Subsystem (SURS) function, which includes data mining. DMAS also contracts with two national auditing firms to assist with provider review activities: Clifton Gunderson, LLP for pharmacy and durable medical equipment (DME) onsite reviews and Myers & Stauffer LC for ancillary provider auditing services. DMAS also contracts with First Health Services Corporation (FHSC) to maintain the Medicaid Management Information System (MMIS) and perform provider

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enrollment and claims processing services. In addition, the Division has a contract with Logisticare for management of FFS transportation services and KePro Innovative Healthcare Management Solutions for prior authorization services.

The table below presents the total number of audits and amounts collected in the past three SFYs as a result of Virginia Medicaid's program integrity activities.

**Table 1**

SFY	Number of Audits	Recoveries
2005	30	\$219,097
2006	71	\$1,618,833
2007	84	\$3,046,842

Virginia's Program Integrity Director indicated that the significant upward trend in recoveries from SFY 2005 to SFY 2007 was the result of improved PID coordination and communication with other Medicaid agency components and enhanced auditing activities.

### ***Methodology of the Review***

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

During the week of July 31, 2007, the MIG review team visited the DMAS and MFCU offices. The team conducted interviews with numerous DMAS officials, the Deputy Director and a senior investigative supervisor with the MFCU, the Director and key staff from the provider enrollment broker, and representatives of the Medicaid transportation broker. To determine whether managed care plans were complying with the contract provisions and other Federal regulations relating to program integrity, the MIG team reviewed the contract provisions and gathered information from the MCOs through in-depth interviews with representatives from two MCOs.

### ***Scope and Limitations of the Review***

This review focused on the activities of the PID. Virginia operates a combination State Children's Health Insurance Program (SCHIP), which is part Medicaid expansion and part stand alone under Title XXI of the Social Security Act. The stand alone portion of the program was not included in this review. However, the Medicaid expansion portion of the SCHIP program operates under the same FFS billing and provider enrollment policies as Virginia's Title XIX program. The same findings, vulnerabilities, and noteworthy practices discussed in relation to the Medicaid program apply to this part of the SCHIP program as well. Unless otherwise noted, DMAS 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 DMAS provided.

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## RESULTS OF THE REVIEW

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### *Effective Practices*

The State has highlighted several practices that demonstrate its commitment to program integrity. These practices involve rigorous claims processing and prior authorization methods, enhanced auditing efforts, and early compliance with the National Provider Identifier (NPI) initiative.

#### *Virginia Medicaid Management Information System (VAMMIS)*

PID staff stated that VAMMIS, which was implemented in 2003, is one of the most advanced claims processing systems in the nation. Thousand of edits are built into the system to prevent inappropriate payment of claims.

#### *Prior Authorization (PA) program*

DMAS has implemented prior authorization for services that have a high potential for fraud and abuse. The PA program requires providers to meet strict clinical and administrative requirements before claims are authorized for payment.

#### *Enhanced auditing*

Besides utilizing State staff in the post-payment audit program, DMAS has contracted with independent audit contractors for pharmacy, DME and long term care audits as well as other services. These contracts have helped triple audit recovery totals over a two year period.

#### *Early compliance with National Provider Initiative (NPI)*

Interviews with DMAS and contractor provider enrollment staff revealed that DMAS complied with NPI requirements a full year prior to the required implementation date.

Additionally, the MIG review team identified two practices that are particularly noteworthy. CMS recognizes DMAS' strong organizational commitment to program integrity activities and the high level of cooperation between the PID and the MFCU as further evidence of the State's program strengths.

#### *Single State Agency commitment to PI activities*

In many respects, DMAS' commitment to program integrity is not limited to a single division but involves the entire agency. Virginia Medicaid program integrity efforts are supported by the Commonwealth's highest level of government. In the past two years, the Single State Agency has focused on program integrity as an agency-wide priority, reorganizing the PID and hiring a new management team that included the current division director and three new managers. In addition, the agency targeted DME, home health care and pharmacy services as priority areas. It increased staffing for the PID, while contracting with nationally recognized companies such as Affiliated Computer Services, Clifton Gunderson, and Health Management Systems to undertake specialized audits. Other activities initiated to strengthen the Commonwealth's PI efforts include:

enhancing tracking systems and processes; playing a larger role in Federal program integrity activities (such as participation in the Medicaid Fraud and Abuse Technical Advisory Group); and improving its relationship with its Medicaid Fraud Control Unit. Since the restructuring of the division, the PID works under an audit plan and has greatly increased the amount of money recovered in both recipient and provider reviews.

***Relationship with the MFCU***

The review team conducted separate interviews with PID staff and the MFCU Deputy Director and staff about the quality of interaction between DMAS and the MFCU. Both units agreed that they have an outstanding working relationship. Under the current Memorandum of Understanding between the two entities, the MFCU is obligated to investigate allegations of fraud referred by the Commonwealth and meet quarterly with the PID. The MFCU and DMAS have a liaison agreement whereby a MFCU Investigative Supervisor meets monthly with the head of the SURS Unit to discuss possible referrals. Informal meetings and conversations via telephone and email also occur regularly. In addition, the MFCU Director and the PID Director discuss issues by phone on a weekly basis.

During the regular quarterly meetings, the MFCU and DMAS staff discuss open investigations and reconcile their case logs. The MFCU also regularly sends DMAS a spreadsheet of all its open cases under investigation. If the MFCU declines a case, it informs DMAS in writing. With large cases, the MFCU and DMAS administration conduct joint press conferences. In addition, the MFCU sends copies of its quarterly reports showing convictions and sentencing to DMAS.

To further enhance the communication and working relationship, the two units engage in regular cross-training. During the monthly meetings between the MFCU Investigative Supervisor and DMAS' SURS Unit Manager, the MFCU provides tips on ways to uncover Medicaid fraud. Reciprocally, DMAS provides MMIS training to MFCU staff and has participated in the MFCU's yearly in-service training.

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***Regulatory Compliance Issues***

The review found the State out of compliance with Federal regulations related to required disclosures in the provider enrollment process and notification of actions taken on provider applications.

***DMAS does not meet Federal disclosure requirements concerning ownership and control of providers and subcontractors.***

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,

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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.

Virginia's provider enrollment forms do not capture all of the required ownership and control disclosure information. For example, the enrollment form for Home and Community Based Services providers requests the ownership of the disclosing entity, but the hospital form does not. The enrollment forms reviewed do not capture the relationship of persons with a greater than five percent interest in the provider or in relevant subcontractors; nor do they ask for the names of other disclosing entities in which persons with ownership and control interests also have an ownership and control interest.

**Recommendation:** Modify all enrollment packages and forms to require the full range of disclosures required under § 455.104.

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### ***Provider Enrollment agreements lack required disclosures of business transactions.***

The regulation at 42 CFR § 455.105(b) requires that, upon request, providers furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractors. Neither Virginia's FFS provider enrollment agreement nor its MCO credentialing application requires such disclosures.

**Recommendation:** Modify the FFS enrollment and MCO credentialing packages to request the information required to be disclosed under § 455.105.

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### ***DMAS does not meet Federal regulations requiring the disclosure of criminal conviction information.***

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 HHS-OIG within 20 working days whenever such disclosures are made. A review of the DMAS provider enrollment and credentialing applications showed that the physician, hospital, and MCO applications do not ask for the full range of required criminal conviction disclosures. In addition, DMAS does not report the required disclosure information to HHS-OIG within the 20-day timeframe.

**Recommendations:** Modify FFS enrollment and MCO credentialing packages to request criminal conviction information. Ensure timely referral of criminal conviction information to HHS-OIG.

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### ***DMAS does not notify HHS-OIG of actions taken on provider applications.***

The regulation at 42 CFR § 1002.3 requires reporting to HHS-OIG any actions a State takes on provider applications for participation in the program. Under that regulation, actions to deny or

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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. DMAS does not currently report to HHS-OIG actions it takes on provider applications, including actions which limit the ability of providers to participate in the program.

**Recommendation:** Promptly report to the HHS-OIG adverse actions taken against and limits placed on a provider's application for participation.

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### ***Vulnerabilities***

The review team identified two areas of vulnerability in Virginia's practices regarding disclosures and exclusion searches in the course of provider enrollment.

#### ***Not capturing information on agents or managing employees in the FFS provider enrollment and MCO provider credentialing processes***

Although DMAS requires providers to disclose the identities of managing employees who have been convicted of a health care-related offense, as is required under 42 CFR § 455.106, Virginia does not capture information on all managing employees in either the FFS or managed care enrollment processes. As a result, DMAS cannot ensure that providers or entities billing the Medicaid program do not employ individuals who may be excluded from the program.

**Recommendations:** Require submission of managing employee information in FFS enrollment and MCO credentialing forms. Capture managing employee information in the application database for comparison during the enrollment process and routinely thereafter.

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#### ***Not performing automated exclusion searches after initial enrollment***

DMAS contracts with FHSC to maintain the MMIS. FHSC's policy on processing provider enrollments includes an automated comparison of provider identifying data, such as the practitioner's last name or social security number, business name, or employee identification number, against the HHS-OIG List of Excluded Individuals and Entities. The Commonwealth established this policy after a 2000 CMS review. FHSC performs this comparison during a provider's initial enrollment and when a provider is recertified or reinstated. However, once a provider is enrolled, the Commonwealth does not perform subsequent automated exclusion searches. The Commonwealth is alerted to exclusions only when it receives an exclusion letter from HHS-OIG, creating the potential for error if FHSC does not receive or process the letter. DMAS manually compares the letter to the provider file in MMIS to determine if an excluded provider is enrolled in the Medicaid program.

**Recommendation:** Institute policies and procedures for conducting periodic automated exclusion searches on enrolled providers.

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## **CONCLUSION**

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The Commonwealth of Virginia applies several effective practices that demonstrate program strengths and the State's commitment to program integrity. These effective practices include:

- DMAS' commitment to program integrity
- the State's MMIS-VAMMIS
- enhanced auditing activity
- the prior authorization program
- NPI implementation
- the agency's cooperative working relationship with the MFCU

CMS supports the State's efforts and encourages the State 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, two areas of vulnerability were identified. CMS encourages DMAS to closely examine each area of vulnerability that was identified in the review.

To that end, we will require DMAS 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 Commonwealth 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 Commonwealth of Virginia will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps Virginia expects will occur. It should also explain why correcting any of the areas of non-compliance or vulnerability will take more than 90 calendar days from the date of the letter. If DMAS 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 Commonwealth of Virginia on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on program strengths.