Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Colorado Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Colorado Medicaid Program. The MIG review team conducted the onsite portion of the review at the Colorado Department of Health Care Policy and Financing (HCPF). The review team also met with the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Program Integrity Section (PI Section), which is located within the Audits and Compliance Division of HCPF. This report describes two noteworthy practices, one effective practice, six regulatory compliance issues, and six vulnerabilities in the State's program integrity operations.

The CMS is concerned that the review identified four full or partial uncorrected repeat findings and three uncorrected repeat vulnerabilities from its 2009 review of Colorado. The CMS will work closely with the State to ensure that all issues, particularly those that remain from the previous review, are resolved as soon as possible.

THE REVIEW

Objectives of the Review

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

Overview of Colorado's Medicaid Program

The HCPF administers the Medicaid program in Colorado. As of June 30, 2011, the program served 588,925 beneficiaries. While most beneficiaries are enrolled in a behavioral health managed care organization, the large majority of physical health services are paid on a fee-for-service (FFS) basis. At the time of the review, Colorado contracted with one managed care organization and one prepaid inpatient health plan (PIHP) providing physical health care services in limited regions of the State as well as five regional behavioral health organizations (BHOs), some of which serve broader areas. The BHOs are also contracted as PIHPs. All of these organizations will be referred to as managed care entities (MCEs) throughout this report. Per CMS data, total computable Medicaid expenditures in Colorado for the State fiscal year (SFY) ending June 30, 2011 were $4,533,568,285. As of January 1, 2012, the State had 35,743 participating Medicaid FFS providers and 5,986 participating managed care providers.

Program Integrity Section

The PI Section within HCPF is the organizational component dedicated to addressing fraud and abuse activities. At the time of the review, the PI Section had 12 full-time equivalent positions

allocated to Medicaid program integrity functions with 1 vacancy. The table below presents the total number of preliminary and full investigations and overpayment amounts identified and collected by the PI Section and its MCE contractors in the last four SFYs as a result of program integrity activities.

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified	Amount of Overpayments Collected ***
2008	172	12	$7,005,116	$7,198,990
2009	172	9	$6,501,414	$ 6,221,317
2010	81	16	$8,515,381	$ 8,203,566
2011	35	13	$8,939,404	$5,532,554****

*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 include global settlements, which comprised 73.16 percent of the collections in 2008, 67.62 percent in 2009, and 62.26 percent in 2010. A detailed breakdown was not available for 2011.
****The figure is for the first eight months of SFY 2011.

Methodology of the Review

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

During the week of January 30, 2012, the MIG review team visited the HCPF and MFCU offices. The team conducted interviews with numerous HCPF officials as well as with staff from the MFCU. To determine whether the MCEs and Medicaid fiscal agent were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team interviewed State and contractor staff responsible for managed care and provider enrollment oversight. The team also reviewed relevant contract provisions and conducted sampling of provider enrollment applications, case files, selected claims, and other primary data to validate HCPF's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of HCPF, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, contract management, and provider training. Colorado's Children's Health Insurance Program operates as a stand-alone program under Title XXI of the Social Security Act and was, therefore, excluded from this review.

Unless otherwise noted, HCPF 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 provided.

RESULTS OF THE REVIEW

Noteworthy Practices

As part of its comprehensive review process, the CMS review team identified two practices that merit consideration as noteworthy or "best" practices. The CMS recommends that other States consider emulating these activities.

Advance notices for demand payments

The PI Section began giving providers advance notices of demand for payment letters in SFY 2008. The advance notice gives providers additional time to respond and has been effective in reducing time for the appeals process as well as the number of appeals while increasing improper payment recoveries. In 2009, the State added another step in the process that involves the State contacting the providers via telephone prior to sending out the actual demand for payment letters.

From one home health project that took place over a two year period, 70 providers received withhold notices in 2008/2009 before the policy of advance notification was in place. There were 16 appeals for an appeal rate of 23 percent. In 2009/2010, 95 providers received written advance notices for demand payment and telephone calls. There were 3 appeals for an appeal rate of 3 percent.

Colorado reported that the telephone calls have increased efficiencies at many levels - for the provider, program integrity staff, and for the Attorney General's Office of Administrative Courts. Making advance notice telephone calls gives State staff the opportunity to speak with providers directly to discuss documents needed for the review of overpayments and to educate providers on Medicaid coverage, billing and reimbursement rules. Prior to the telephone calls, providers submitted documentation and conversations took place only during the appeals process, after the State had already incurred attorney costs and much time had been spent in staff preparation.

Close coordination of all program integrity functions in the FFS program

Program integrity operations are well coordinated across all components of the State's FFS program. The PI Section has developed a variety of operational mechanisms and tools to support its work and promote a high degree of coordination.

- The PI Section tracks audits that are taking place in all parts of Colorado's FFS program and proactively coordinates audit activities conducted by State staff with audits performed by a growing number of outside entities and contractors. The latter include the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG), Medicaid Integrity

Contractors (MICs), and the State's two Medicaid Recovery Audit Contractors (RACs).

- The PI Section maintains a master database of all Transaction Control Numbers (TCNs) audited by any entity. This allows it to maintain a record of all claims reviewed by the contractors mentioned above. The PI Section matches all TCNs requested by MICs, RACs, HHS-OIG, the Medicaid agency, MFCU, and Office of the State Auditor against previously audited TCNs. Any matching TCNs are removed from current audits, thereby preventing duplicative work, unnecessary appeals and the revision of audit findings and reports. This activity was also referenced in the 2009 MIG report.

- The PI Section performs medical record audits in the State's home and community-based services (HCBS) waiver programs. It has access to the HCBS waiver case management tracking system (known as the Business Utilization System). As a result of these audits, the PI Section has suggested policy changes in an effort to establish more rigorous time sheet reporting for waiver services.

- The PI Section has a case tracking system that is very organized and from which files were retrieved quickly in response to sampling requests made while the CMS review team was onsite. This system allows the staff to run reports by issues, source, and open and close dates and contains many other features that promote an effective and efficient work environment. The system is also used to discuss and update cases referred to the MFCU during monthly case discussions.

- The adoption of an Electronic Surveillance Utilization Review System (ESURS) has created an electronic data query mechanism for more than 60 people who have access to data and who share and post reports on audits and other inquires. The State reports that ESURS is actively used and updated by its authorized users and informs the work of multiple units, providing a program integrity focus within the State agency and reducing duplication of effort.

Effective Practice

As part of the comprehensive review process, CMS invites each State to self-report practices that it believes are effective and demonstrate a commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Colorado reported that it coordinates with State long term care staff in the enrollment of HCBS providers.

Coordination of HCBS provider enrollment with State Long Term Care staff

The oversight of HCBS waiver programs for persons in need of personal care services, ongoing behavioral health services, and in-home support services is conducted by the HCPF Long Term Benefit Operations Division within the State agency. This division's

oversight functions include reviewing whether entities that provide waiver services meet specific enrollment criteria and certification standards. While the process is largely coordinated by Long Term Care staff working with the Department of Public Health & Environment, it includes procedures for checking with the PI Section on whether certain applications should be approved. The mechanism for obtaining program integrity input on waiver provider applications is a potentially valuable tool for preventing problem providers from gaining entry to HCBS waiver programs.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to payment suspensions, ownership and control, business transaction, and criminal conviction disclosures, searches for excluded and debarred individuals and entities, and appropriate exclusion notifications.

The State does not suspend all payments in cases of credible allegations of fraud in a timely manner.

The Federal regulation at 42 CFR 455.23(a) requires that upon the State Medicaid agency determining that an allegation of fraud is credible, the State Medicaid agency 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. Under 42 CFR 455.23(d) the State Medicaid agency must make a fraud referral to the MFCU or to an appropriate law enforcement agency in States with no certified MFCU. The referral to the MFCU must be made in writing and conform to the fraud referral performance standards issued by the Secretary.

Colorado indicated that it did not yet have a State regulation that addresses the current requirements of 42 CFR 455.23, but it provided a Standard Operating Procedure for handling payment suspensions with cases dated Oct. 1, 2011. While the PI Section has the authority to refer all credible allegations of fraud to the MFCU for a full investigation, it also refers these cases to the Office of the Medicaid Director and Office of Legal Counsel to receive clearance before actual payment suspension actions can be taken. In response to review team concerns that this secondary referral could delay the effective suspension of payments, the State indicated that the clearance process takes no longer than 24 hours. However, the team found several sampling cases in which the suspension or written exception request was not done in a timely manner.

There were 12 cases referred to the MFCU after March 25, 2011, when the current payment suspension requirement took effect. Of those 12 cases, 7 did not require immediate suspension because they involved already terminated providers, existing payment suspensions, a non-Medicaid provider, or limitations imposed by the consumer directed program. In four of the other cases, however, payments were not immediately suspended upon referral. Although the MFCU invoked a good cause law enforcement exception in three of these cases, the exception requests were not filed in a timely manner before the suspensions were supposed to take effect. The review team did find that in those cases where suspensions were taken, the language in the State's notice of withhold letter was consistent with the regulation.

The delay in payment suspensions in the above four cases resulted in continued payments of $10,258. The last case involved the Medicaid agency sending the MFCU self-disclosed

information on the billing practices of a provider that was already under MFCU investigation for other reasons. As this was a high volume provider who submitted over $2.7 million in claims while the MFCU had the case, the State agency could have halted a substantial outflow of questionable payments by imposing a full or partial suspension when it made its own MFCU referral. In August 2012, the MFCU announced that it would no longer pursue civil or criminal charges against the provider, leaving the State agency with potentially large sums to recoup on a pay and chase basis.

Recommendations: When an investigation determines there is a credible allegation of fraud, suspend payments to providers or provide written documentation of a good cause exception not to suspend in the case files. Refer such cases to the MCFU and ensure compliance with the notification requirements of 42 CFR 455.23. When the State agency becomes aware of Medicaid providers referred by other sources to the MFCU, engage the MFCU in immediate discussions about possible payment suspensions, withholds, or other administrative actions if appropriate to prevent an outflow of improper Medicaid payments.

The State does not capture all required ownership and control disclosures from disclosing entities. (Uncorrected Partial Repeat Finding)

Under 42 CFR 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or MCE, must disclose to the State Medicaid agency the name, address, date of birth (DOB), and Social Security Number (SSN) of each person or entity 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. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling. Moreover, under 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

Colorado has developed a Standard Provider Application which is used by all FFS providers, the non-emergency medical transportation (NEMT) broker, agencies serving the State's HCBS waiver programs, and the fiscal agent. In response to the 2009 MIG review, the Standard Provider Application was revised. The current version captures the name and address of each person with an ownership or control interest in the provider or in any subcontractor in which the provider has direct or indirect ownership of 5 percent or more, whether the persons named are related to any other persons named, and the name of any other disclosing entity in which the persons named also have an ownership or control interest.

However, at the time of the 2012 review, the Standard Provider Application was not revised to

capture new 42 CFR 455.104 requirements that went into effect on March 25, 2011. These new disclosure of ownership requirements apply both to FFS providers and BHOs that rely on the State enrollment process and require their network providers to enroll directly with the State (using the Standard Provider Application). The data elements missing in the Standard Application include:

- The DOB and SSN of each person or entity 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,
- Applicable primary business address, address of every business location, and P.O. Box address for corporate entities, and
- Required information about the managing employees of disclosing entities.

The CMS team also found that the State's contracts with all MCEs required the disclosure of ownership and control information consistent with 42 CFR 455.104 before it was amended on March 25, 2011. However, the contracts failed to solicit post-March 25 information. Additionally, with the exception of one recently renewed contractor, Colorado did not produce evidence that disclosures were actually collected and on hand as part of the contract procurement process.

The team found the following gaps in the MCE contracts:

- The contracts do not solicit the names, addresses, DOBs, tax identification numbers and SSNs of those persons with an ownership or control interest in the MCE [455.104(b)(1)(i-iii)];
- Similar information is missing about persons with an ownership or control interest in any owned subcontractors of the disclosing entity, relationships among the names listed, and other disclosing entities. [455.104(b)(2-3)];
- The BHO contracts require the naming of all key personnel, such as managing employees. However, the State does not collect DOBs, addresses, or SSNs for managing employees [455.104(b)(4)]; and
- While disclosures from the most recently renewed contract include the names of all managing employees, corporate officers and Board members, they do not include DOBs, SSNs, enhanced address information, or information about persons with an ownership or control interest in any owned subcontractors of the disclosing entity. They are also silent on familial relationships among parties named by the managed care organization and other disclosing entities. [455.104(b)(1-4)].

Recommendations: Develop policies and procedures and modify contracts (where appropriate) to provide for the appropriate collection of disclosures from disclosing entities, the fiscal agent, NEMT broker, and MCEs regarding persons with an ownership or control interest, or who are managing employees of the disclosing entities, fiscal agent, NEMT broker, or MCEs. Modify disclosure forms and contracts where applicable to capture all disclosures required under the regulation at 42 CFR 455.104. The MIG made the same recommendation regarding collection of disclosures for the fiscal agent and NEMT broker in the 2009 review report.

The State does not adequately address business transaction disclosure requirements in its provider agreement or contracts. (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.

In the 2009 MIG review, the team found that Colorado's FFS provider agreement and MCE contracts did not include a statement that the provider agrees to furnish business transaction disclosures within 35 days of request by the Medicaid agency or HHS.

During the 2012 review, Colorado provided the review team with evidence that changes had been made to the managed care contracts. However, there has not been a similar change made in the FFS provider agreement and the NEMT broker contract.

Recommendation: Revise the provider agreements and NEMT contracts to require disclosure upon request of the information identified in 42 CFR 455.105(b). The MIG made the same recommendation regarding FFS provider agreements in the 2009 review report.

The State does not capture required criminal conviction disclosures from providers or contactors. (Uncorrected 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 HHS-OIG whenever such disclosures are made. In addition, pursuant to 42 CFR 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

In the 2009 MIG review, the review team found that Colorado did not collect health care-related criminal conviction information on managing employees affiliated with FFS providers and therefore could not notify HHS-OIG of such disclosures as required by the regulation.

During the 2012 review, the review team found that while the Standard Application requires provider applicants and persons with ownership and control interests to disclose any criminal convictions related to Medicare, Medicaid or Title XX services programs since the inception of those programs, it still does not solicit the same disclosures regarding persons who are agents or managing employees of the providers. These 455.106-related issues apply to all FFS providers and those BHOs that require their network providers to enroll directly with the State using the Standard Application.

Recommendations: Develop policies and procedures for the appropriate collection of disclosures from FFS and BHO-enrolled providers regarding persons with an ownership or control interest, or persons who are agents or managing employees of the providers, who have been convicted of a criminal offense related to Medicare, Medicaid, or Title XX since the inception of the programs. Modify disclosure forms and MCE contracts as necessary to capture all disclosures required under the regulation at 42 CFR 455.106. The MIG made the same

recommendation regarding the collection of health care-related criminal conviction disclosures from managing employees in 2009.

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid. (Uncorrected Partial Repeat Finding)

The Federal regulation at 42 CFR 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System (EPLS[1]) no less frequently than monthly.

Colorado's fiscal agent conducts LEIE searches on names disclosed on the Standard Provider Application. Exclusion checks occur at the time of initial enrollment for FFS providers, NEMT brokers and agencies enrolled in the HCBS waiver program. However, the interview with the fiscal agent revealed that there is no policy as to how many or which names collected on the Standard Application should be checked against the LEIE. The Standard Application face sheet at element 19 contains room for disclosure information on 4 persons. Relevant disclosure information about other persons with ownership and control interests, agents and managing employees must be attached to the application. During interviews, State representatives told the team that if a hospital submitted disclosure attachments, "probably" the top 4 to 10 names would be checked in the order they appear on any attachment even though the first 4 names might not represent key officers or personnel. For other provider types, the team was told that fiscal agent provider enrollment staff would only check the four names listed on the application face sheet and not review any attached pages.

Since the Standard Provider Application does not consistently capture all required ownership, control, and relationship information for FFS providers, NEMT brokers, and agencies in the waiver programs, LEIE checks on providers and affiliated parties during the enrollment process are frequently incomplete. In addition, based on interviews with the fiscal agent and team sampling of provider applications, the CMS team determined that the EPLS is not checked during the initial enrollment process.

After initial enrollment, the PI Section conducts LEIE and EPLS monthly searches. However, since Colorado's Medicaid Management Information System (MMIS) only captures the names of active providers and not all disclosed parties, only active providers are being checked on a monthly basis. The 2009 MIG review team observed that the State was only checking the LEIE for active providers and that only information on active providers was being maintained in a searchable database. This problem remains.

With regard to MCEs, at the time of the 2012 review, Colorado was checking MCE corporate entities against the EPLS and LEIE as part of the contract initiation and renewal process, but not on a monthly basis. In addition, the EPLS and LEIE checks do not include persons with

[1] On July 30, 2012, the EPLS was migrated into the new System for Award Management (SAM). State Medicaid agencies should begin using the SAM database. See the guidance at http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-01-12.pdf for assistance in accessing the database at its new location.

ownership and control interest in the MCE, agents or managing employees.

During interviews, agency representatives indicated that Colorado is undertaking a Provider Enrollment & Screening Project to conform to new CMS enrollment and risk-based screening requirements. In the new project, the State will enroll MCEs into the provider system as it would any disclosing entity, obtain a full set of disclosures, and match these names against the LEIE and EPLS not only at contract renewal but also monthly. However, this system was not in place at the time of the review.

Recommendations: Develop policies and procedures for appropriate collection and maintenance of disclosure information about the provider, any person with an ownership or control interest, or who is an agent or managing employee of the provider. Search the LEIE (or the Medicare Exclusion Database [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. The MIG made the same recommendation at the time of its 2009 review.

The State does not provide notice of exclusion consistent with the regulation.
Under the regulation at 42 CFR 1002.212, if a State agency initiates exclusion pursuant to the regulation at 42 CFR 1002.210, it must provide notice to the individual or entity subject to the exclusion, as well as other State agencies; the State medical licensing board, as applicable; the public; beneficiaries; and others as provided in 1001.2005 and 1001.2006.

When Colorado initiates a Medicaid provider termination[2], the State provides notice to the provider, licensing boards, beneficiaries and others as appropriate. However, State agency has no mechanism for informing the general public of terminations.

Recommendation: Develop and implement policies and procedures to ensure that all parties identified by the regulation are notified of a State-initiated exclusion consistent with 42 CFR 1002.212.

Vulnerabilities

The review team identified six areas of vulnerability in Colorado's Medicaid program integrity practices. These involved not capturing full ownership and control, business transaction, and criminal conviction disclosures from managed care and NEMT network providers, not conducting complete exclusion searches, and not verifying whether MCE enrollees are receiving services as billed. Contracted MCEs are also not reporting all adverse actions taken against network providers to the State agency.

Not capturing ownership and control disclosures from network providers.
Under 42 CFR 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or managed care entity, must disclose to the State Medicaid agency the name, address, DOB, and SSN of each

[2] For reporting purposes, CMS refers to State actions in accordance with this regulation as "terminations" whether the State calls them "terminations" or "exclusions."

person or entity 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. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling. Moreover, under 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

For credentialing purposes, all MCEs in the State use the standard Colorado Health Care Professional Credentials Application which does not solicit any of the data elements required by 42 CFR 455.104. The NEMT broker also does not collect any 455.104-related disclosure information from its provider network.

Recommendations: Modify the managed care contract and NEMT broker contract to require, or ensure that managed care provider enrollment forms and the NEMT broker contract require, the disclosure of complete ownership, control, and relationship information from all MCE and NEMT network providers consistent with 42 CFR 455.104. Include contract language requiring the MCEs and NEMT broker to notify the State of such disclosures on a timely basis.

Not adequately addressing business transaction disclosures in network provider contracts. (***Uncorrected Repeat Vulnerability***)

The regulation at 42 CFR 455.105(b)(2) requires that, upon request, providers furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractors.

In the 2009 MIG review, Colorado's managed care provider agreements and contracts had no language requiring providers to furnish business transaction information upon request to the Medicaid agency or the HHS Secretary within 35 days. While the State's model managed care contract subsequently required MCE corporate organizations to provide this information on request, at the time of the review in 2012, MCE network provider agreements still lacked a provision obligating providers to do the same. The provider agreement used by the NEMT broker with contracting transportation providers likewise does not contain such a provision.

Recommendation: Modify managed care network provider agreements and NEMT network provider contract to require disclosure upon request of the information identified in 42 CFR 455.105(b). The MIG made the same recommendation regarding business transactions for MCE provider agreements in 2009.

Not capturing criminal conviction disclosures from network providers.
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 whenever such disclosures are made. In addition, pursuant to 42 CFR 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

In the NEMT program, Colorado's Public Utility Commission conducts a background check on NEMT network providers. However, the NEMT broker does not solicit information on health care-related criminal convictions on the part of persons with ownership or control interests in the provider, or agents or managing employees since the inception of Medicare, Medicaid and Title XX.

Recommendations: Modify the NEMT broker contract to require, or ensure that NEMT provider enrollment forms require, the disclosure of health care-related criminal convictions on the part of persons with an ownership or control interest, or persons who are agents or managing employees of network providers consistent with 42 CFR 455.106. Include contract language requiring the NEMT broker to notify the State of such disclosures on a timely basis.

Not conducting complete searches for individuals and entities excluded from participating in Medicaid. (Uncorrected Repeat Vulnerability)
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. If the State neither collects nor maintains complete information on owners, officers, and managing employees in the MMIS, then the State cannot conduct adequate searches of the LEIE or the MED.

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 LEIE or the 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 (#09-001) 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 EPLS on a monthly basis.

Two of the four MCEs interviewed check both the LEIE and EPLS at the time of enrollment and on a monthly basis thereafter for all parties disclosed at enrollment. Two others check the LEIE at the time of enrollment, recredentialing and on a monthly basis, but they do not check the

EPLS. Furthermore, the exclusion checking undertaken by the latter two is done for providers only.

The NEMT broker does not conduct initial or monthly checks for its network providers. Unless they happen to be Medicaid enrolled providers already, transportation providers under contract with the broker would not be checked in the recommended manner.

Recommendations: Amend MCE and NEMT contracts to require the 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. Require the contractor to search the LEIE and the EPLS upon enrollment, reenrollment, credentialing or recredentialing of network providers, 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 pursuant to 42 CFR 455.436. The MIG made the same recommendation regarding exclusion searches for MCEs in 2009.

Not verifying with managed care enrollees whether services billed were received. (Uncorrected Repeat Vulnerability)

The regulation at 42 CFR 455.20 requires the State Medicaid agency to have a method for verifying with beneficiaries whether services billed by providers were received. An HHS-OIG report on managed care safeguards, *Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards*, OEI-01-09-00550, recommended that State Medicaid agency contracts with MCEs require verification with enrollees that services were provided either through the use of explanations of medical benefits or beneficiary questionnaires. To the extent that the State Medicaid agency has delegated the responsibility to its MCE to verify with enrollees whether services were received, the failure of the MCE to have a method for verifying with enrollees whether services were received and to implement that method leaves the State Medicaid agency vulnerable to fraud.

In the 2009 MIG review, CMS found that MCE contracts did not require plans to verify with beneficiaries the receipt of services billed by providers. The four MCEs interviewed in 2012 indicated that they also do not currently verify receipt of Medicaid services with their beneficiaries. Several BHOs, however, discussed the difficulty of using Explanation of Medical Benefit Forms when providing mental health services, given concerns about client confidentiality and the difficulty of developing alternatives to this approach.

Recommendation: Develop and implement procedures to verify with MCE enrollees whether services billed by providers were received. The MIG made the same recommendation regarding verification of services in 2009.

Not reporting all adverse actions taken on provider participation to the HHS-OIG.

The regulation at 42 CFR 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. The State Medicaid agency's policies and procedures and contract requirements do not adequately direct the MCOs

to report to it any program integrity-related adverse actions the MCO takes on a provider's participation in the network, e.g., denials of credentials, enrollment, or contracts, or terminations of credentials, enrollment, or contracts. Program integrity reasons include fraud, integrity, or quality.

The State's Program Integrity Standard Operating Procedures, *Reporting Provider Sanctions to HHS-OIG PI-07*, directs the State to report denials and terminations. However, the policy does not address the responsibility of reporting by MCEs. The team identified that MCE physical health contract provisions require adverse action reporting related to suspected fraud, abuse or quality concerns. However, it does not require the reporting of denied credentialing and enrollment.

Recommendations: Require contracted MCEs to notify the State when they take adverse action against a network provider for program integrity-related reasons. Develop and implement procedures for reporting these actions to HHS-OIG consistent with 42 CFR 1002.3(b)(3).

CONCLUSION

The State of Colorado applies some noteworthy and effective practices that demonstrate program strengths and the State's commitment to program integrity.

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

However, the identification of six areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, six areas of vulnerability were identified. The CMS is particularly concerned over the seven uncorrected repeat findings and vulnerabilities. The CMS expects the State to correct them as soon as possible.

To that end, we will require Colorado 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 Colorado 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 Colorado 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 Colorado on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.