

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

**Medicaid Integrity Program  
Vermont Comprehensive Program Integrity Review  
Final Report  
September 2011**

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**September 2011**

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## **INTRODUCTION**

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The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Vermont Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Department of Vermont Health Access (DVHA) and the Medicaid fiscal agent. The review team also met with the State's Medicaid Fraud Control Unit (MFCU), which in Vermont is called the Medicaid Fraud and Residential Abuse Unit (MFRAU).

This review focused on the activities of the Program Integrity Unit (PI Unit) within the DVHA which is responsible for Medicaid program integrity in Vermont. This report describes two effective practices, three regulatory compliance issues, and three 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 Vermont improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

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

The DVHA is located within the Vermont State Agency of Human Services which administers the Vermont Medicaid program. Vermont describes itself as a unique, publicly run, statewide managed care organization, the first of its kind in the country. The program operates under Section 1115 waiver authority, but functions in practice as a statewide primary care case management program. Most Medicaid beneficiaries are assigned to primary care physicians who serve as gatekeepers for specialty services, receive case management fees for their efforts, and submit billings to the Medicaid agency on a fee-for-service basis. All providers must be enrolled as authorized Medicaid providers.

As of January 1, 2011, the program served a total of 169,720 beneficiaries, all of whom were enrolled in programs administered by DVHA, and had 17,860 active Medicaid providers. Per CMS data, total computable Medicaid expenditures during the State fiscal year (SFY) ending on June 30, 2010 were \$1,262,114,825. The Federal medical assistance percentage (FMAP) for Vermont for Federal fiscal year (FFY) 2010 was 58.73 percent. However, with adjustments attributable to the American Recovery and Reinvestment Act of 2009, Vermont's effective FMAP was 69.96 percent during FFY 2010.

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### ***Program Integrity Section***

The PI Unit within DVHA is the organizational component dedicated to anti-fraud and abuse activities. At the time of the review the PI Unit had 10 full-time equivalent staff focusing on Medicaid program integrity. The table below represents the total number of investigations and overpayments identified and collected in the past four SFYs as a result of program integrity activities overseen by DVHA.

**Table 1**

<b>SFY</b>	<b>Number of Preliminary Investigations*</b>	<b>Number of Full Investigations**</b>	<b>Amount of Overpayments Identified</b>	<b>Amount of Overpayments Collected</b>
2007	45	3	\$328,041.00	\$328,041.99
2008	75	4	\$ 1,928,749.96	\$ 1,885,100.96
2009	160	7	\$ 2,843,875.74	\$ 2,740,404.78
2010	223	7	\$ 1,384,865.42	\$ 1,268,148.40

\*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 through a referral to the MFCU or administrative or legal disposition. The figures represent all program integrity cases.

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

In advance of the onsite visit, the review team requested that Vermont complete a comprehensive review guide and supply documentation to support its answers. The review guide included such areas as program integrity, provider enrollment/disclosures, and the MFRAU. A four-person team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of March 7, 2011, the MIG review team visited the DVHA, fiscal agent, and MFRAU offices. The team conducted interviews with numerous DVHA officials, the State's provider enrollment contractor, and the MFRAU director. Finally, to determine whether non-emergency medical transportation (NEMT) providers were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team interviewed NEMT staff. In addition, the team conducted sampling of provider enrollment applications, 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 DVHA 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 and NEMT.

Vermont operates a stand-alone Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. Although CHIP operates in close concert with the Medicaid program, using the same eligibility, billings, and benefit counseling systems, as a Title XXI program, it was not covered in this review. Unless otherwise noted, Vermont provided the program

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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 DVHA provided.

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## **RESULTS OF THE REVIEW**

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### ***Effective Practices***

As part of its comprehensive review process, CMS 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. Vermont's practices include a provider self-audit program and a provider enrollment process involving thorough license checks and periodic provider recertification.

#### ***Provider self-audit program***

Vermont has a self-audit program which enables the State to capture more improper payments than program integrity staff could do alone through State-initiated audits and investigations. The Medicaid agency may require providers to conduct self-audits following preliminary investigations of suspected overpayments. A team of auditors and appropriate subject matter experts review all questionable claims to verify the likelihood of a suspected overpayment. Once this analysis is completed, the PI Unit invokes its self-audit protocol to address the disputed claims.

Recently, the PI Unit identified 156 pharmacies that were not in compliance with billing requirements for "other coverage code 3," a designation indicating that the drug billed is a Medicare-excluded drug. The unit mailed letters to all 156 pharmacies. All were informed as to which claims were being questioned and the pharmacies were required to conduct a self-audit to explain the circumstances. The pharmacies agreeing with the overpayment findings were instructed to adjust the claim or refund the money to the State agency. At the time of the review, 80 percent of the pharmacies had responded and the State had recovered approximately \$156,000.

#### ***License checks and periodic recertification of all Medicaid provider licenses***

Vermont verifies all provider licenses at the time of enrollment, including out-of-state providers. The DVHA uses State websites to verify the validity and status of all out-of-State licenses. The State review process involves the use of a publicly accessible database to verify license status and takes into account restrictions, violations, and sanctions listed on the license. Following initial enrollment, providers are certified for continuing participation in Medicaid either annually or when their license is renewed. The recertification procedures apply to all providers, including unlicensed ones for whom the recertification time is automatically set at one year.

The process helps to ensure that the Medicaid numbers of inactive providers are not misused. It also enables the State to identify providers with licensure issues on a timely basis. Where licensed providers are involved, Vermont's recertification procedures

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involve a check for possible new restrictions or limitations that may have been imposed on the license. Providers are no longer required to resubmit complete disclosures during the recertification process, as they were at the time of MIG's 2008 review. This was done to streamline the re-enrollment process for Vermont providers. In addition, the MIG review team identified an inconsistency in processing provider applications as discussed in the Vulnerabilities section of this report.

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### ***Regulatory Compliance Issues***

Vermont is not in compliance with Federal regulations related to ownership and control disclosures, as well as the disclosure of specified business transactions and health care-related criminal convictions.

#### ***The State does not capture information on ownership and control interests in subcontractors and from its fiscal agent. (Uncorrected Partial Repeat Finding)***

Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, 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 5 percent or more. A disclosing entity that is not subject to periodic survey under 42 CFR§ 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 5 percent or more. Additionally, under 42 CFR§ 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 42 CFR§ 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. In addition, under 42 CFR§ 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

Vermont was found to be non-compliant with the ownership and control disclosure requirements at 42 CFR§ 455.104 during the 2008 CMS program integrity review. Following the review, the State agency revised its provider applications to address these issues and make the applications less confusing. However, the applications still do not request the name and address of subcontractors in which the disclosing entity has a direct or indirect ownership of 5 percent or more. The DVHA also could not document that it collected the required ownership and control disclosures from its fiscal agent in accordance with 42 CFR §455.104(c).

NOTE: The MIG team reviewed the provider enrollment forms and contracts for compliance with 42 CFR § 455.104 as it was effective at the time of our review. That section of the program integrity regulations has been substantially revised and the amendment was effective on March 25, 2011. The amendment adds requirements for provision of Social Security Numbers and dates of birth as well as more complete address information regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any

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actions the State takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

**Recommendation:** Modify provider enrollment forms and the fiscal agent contract to require and collect the full ownership and control disclosure information specified in the regulation at 42 CFR § 455.104.

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***The State does not require all providers to submit business transaction information upon request. (Uncorrected Partial Repeat Finding)***

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

During the last program integrity review in 2008, the DVHA did not meet the business transaction disclosure requirements in the regulation. The State agency has made an effort to correct this in the interim. However, in lieu of referring to the requirements of 42 CFR § 455.105 in general, the current provider agreement lists individual components of the regulation and does not do so completely or correctly. For example, it states that providers must make business transaction records available for inspection rather than indicating that providers must submit information on transactions upon request of the State agency or HHS Secretary. The provider agreement also does not reference another part of the regulation which specifies that when requested, business transaction information must be provided within 35 days.

**Recommendation:** Modify the State's provider agreements to meet the full requirements specified in 42 CFR § 455.105(b).

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***The State does not request health care-related criminal convictions from agents of the provider. (Uncorrected Partial Repeat Finding)***

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 HHS Office of Inspector General (HHS-OIG) whenever such disclosures are made.

During the 2008 program integrity review, Vermont's provider enrollment application did not directly solicit health care-related criminal conviction information from key parties affiliated with the provider applicant as provided in the regulation. The State largely corrected this after the review and provided for all disclosures to be reported to HHS-OIG as required by 42 CFR § 455.106(b)(1). However, while the DVHA application currently asks for the required disclosures from persons with ownership and control interests and managing employees, it does not request this from agents of the provider and thus continues to be missing one component of the regulation.

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**Recommendation:** Modify the State's provider enrollment application to require the full range of health care-related criminal conviction disclosures required by 42 CFR § 455.106.

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### ***Vulnerabilities***

The review team identified three areas of vulnerability in Vermont's program integrity practices. These related to shortcomings in fraud referrals to MFRAU, the failure to conduct complete exclusion searches, and inconsistencies in the State's policy for processing provider enrollment applications.

#### ***Not following minimum criteria set forth in CMS guidance for fraud referrals.***

In September 2008, CMS issued a document entitled "*CMS-MIG Performance Standards for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit.*" A MFCU referral must contain at least the minimum elements set forth in this guidance document. Effective March 25, 2011, compliance with the referral performance standards is required as part of the regulation at 42 CFR § 455.23. In reviewing a sample of fraud referral forms submitted to the MFRAU, the team noticed that several forms did not provide information on the category of service and relevant statutes, rules or policies. They also did not include a calculation of the dollar amount paid to the provider during the past three years (or period of the alleged misconduct) and the estimated dollars at risk because of fraud.

**Recommendation:** Develop and implement policies and procedures to ensure that fraud referrals include the minimum criteria identified in the CMS referral performance standards.

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#### ***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. 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 List of Excluded Individuals/Entities (LEIE) or the Medicare Exclusion Database (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 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 Excluded Parties List System (EPLS) on a monthly basis. While the State is collecting the required disclosures, the State is not conducting monthly searches of the LEIE or the MED.



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The fiscal agent does not place managing employee information in the Medicaid Management Information System or an alternate searchable data repository during the application process. This precludes automated exclusion checks on all relevant individuals from being undertaken on a monthly and ongoing basis. During the random sampling of provider applications, the team found that a sample LEIE printout was included in most of the sampled files. However, the reviewers found three applications with no documentation that the LEIE had been checked. Lastly, even though Vermont's NEMT brokers check all employees during the application process, the team determined they do not conduct exclusion checks on a monthly basis.

***Recommendations:*** Develop policies and procedures for 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. 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.

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#### ***Inconsistencies in processing provider enrollment applications.***

Vermont's fiscal agent has the responsibility for processing provider enrollment applications and provided the review team with a written policy for handling incomplete applications. According to the written policy, if any application sections are missing or incomplete, staff processing the enrollment applications are to contact the provider via phone or e-mail, although the policy recommends personal contact. The team identified one source of confusion about this policy during an interview with the Vermont Provider and Member Relations Director, who said that based on discussions with the fiscal agent, incomplete applications were to be returned to the provider. This contradicts Vermont's stated policy. Disclosure information or signatures cannot be changed over the phone, but address and other demographic changes can be done over the phone.

During the sampling of provider enrollment applications, the team identified one application that was incomplete and problematic, however the provider was still enrolled. While reviewing the application in question, team members noted that the provider's medical license was previously suspended in Vermont, Arizona and Indiana. On the Vermont enrollment application, the provider also left questions blank or unanswered pertaining to the health care-related criminal conviction disclosures required under 42 CFR §455.106. The provider marked "see attached" and attached his court documents to the application in place of a response to these questions.

When this information was brought to the attention of Vermont program integrity and provider enrollment staff, they indicated that they had knowledge of the provider and mentioned that this individual was currently being investigated by the PI Unit. However, it was not clear whether the State staff were aware of all of the adverse actions taken against the provider in the past, although all relevant records were publicly accessible via the Internet. When asked why they allowed this person to enroll as a medical provider in the program when they could have denied

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his application, State staff advised that Provider and Member Relations followed the established enrollment procedure in this instance. Because the provider did not appear on the LEIE or MED lists, there was no probable cause to deny enrollment. However, staff acknowledged that in the future, additional criteria may need to be considered.

***Recommendations:*** Review and modify all policies and procedures regarding the handling of provider applications to ensure clarity and consistency. Provide training as needed for State and fiscal agent staff on the policies in effect. Develop and implement a policy and procedure for subjecting provider applications to special scrutiny where there is evidence of adverse actions or program integrity problems in the past.

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## **CONCLUSION**

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

- a provider self-audit program, and
- periodic recertification of Medicaid providers based on license renewals.

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of three areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, three areas of vulnerability were identified. The CMS encourages DVHA 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 DVHA 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 Vermont 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 Vermont 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 Vermont on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

**Official Response from Vermont**  
**November 2011**



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*Agency of Human Services*

November 2, 2011

Robb Miller, Director  
Division of Field Operations  
Medicaid Integrity Group  
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233 North Michigan Avenue, Suite 600  
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Re: Response to CMS

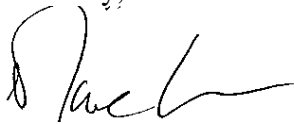
Dear Mr. Miller:

Thank you for the September 2011 Final Medicaid Integrity Report from the Department of Health and Human Services Centers for Medicaid and Medicare (CMS) regarding the Vermont Comprehensive Program Integrity Review.

Please find our responses to the CMS audit report with our corrective action plans to address the issues outlined in the final report. We have completed the described actions to address the three areas of regulatory compliance as well as the three areas of vulnerability.

Please let me know if you have any questions or need additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "Mark Larson".

Mark Larson  
Commissioner, Department of Vermont Health Access  
Vermont Agency of Human Services

