Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Pennsylvania Focused Program Integrity Review

Final Report

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

The CMS conducted a focused review of Pennsylvania 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 entities (MCEs) under contract with the state Medicaid agency. HealthChoices Physical Health is the Commonwealth's Medical Assistance mandatory managed care model that provides all physical health Medicaid services to eligible beneficiaries in five distinct zones across Pennsylvania. HealthChoices Physical Health uses at-risk, capitated Managed Care Organizations (MCOs) to provide all services except long-term supports/services and behavioral health.

During the week of September 9, 2019, the CMS review team visited the Department of Human Services (DHS), Pennsylvania's single state Medicaid agency. The CMS team conducted interviews with DHS officials, as well as with staff from DHS's contracted MCOs. In addition, the CMS review team conducted sampling of program integrity cases investigated by the MCE special investigations units (SIUs), as well as other primary data in order to validate the state and the selected MCEs' program integrity practices. The onsite review also included a follow up on the state's progress in implementing corrective actions related to CMS's previous comprehensive program integrity review conducted in calendar year 2015.

Summary of Recommendations

The CMS review team identified a total of eight 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: State Oversight of Managed Care Program Integrity Activities, MCO Investigations of Fraud, Waste, and Abuse, Encounter Data, Payment Suspensions, and Terminated Providers and Adverse Action Reporting. The recommendations will be detailed further in the next section of the report.

Overview of Pennsylvania Medicaid

- The DHS is the single state agency charged with administering, and overseeing the Medicaid program in Pennsylvania.
- HealthChoices Physical Health is the Medicaid and Children's Health Insurance Program in Pennsylvania.
- The Office of Medical Assistance Programs, Bureau of Managed Care Operations (BMCO) is the organizational unit responsible for programmatic oversight of the HealthChoices Medicaid program.

- The Bureau of Program Integrity (BPI) is the office for the state's program integrity activities for fee-for-service program and the Managed Care program integrity operations all operating under the same administration.
- In 2018, Pennsylvania's Medicaid expenditures exceeded $28.7 billion. The Federal Medical Assistance Percentage matching rate was 52 percent.

Overview of Managed Care in Pennsylvania

- Pennsylvania has approximately 2.8 million Medicaid beneficiaries. Approximately 79 percent of the Medicaid population were enrolled in Physical Health Plans during FFY 2018. Medicaid Managed care accounts for the majority of the Medicaid expenditures in Pennsylvania.
- During the onsite review three MCEs were interviewed; Geisinger Health Plan (Geisinger), University of Pittsburgh Medical Center (UPMC), and Health Partners Plan (HPP). Table 1 and Table 2 below provide enrollment/SIU and expenditure data for each MCE.

Table 1.

	Geisinger	**UPMC**	**HPP**
Beneficiary enrollment total	179,405	422,381	234,654
Provider enrollment total	10,480	34,611	8,405
Year originally contracted	2013	1996	2009
Size and composition of SIU	10 FTEs	7 FTEs	9 FTEs
National/local plan	Local	Local	Local

Table 2.

MCEs	**FFY 2016**	**FFY 2017**	**FFY 2018**
Geisinger	$745 Million	$875 Million	$958 Million
UPMC	$1.6 Billion	$1.8 Billion	$1.9 Billion
HPP	$1.35 Million	$1.46 Million	$1.48 Million

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 BMCO is responsible for administrative and programmatic oversight of HealthChoices Physical Health plans. Programmatic oversight of the PH-MCOs falls under the ultimate responsibility of the BMCO contract managers and contract management teams. The BMCO contract manager has ultimate compliance responsibility; however, program specific element reviews and oversight are performed by

members of the contract management teams. All contract management teams have a member from BPI, and they coordinate with contract managers on compliance determination and enforcements.

The BPI has a permanent place on all contract management teams. Each contract management team meets monthly, and team members present any issues or concerns for compliance determination or technical assistance. Each month, BPI Executives meet with the BMCO monitoring and compliance division executives to discuss PI and other related issues that pertain to the managed care programs to address potential PI issues within managed care.

The DHS contractually requires plans to have administrative and management arrangements or procedures, including a mandatory compliance plan, which is designed to guard against fraud, waste and abuse. The PH-MCOs 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 DHS 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.

When asked how often compliance plans are submitted to DHS, each plan provided different responses that were inconsistent with the aforementioned contract requirement. It was noted during the review that the compliance plan for one PH-MCO was submitted to the state 2-3 years ago. Another PH-MCO indicated that they submit their compliance plan annually, and the remaining PH-MCO advised CMS that they submit the compliance plan when requested by DHS, or if there was a material change to the compliance plan. The DHS was unable to provide a defined internal process for annually reviewing the PH-MCO compliance plans. The next review of the compliance plans is scheduled for 2020.

Recommendation #1: The DHS should develop an effective monitoring tool to annually obtain and review the PH-MCOs compliance plans annually, as required by the HealthChoices Physical Health contract.

The state confirmed that it does not have formal operational guidelines, policies and procedures, or interagency agreements which govern the interaction between the state's program integrity efforts and programmatic oversight for each managed care plan. Further, DHS staff advised CMS that the multiple divisions responsible for programmatic and program integrity oversight are "siloed." However, DHS utilizes an excel spreadsheet of SMART standards that identify which divisions are responsible for certain oversight provisions listed in the HealthChoices contract. CMS recognizes that DHS utilizes processes that they may consider effective, but those processes are not memorialized in policy or procedure. The DHS could benefit from enhancing the SMART standards into a more formal, documented process that helps ensure the appropriate DHS teams are collaborating efficiently.

Recommendation #2: The DHS should consider documenting its existing processes in an intra-agency agreement that clearly describes the administrative roles, responsibilities, and notification processes for each division or unit related to DHS oversight of program integrity activities.

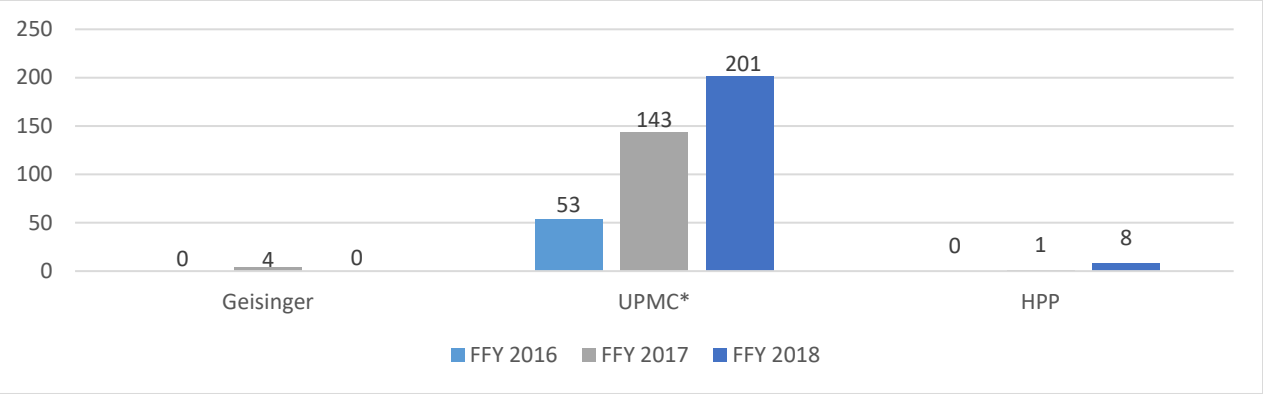
MCE Investigations of Fraud, Waste, and Abuse

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 by providers and MCEs.

Pennsylvania's MCE contract requires that the PH-MCOs program integrity program 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. In addition, the HealthChoices contract requires MCEs to have a ratio of one dedicated full time, HealthChoices Medicaid investigator, devoted to fraud, waste, and abuse activities per 60,000 beneficiaries. Pursuant to 42 CFR 455.14, if the agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a "preliminary" investigation to determine whether there is sufficient basis to warrant a full investigation. The MCEs make referrals directly to BPI, and the Pennsylvania Attorney General Medicaid Fraud Control Section (MFCS). The DHS has defined policies and procedures for handling case referrals from PH-MCOs. All referrals are tracked in two databases; the BPI case tracking database and MFCS case tracking database. The BPI case tracking database is utilized to track BPI cases through all the review activities, and the MFCS database is used to track only MFCS cases accepted for further investigation. When a case is referred to MFCS, it is entered in the MFCS database to document payment suspensions, law enforcement exceptions, and criminal sanctions. Weekly reports are pulled from the MFCS database to identify any quarterly recertifications necessary for ongoing payment suspensions and law enforcement exceptions. The BPI maintains a record of recertifications in the case tracking database.

Table 3 lists the number of referrals that Geisinger's SIU, UPMC's SIU, and HPP's SIU made to the state in the last three FFYs. Overall, the number of Medicaid provider investigations and referrals by the MCEs are low, compared to the size of the plans. The level of investigative activity by the MCEs has not changed over time.

Table 3.



*UPMC referrals include instances when pre-payment holds were placed when aberrant billing patterns were detected, which may not rise to the level of a suspected fraud referral.

As illustrated above, the PH-MCOs collectively referred a limited amount of credible allegations of fraud during the review period. The low amount of referrals was of particular concern to the review team. The UPMC had the most referrals by a wide margin; however, UPMC referrals include notifications to the state when pre-payment holds were imposed on providers to verify services.

Geisinger had the lowest amount of referrals to the state, and HPP has made improvements to increase program integrity activities to achieve greater results.

Encounter Data

Encounters are submitted directly from plans in accordance with the HealthChoices Physical Health contract, once per month. The DHS has certain rules and the expectations for the plans to submit specific, identified data fields each month. The HealthChoices Physical Health plans are responsible for validating each data field. Reported overpayments are identified and accounted for in the rate development process, but does not factor into rate setting since the plans are allowed to keep all overpayments recouped. The DHS requires the plans to adjust encounters when overpayments are offset, or adjusted. The DHS does not have a process to verify whether the plans adjusted encounters accordingly to reflect accurate encounters. The DHS has not initiated an audit of the encounter data submitted by the HealthChoices Physical Health plans to ensure accuracy, and DHS does not have a corresponding audit policy to ensure accuracy of encounters.

The PH-MCOs are required to provide quarterly statistical reports on recoveries and overpayments to the contract monitoring unit. The MCOs do not provide a comprehensive, annual report of the quarterly statistical recoveries and overpayments. CMS acknowledges DHS may consider quarterly reports to be sufficient; however, the new CMS managed care rule also requires the PH-MCOs to report overpayments, annually.

Recommendation #3: The DHS should create processes and policies to arrange for independent audits of the accuracy, truthfulness, and completeness of encounter data submitted by the MCEs in accordance with 42 CFR 438.602(e).

Recommendation #4: Pursuant to 42 CFR 438.608(d)(3) and (d)(4), DHS should amend the HealthChoices contract to require managed care plans annually report overpayment recoveries to DHS.

Payment Suspensions

In Pennsylvania, Medicaid MCEs are contractually required to suspend payments to providers at the state's request. The state confirmed that there is contract language mirroring the payment suspension regulation at 42 CFR 455.23.

The regulation at 42 CFR 455.23(a) requires that when the State Medicaid agency determines that there is 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. The HealthChoices Physical Health contract requires the plans to suspend provider payments when directed by DHS. The three plans that participated in the onsite review had processes and procedures to suspend payments at the direction of DHS.

In the last three FFYs, DHS imposed 14 PH-MCO provider suspensions in the last three FFYs. A good cause exception was imposed on 75 suspected fraud referrals, which is a high amount and atypical when considering the low amount of suspensions that were imposed. All three PH-MCOs interviewed advised CMS that they had not receive a request to suspend provider payments within the last three FFYs. As a general practice, MFCS regularly requests that DHS not impose a payment suspension in order to not compromise the criminal investigation

Recommendation #5: The DHS should give further consideration to current processes and criteria related to 42 CFR 455.23, especially imposing provider payment suspensions.

Terminated Providers and Adverse Action Reporting

The PH-MCOs are required to notify DHS of any changes to its provider network (closed panels, relocations, death of a provider, etc.) through the quarterly additions/deletions provider network reporting. The HealthChoices contract does not contain prompt reporting requirements consistent with 42 CFR 438.608(a)(4).

Table 4:

MCEs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs	Total # of Providers Terminated For Cause in Last 3 Completed FFYs
Geisinger	2016-578 2017-637 2018-518	2016-0 2017-0 2018-0
UPMC	2016-1,002 2017-1,281 2018-1,434	2016-74 2017-8 2018-9
HPP	2016-724 2017-837 2018-766	2016-43 2017-23 2018-52

Overall, the number of providers terminated for-cause by the plans appear to be low, compared to the number of providers enrolled with the MCEs and compared to the number of providers disenrolled or terminated for any reason. One MCE reported zero for cause terminations within the last three FFYs.

The DHS has not adopted clear contract language, policies, and procedures for identifying and reporting adverse provider terminations. The Medicaid Provider Enrollment Compendium (MPEC)[1] states for-cause adverse terminations may include, but is not limited to, termination for reasons based upon fraud, integrity, or quality. The MPEC provides guidance on identifying and mandatory reporting of for cause terminations.

The DHS advised the onsite team that provider terminations based on violations of fraud, integrity, and quality are considered for-cause terminations. CMS acknowledges that this may be an expectation of the PH-MCOs, but the HealthChoices Physical Health contract does not support this assertion, and does not specify that terminations due to fraud, integrity, or quality are considered for-cause.

The PH-MCOs do not appear to have a clear understanding of what constitutes a for-cause action and how it should be effectively reported. Each MCE interviewed provided varying responses about how they describe for-cause provider terminations, and how those provider terminations are reported to DHS. At least two PH-MCOs had reported provider terminations due to “miscellaneous” or “performance”

[1] https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf

that would meet the requirements of a for-cause termination. When reported to DHS, the provider terminations did not clearly identify that the providers were terminated for fraud, integrity, or quality. It is necessary for the PH-MCOs to clearly identify and report for-cause terminations so that DHS can take the appropriate actions to safeguard the Medicaid program.

Recommendation #6: The DHS should consider the following: **1**) Adopt for-cause provider termination criteria consistent with guidance listed in the MPEC, and amend the HealthChoices Physical Health Contract to include such provisions; **2**) Implement policies and/or contract language to address clear reporting of for-cause terminations; and **3**) Require prompt reporting requirements regarding for-cause terminations that should be adopted by all HealthChoices Physical Health plans. Accordingly, additional education is warranted in order to ensure provider for-cause terminations are identified, reported, and handled appropriately.

The DHS does screen and enroll PH-MCOs only providers in accordance with 42 CFR 455.436. All PH-MCO providers are required to obtain a DHS Promise ID, a DHS Medicaid provider number, as a requirement to enroll with a PH-MCO. The DHS also requires PH-MCOs to screen providers in accordance with 42 CFR 455.436. The DHS has identified high risk providers, but have not identified moderate risk providers in accordance with 42 CFR 455.450. High risk and moderate risk providers are subject to enhanced screening that may include onsite visits, FBI background checks, and FBI fingerprinting. Each PH-MCO advised the onsite team that they do not have separate credentialing requirements for high risk, or even moderate risk provider types. Each provider type is credentialed and enrolled utilizing the same standards, which do not include onsite visits, FBI background checks, or fingerprinting. The DHS does utilize a vendor to conduct site visits, FBI background checks, and fingerprinting for high risk providers in order to obtain a Promise ID.

Recommendation #7: The DHS should formally identify moderate risk providers, and adopt enhanced credentialing requirements listed in 42 CFR 455.450. Further, DHS should develop strategies to ensure PH-MCOs providers are appropriately screened in accordance with 42 CFR 455.436.

Pursuant to 42 CFR 438.608(c), the HealthChoices Physical Health contract requires the PH-MCOs and subcontractors must comply with all applicable certification, program integrity and prohibited affiliation requirements, including written disclosure of ownership, control, and prohibited affiliations. The

Recommendation #8: The DHS should develop a policy and procedure to ensure compliance with

Status of Corrective Action Plan from Year 2015 Review

Pennsylvania's last CMS program integrity review was in July 2015, and the report for that review was issued in March 2016. The report contained one regulatory compliance risk, and six programmatic vulnerabilities. CMS completed a desk review of the corrective action plan in June 2018. The desk review indicated that the findings from the 2015 review have all been satisfied by the state.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Pennsylvania 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 Pennsylvania 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/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf.
- Access the Toolkits to Address Frequent Findings: Payment Suspension Toolkit website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.html.
- Access the Toolkit to Address: State Toolkit for Validating Medicaid Managed Care Encounter Data at https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/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 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 Pennsylvania to build an effective and strengthened program integrity function.