Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Missouri Focused Program Integrity Review

Final Report

March 2020

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Executive Summary

The Centers for Medicare & Medicaid Services (CMS) is committed to performing program integrity reviews with states in order to identify risks and vulnerabilities to the Medicaid program and assist states with strengthening program integrity operations. The significance/value of performing onsite program integrity reviews include: (1) assess the effectiveness of the state's PI efforts, including compliance with certain Federal statutory and regulatory requirements, (2) identify risks and vulnerabilities to the Medicaid program and assist states to strengthen PI operations, (3) help inform CMS in developing future guidance to states and (4) help prepare states with the tools to improve PI operations and performance.

The CMS conducted a focused review of Missouri to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the Department of Social Services (DSS), MO HealthNet Division (MHD). The review also included a follow up on the state's progress in implementing corrective actions related to CMS' previous comprehensive program integrity review conducted in calendar year 2015.

During the week of August 22, 2019, the CMS review team visited the offices of Missouri's single state Medicaid agency, DSS-MHD. The team conducted interviews with numerous state officials involved in program integrity and managed care. The team also conducted interviews with MCO representatives from their special investigations units (SIUs) and/or compliance offices. In addition, the CMS review team conducted sampling of randomly selected program integrity cases and other primary data to validate the state and the selected MCOs' program integrity practices.

Summary of Recommendations

The CMS review team identified a total of six recommendations based upon the completed focused review modules and supporting documentation, as well as discussions and/or interviews with key stakeholders. The recommendations were in the following areas: MCO Investigations of Fraud, Waste and Abuse, Encounter Data, Terminated Providers and Adverse Action Reporting. The recommendations will be detailed further in the next section of the report.

Overview of Missouri Medicaid

- The DSS-MHD is the single state agency charged with overseeing the Medical Assistance Plans in Missouri.
- The Department of Social Services, Missouri Medicaid Audit and Compliance division (DSS- MMAC) is the organizational unit responsible for the overall program integrity operations.
- In FFY 2018, Missouri's total Medicaid program expenditures were approximately $10,979,093,900 billion. The Federal Medical Assistance Percentage matching rate was 64.61 percent.

Overview of Managed Care in Missouri

- In FFY 2018, the MHD made $2,501,007,949.11 in total payments to cover 8,761,346 member months of Managed Care enrollees. Total payments include Capitation, supplemental Delivery and Neonatal Intensive Care Unit payments.

- In FFY 2018, there were 72.95% of beneficiaries enrolled in the managed care program. These numbers are based on the enrollment mix at the end of the FFY and not an average for the year. During FFY 2017, the MHD moved to Statewide Managed Care causing the increase in percentages.
- During the onsite review all three of the MCOs were interviewed; Home State Health, Missouri Care and UnitedHealthcare. Table 1 and Table 2 below provide enrollment/SIU and expenditure data for each MCO.

Table 1.

	Home State Health	Missouri Care	UnitedHealthcare
Beneficiary enrollment total	216,925	226,205	168,226
Provider enrollment total	31,632	24,337	48,465
Year originally contracted	2012	2013	2017
Size and composition of SIU	23	52	70
National/local plan	Local	Local	Local

Table 2.

MCOs	FFY16	FFY17	FFY18
Home State Health	$358,403,599	$617,736,906	$947,400,072
Missouri Care	$331,110,096	$610,534,753	$936,358,326
UnitedHealthcare	Plan not active in 2016	$236,699,084	$456,318,986

*Expenditure data reported above were submitted by each of the MCOs.

Results of the Review

The CMS review team identified areas of concern with the state's managed care program integrity oversight, thereby creating risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible. These issues and CMS' recommendations for improvement are described in detail in this report.

State Oversight of Managed Care Program Integrity Activities

The Department of Social Services (DSS) administers the MO HealthNet Managed Care program through the MO HealthNet Division (MHD). The program is authorized through a 1915(b) waiver and contracts with three MCOs. The state's PI efforts are primarily the role of Missouri Medicaid Audit and Compliance (MMAC) while MO HealthNet is responsible for PI programmatic requirements.

The MHD executive leadership include a Director, a Chief Operating Officer and a Chief Financial Officer. The Director of Managed Care is primarily responsible for the program. While responsibility for facets of the Managed Care Program are shared by the entire division, contract oversight is managed by the Managed Care Policy, Contracts and Compliance Unit.

Missouri Medicaid Audit and Compliance (MMAC) is a separate division in the DSS and is responsible for program integrity, provider enrollment, auditing, and fraud, waste and abuse activities for both fee for service and managed care programs.

In Missouri MCEs are contractually required to have administrative and management arrangements or procedures, including a mandatory compliance plan, which is designed to guard against fraud, waste and abuse. The MCEs must also have written internal controls, designed to prevent, detect, reduce, investigate, and report known or suspected fraud, waste, and abuse activities in accordance with the requirements at 42 CFR 438.608. Compliance plans are required to be provided to DSS by the contract operational start date, and annually thereafter. The contract monitoring unit is responsible for obtaining and reviewing the compliance plans in accordance with the contract requirement.

The Missouri managed care contract requires the MCOs to comply with the regulation at 42 CFR 438.608. The compliance requirements of 42 CFR 438.608 require that MCOs have specific administrative and management procedures designed to guard against fraud and abuse. Missouri's MCOs are required to submit a compliance plan yearly. The MO HealthNet reviews the MCOs' annual compliance plans.

Provider Screening and Enrollment

Effective January 1, 2018 pursuant to 42 CFR 438.602**,** states must screen and enroll, and periodically revalidate, all network providers of managed care organizations (MCOs). Missouri reports being compliant with enrolling all MCO "In-Network" providers. All three of the MCOs contracted with Missouri Medicaid (MO HealthNet) have chosen to require enrollment with the SMA prior to approval of their MCO enrollment, and only use the 120-day window in unusual circumstances. Twice monthly, the state sends the three contracted MCOs a list of active providers, and newly inactive providers, in order for the MCOs to compare the information to ensure that only active providers are participating in the MCO provider network.

MCO Investigations of Fraud, Waste, and Abuse

As required by 42 CFR 455.13, 455.14, 455.15, 455.16, and 455.17, the state does have an established process for the identification, investigation, referral and reporting of suspected fraud, waste, and abuse (FWA)by providers and MCOs.

The managed care contracts require that program integrity activities "include policies, procedures, and standards of conduct for the prevention, detection, reporting, and corrective action for suspected cases of fraud, waste and abuse in the administration and delivery of services under this contract."

The Missouri managed care contract includes program integrity guidelines for the MCOs. The guidelines provide direction on implementing internal controls, and policies and procedures designed for identifying, reporting, investigating, and referring suspected fraud, waste, and abuse. The contractual requirements provide direction to the MCOs for practices which ultimately lead to the prosecution of fraud, waste, and abuse activities by providers. The MCOs are required to report to the state Medicaid agency, within one business day of receiving such information, any information concerning member fraud, waste, and abuse. The MCOs are also required to report any suspected case(s) of provider fraud, waste, and abuse to the SMA within one business day initiating an investigation, and report all instances of suspected provider fraud, abuse, or waste on

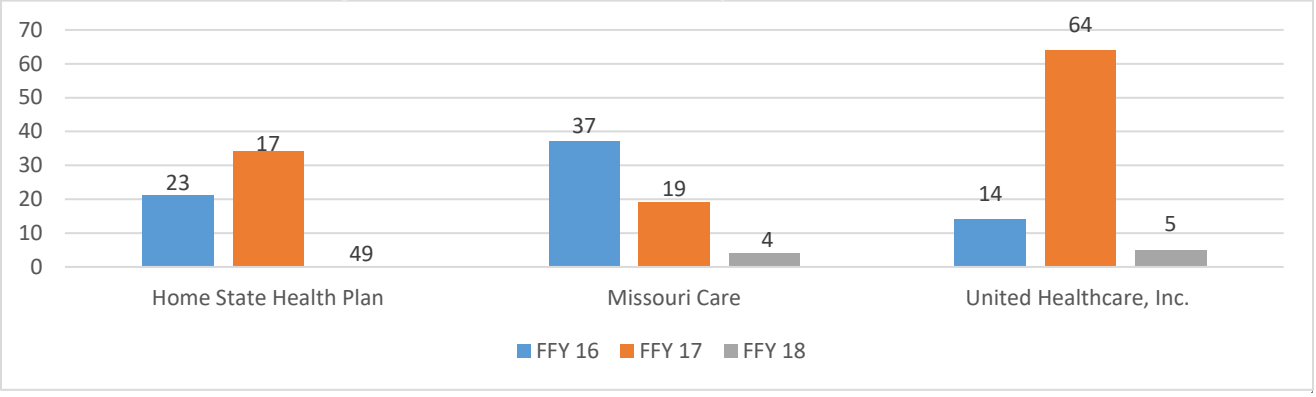
a quarterly basis.

The MO HealthNet Managed Care unit and key MMAC staff typically meet quarterly with the MCOs to discuss program integrity issues pertaining to FWA matters and relevant contractual concerns. The Managed Care Unit usually has about five staff including managers and program specialists.

The MMAC is usually represented by the Director, MCO Liaison, Provider Review Manager, Investigations/Suspensions/Terminations Manager, Provider Enrollment Manager and some Medicaid Unit Supervisors.

All three of the MO HealthNet MCOs have an SIU that is responsible for investigating fraud, waste, and abuse. Table 3 below indicates the number of referrals that Home State Health Plan SIU, Missouri Care SIU and United Healthcare, Inc. SIU reported submitting to the state in the last three FFYs. Overall, the number of Medicaid provider investigations and referrals by the MCEs for 2 of the 3 plans appeared low, compared to the size of the plans.

Table 3.



The CMS review team has concerns related to both the limited number of MCO provider investigations and referrals; and the quality of the cases the MCOs are submitting to the state. The MMAC told the CMS Review Team that they do not consider the cases referred by the three contracted Managed Care plans to be of an adequate quality. They also indicated that the majority of the cases that the MCOs are referring to the state are solely on up-coding and transportation issues. The MCOs need to be proactive in identifying fraud or abuse being committed by MCO enrolled network providers.

The state should incorporate a specific referral policy and procedure that provides a description of the MCO's internal procedures for the SIU to identify and report suspected FWA by providers to MHD. The MHD should consider developing a customized Missouri fraud referral form for reporting purposes. The referrals should include an investigative report identifying the following: (1) allegation; (2) the relevant statutes and regulations violated or considered; (3) the results of investigation; (4) the covered conduct, i.e., time period at issue; (5) the estimated identified overpayment; a summary of the interviews conducted; (6) the encounter data submitted by the provider during the time period at issue; and (7) all supporting documentation obtained associated with the investigation.

Recommendation 1 - The state should ensure the managed care contractual language provides

clear and concise guidance related to roles and responsibilities and the contract should specify that the MCOs need to refer cases of fraud, waste and abuse.

Recommendation 2 - Given the limited number of provider investigations and referrals by two out of the three MCOs and the quality of the referrals the state should ensure that its MCOs are allocating sufficient resources to the prevention, detection, investigation and referral of suspected provider fraud. The state should ensure that MCOs have adequate training opportunities related to fraud prevention, detection, investigation and referral of suspected provider fraud at least annually.

The MMAC, Medicaid Fraud Control Unit (MFCU) and the MCOs would benefit from meeting more frequently to discuss the status of investigations, referrals and reporting of suspected FWA by providers. Some of the meetings could be designated as training sessions between the MMAC, and the MCOs on various Medicaid program integrity topics. The opportunity for education related to Medicaid program integrity referral, overpayment and termination policy and procedures is a proactive and critical action that may yield a positive benefit to increasing the response from MCOs.

Recommendation 3 - The state, in conjunction with the MFCU when possible, should work with the MCOs to develop and provide program integrity training on a routine basis to enhance case referrals from the MCOs. The state should ensure that MCO staff, primarily the SIU and/or compliance officer, is receiving adequate training in identifying, investigating, referring, and reporting potential fraudulent billing practices by providers.

The tables below list the number of preliminary and full investigations along with the total amount of overpayments identified and recovered by each of the three MCOs interviewed.

Table 4-A.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2016	349	158	$591,374.04	$2,587.66
2017	942	151	$125,458.00	$11,874.28
2018	101	67	$8,138.99	$25,345.83

Table 4-B.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2016	41	56	$8,085.50	$6,453.50
2017	56	40	$389,051.37	$166,561.58
2018	196	69	$147,386.64	$65,140.15

Table 4-C.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2016*	0	0	$0	$0
2017	90	22	$1,780.42	$0
2018	758	52	$263,444.00	$3,258.00

*United Healthcare was not active in FFY 2016

Overall, the amount of overpayments identified and recovered by the MCOs appears to be low. Further, although MCOs may not be required to return overpayments from their network providers to the state, it is important that the state obtain a clear accounting of any recoupments, in order for these dollars to be accounted for in the annual rate setting process. Without these adjustments, MCOs could be receiving inflated rates per member per month.

Recommendation 4 -The state should ensure that its MCOs are being proactive in identifying and collecting overpayments. The state should ensure that the MCOs have overpayment /collection policies and procedures.

Encounter Data

The state's Medicaid Management Information System (MMIS) receives encounter claims data from all three contracted MCOs. This is a standard reporting requirement. The MFCU conducts data mining of claims using the state MMIS data for FFS claims and the enhanced MCO encounter claims data. The low volume of MCO provider case referrals generated from the encounter data was of particular concern to the review team.

Recommendation 5 - The state should conduct analytics of validated encounter data in order to identify potential leads for fraud, waste and abuse.

Payment Suspensions

In Missouri, Medicaid MCOs are contractually required to suspend payments to providers at the state's request. If there is a credible allegation of fraud, MMAC would investigate and send a referral to the MFCU. MMAC would suspend payments per 42 CFR § 455.23. The reporting time frame is outlined in Section 2.32.5.d of the contract and states, "The health plan shall review all referrals sent to it by the state agency or by the MFCU. The health plan shall report back to the state agency within a timely manner, not to exceed ninety (90) calendar days, regarding the status. The health plan shall report what review was done, what the findings were, and what action(s), if any, were taken. If after ninety (90) calendar days the health plan's investigation is not complete, the health plan shall provide that information as a status report and shall continue to advise the state agency every ninety (90) calendar days of its progress until the investigation is complete or closed."

The regulation at 42 CFR 455.23(a) requires that when the State Medicaid Agency determines that there is a credible allegation of fraud, it must suspend all Medicaid payments to a provider, unless the agency has good cause not to suspend payments or to suspend payment only in part.

There were a total of sixteen (16) provider payment suspensions initiated by MMAC and communicated to all three contracted Managed Care plans during the past federal fiscal year.

While CMS encourages states to communicate frequently with the MFCU and does not limit who a state may consult with in order to determine that an allegation of fraud is credible, the regulation at 42 CFR 455.23(a) requires that upon the State Medicaid Agency determining that an allegation of fraud is credible, the state must suspend all Medicaid payments to a provider, unless the agency has good cause to not suspend payments or to suspend payment only in part. The use of alternative sanctions, such as prepayment review, may be part of a good cause exception, but should be documented as such in the case files. The CMS review team determined that the state is suspending payments to a provider if there is a creditable allegation of fraud.

Terminated Providers and Adverse Action Reporting

The MCO contract does address terminated providers and adverse action reporting and requires the reporting of terminated providers directly to the state when the termination is for program integrity reasons. The team found that all "reported" for-cause program integrity terminations by the MCOs to the state are being reported in turn to the HHS-OIG. The state also uploads the for-cause terminations to the DEX (formerly Tibco) managed file transfer server.

Table 5:

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		Total # of Providers Terminated For Cause in Last 3 Completed FFYs	
Home State Health Plan	2016 2017 2018	3,382 3,436 7,624	2016 2017 2018	241 244 2,486
Missouri Care	2016 2017 2018	396 1,189 1,874	2016 2017 2018	27 20 20
United Health Care	2016 2017 2018	0 2,565 6,558	2016 2017 2018	0 57 212

Overall, the number of providers terminated for-cause by the plans appear low, with the exception of Home State Health Plan compared to the number of providers enrolled with the MCOs and compared to the number of providers disenrolled or terminated for cause.

In addition, the MCOs do not seem to have a clear understanding of what constitutes a for-cause action versus a non for-cause action. The majority of these cases do not involve program integrity, quality or fraud. Accordingly, the CMS review team determined that additional education is warranted in order to ensure provider adverse actions is handled appropriately.

Recommendation 6 - The state should develop a comprehensive termination policy and monitor MCO program integrity related adverse actions in order to consistently account for all MCO program integrity related terminations due to fraud, integrity or quality.

Status of Corrective Action Plan from Year Review

Missouri's last CMS program integrity review was in May 2015, and the report for that review was issued in May 2016. The report contained two risk areas with five recommendations. During the onsite review in August 2019, the CMS review team conducted a thorough review of the corrective actions taken by Missouri to address all issues reported in calendar year 2015. The risk areas from the 2016 Missouri comprehensive review report have all been satisfied by the state.

1. A risk was identified in the state not having a process to ensure the collection of ownership and disclosure information at the time of contracting.
   Status of the time of the review: Corrected.

2. A risk was identified in the state not having a clear process and contract requirements for MCOs to follow regarding payment suspensions in cases where there are credible allegations of fraud according to 42 CFR 455.23.
   Status of the time of the review: Corrected.

3. A risk was identified in the state needing to improve communications at both the state and MCO levels through routinely scheduled meetings.
   Status of the time of the review: Corrected.

4. A risk was identified in the state not providing compliance departments and SIU staff appropriate training in identifying and investigating potential fraudulent billing practices by providers.
   Status of the time of the review: Corrected

5. A risk was identified in the limited audit work in at least two MCOs, along with the low number of overpayments and terminations that the MCOs reported, the state should ensure that any managed care entity with which it contracts has an established and functioning program integrity infrastructure that includes adequate systems and staff to prevent, detect, and investigate provider fraud.
   Status of the time of the review: Corrected

Technical Assistance Resources

To assist the State of Missouri in strengthening its program integrity operations, CMS offers the following technical assistance resources for Missouri to consider utilizing:

- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to Georgia are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the Regional Information Sharing Systems (RISS) as tool to identify effective program integrity practices.
- Access the Medicaid Provider Enrollment Compendium (MPEC) for information related to Medicaid Provider Enrollment requirements https://www.medicaid.gov/medicaid/program-integrity/affordable-care-act-program-integrity-provisions/index.html.
- Access the Toolkits to Address Frequent Findings: Payment Suspension Toolkit website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf.
- Access the Toolkit to Address: State Toolkit for Validating Medicaid Managed Care Encounter Data at https://www.medicaid.gov/medicaid/downloads/ed-validation-toolkit.pdf.

Conclusion

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a corrective action plan (CAP) for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correcting the issue.

We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

CMS looks forward to working with Missouri to build an effective and strengthened program integrity function.