Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Colorado Focused Program Integrity Review

Final Report

October 2017

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of Colorado to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency. The 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 2012.

Background: State Medicaid Program Overview

The CMS review team conducted the onsite portion of the focused program integrity review of the Colorado state Medicaid agency by meeting with representatives at the offices of the Colorado Department of Health Care Policy and Financing (HCPF). Colorado is a Medicaid expansion state with more than 1.3 million Medicaid beneficiaries. Colorado's Medicaid program consists of various service contractors and subcontractors that comprise its managed care program. At the time of the review, HCPF contracted with three MCOs, seven primary care case management (PCCM) entities, also referred to as Regional Care Collaborative Organizations (RCCOs), and five prepaid inpatient health plans (PIHPs). The MCOs operate in parts of the state and the PCCMs operate statewide. The MCOs and the PCCMs are part of the physical health care delivery system. Since the RCCOs are paid fee-for-service, their services are not reflected in this report.

The PIHPs provide the behavioral health services in the Community Behavioral Health Services Program. This program uses four PIHPs that are referred to as behavioral health organization (BHO) contractors: Colorado Access; Behavioral Healthcare, Inc., (BHI); Foothills Behavioral Health Partners, LLC; and Colorado Health Partnerships, LLC. Colorado Access, with its two contracts, provides services for beneficiaries in 13 counties including Denver. The BHI serves three counties, while Foothills Behavioral Health Partners and Colorado Health Partnership serve five and 43 counties, respectively.

Approximately 80 percent of Medicaid beneficiaries are enrolled with an MCO or a PCCM for physical health care services, while approximately 97 percent are enrolled in a BHO, since Medicaid members can be enrolled in both a physical health MCE and a BHO. The remaining 20 percent are enrolled in Colorado's fee-for-service (FFS) Medicaid program. Enrollment into the MCOs and PCCMs is voluntary. These programs operate under state plan authority. Enrollment into the PIHP or BHO is mandatory and the program operates under a 1915(b)(3) waiver. The total Medicaid expenditures for federal fiscal year (FFY) 2016 totaled approximately $7.0 billion (excluding cash fund financing payments and other adjustments). The state's FFY 2016 Federal Medical Assistance Percentage is 50.72 percent. For purposes of this report, all MCOs and PIHPs or BHOs will be referred to as managed care entities (MCEs).

Methodology of the Review

In advance of the onsite visit, CMS requested that Colorado and the MCEs selected for the focused review complete a review guide that provided the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. A three-person review team has reviewed these responses and materials in advance of the onsite visit.

During the week of May 23, 2017, the CMS review team visited the HCPF offices consisting of the Audits and Compliance Division, which includes the Program Integrity Section, the Payment Reform Section, the Health Programs Office, and the Client and Clinical Care Office. They conducted interviews with numerous state staff involved in program integrity and managed care, including The CMS review team also conducted interviews with three of the MCEs and their personnel responsible for implementing the corporate compliance program. In addition, the CMS review team conducted sampling of program integrity cases and other primary data to validate the state and the selected MCEs' program integrity practices.

Results of the Review

The CMS review team identified areas of concern with the state's managed care program integrity oversight, thereby creating risks 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, particularly those that remain from the earlier review. These issues and CMS's recommendations for improvement are described in detail in this report.

Section 1: Managed Care Program Integrity

Overview of the State's Managed Care Program

As mentioned earlier, approximately 1.3 million beneficiaries were enrolled in the managed care delivery system during FFY 2016. The state spent approximately $1.2 billion, or 17 percent of the state's total Medicaid expenditures (excluding cash fund financing payments and other adjustments), on managed care contracts in FFY 2016. As of March, 2017, the state initiated a central provider enrollment process for all providers seeking to participate in the Medicaid managed care program. Once a provider enrolls with the state, they may apply to participate in the network of an MCE and consequently participate as a provider in the Colorado Medicaid managed care program.

The HCPF has authorized the Program Integrity Section to provide guidance on program integrity activities and to conduct preliminary investigations relating to fraud reported by the MCEs. Abuse and waste are reviewed by multiple sections within the Audits and Compliance Division and the Payment Reform Section. Other HCPF units have roles in oversight of MCE program integrity efforts including: contract managers in the Health Programs Office; rates staff within the Payment Reform Section; quality staff, and the contract managers of the external

quality review organization (EQRO) contract in the Client and Clinical Care Office; and Health Information Office staff.

The organizational structure of the HCPF places the Program Integrity Section under the Finance Office's Audits and Compliance Division along with the Audit Information Management Section and the Eligibility Claim Review Section both of which conduct and support program integrity efforts. Within the Audits and Compliance Division, there is a data unit that is a part of the Audit Information Management Section. During the onsite review, the CMS review team noted communication and oversight limitations that may be attributed to the number of units throughout HCPF tasked with program integrity responsibilities.

The state's contracts requires the MCEs to report alleged or suspicious Medicaid provider cases. The Program Integrity Section utilizes the Claims Investigation Unit when an MCE refers a case of suspected fraud to the state. When suspected provider fraud is reported, a reviewer in the Claims Investigation Unit is assigned to conduct a preliminary investigation. The results of the review are sent to the Program Integrity Section's fraud and abuse specialist to review if the allegation of fraud is credible, and to ensure that all required information is included in the referral to the Medicaid Fraud Control Unit (MFCU). The Program Integrity Section manager reviews and makes a determination as to whether there is a credible allegation of fraud in conjunction with the Audits and Compliance Division director and the Legal Division director, when required.

The Program Integrity Section manager makes referrals to and coordinates with the MFCU. One of the primary functions of the Audits and Compliance Division is to analyze and investigate billing patterns in claims data for fraudulent activity in the Medicaid managed care program. However, the Audits and Compliance Division has been operating without complete and accurate managed care encounter data and has not completed any self-initiated MCE investigative cases to date.

At the time of the review, the Program Integrity Section had a total of 11 full-time equivalent positions (FTEs) dedicated to program integrity responsibilities, including providing program integrity oversight of their MCEs. In addition, the CMS review team analyzed the state's oversight of the program integrity activities for Colorado Access; BHI and Denver Health Medicaid Choice (Denver Health).

Summary Information on the Plans Reviewed

The CMS review team interviewed three MCEs as part of its review.

Colorado Access is a local, nonprofit health plan that provides beneficiaries with access to physical and behavioral health services. Colorado Access is the contracted PCCM entity for Regions 2, 3, and 5; under these contracts, Colorado Access does not pay claims or act as the health plan. In Region 3, Colorado Access is contracted for a RCCO payment reform project called Accountable Care Collaborative (ACC): Access KP. For Access KP, the contract is between Colorado Access and HCPF with the expectation and intention that Colorado Access subcontract with Kaiser Foundation Health Plan of Colorado (Kaiser) for services.

Colorado Access has delegated the payment of claims, among other functions, to Kaiser. Colorado Access also contracts as a PIHP (BHO) for the Medicaid managed behavioral health care benefit in the Denver and the Northeast Regions. The Colorado Access Compliance Department is responsible for all program integrity activities and investigations. The Compliance Department is located in Aurora, Colorado. The Compliance Department staff consists of a chief compliance officer, a compliance specialist, and a quality improvement project manager; the chief compliance officer and the compliance specialist are the only full-time employees focusing on fraud and abuse activities, while the project manager focuses on privacy activities.

The BHI is a local BHO that manages the HCPF's Colorado Community Mental Health Services Program in Colorado's Metro East Region which is made up of Adams, Arapahoe, and Douglas counties as well as the city of Aurora. The BHI provides medically necessary behavioral health services to eligible Medicaid members. The Compliance Department is responsible for program integrity activities and is located in Aurora, Colorado. The Compliance Department is staffed by the director and a compliance monitoring specialist; there is one position for a compliance auditor that is currently vacant.

Denver Health is a staff-model health plan, full-risk capitation contract with a local group of doctors, clinics, hospitals, pharmacies, and other providers who work together to provide healthcare to individuals who are eligible for Medicaid and live in Adams, Arapahoe, Denver, and Jefferson County. Denver Health has eight family health centers and 15 school-based health centers around the metro Denver area. Medicaid Choice includes added benefits beyond those offered by FFS Medicaid, such as over-the-counter medications, immunizations, prescriptions, and office visits at no cost to the member. For its Medicaid line of business, Denver Health has a special investigations unit (SIU) that operates out of Denver Health Medical Plan, Inc. The SIU consists of three FTEs; however, they are able to utilize the additional resources of their corporate compliance department, and they use a subcontractor to conduct all claims analysis and data mining activities. In addition, Denver Health utilizes the internal hospital compliance department of their affiliated hospital, Denver Health Medical Center.

Enrollment information for each MCE provided as of March 2017 is summarized below:

Table 1.

	Colorado Access*	BHI	Denver Health
Beneficiary enrollment total	364,437	314,018	76,465
Provider enrollment total	5,597	646	619
Year originally contracted	1994	1995	1983
Size and composition of the SIU/compliance office	2.0 FTEs	2.0 FTEs	3.0 FTEs
National/local plan	Local	Local	Local

*The RCCOs and any subcontracted pilot programs are not included in beneficiary enrollment and provider enrollment totals.

Total Medicaid expenditure information provided as of March 2017 for each MCE is summarized below:

Table 2.

MCOs	FFY 2014	FFY 2015	FFY 2016
Colorado Access	$95.0 million	$158.7 million	$174.5 million
BHI	$107.7 million	$132.4 million	$131.4 million
Denver Health	$136.1 million	$169.0 million	$199.5 million

State Oversight of MCE Program Integrity Activities

The office responsible for detecting fraud, waste, and abuse in the Colorado Medicaid managed care program is the Audits and Compliance Division, where the Program Integrity Section resides. However, the Audits and Compliance Division is not responsible for performing direct oversight of the MCEs, as that role is predominately reserved for the contract managers in the Health Programs Office. As previously referenced, the HCPF contract managers in the Health Program Office is responsible for addressing the contract requirements, including program integrity contract requirements. The CMS review team found that complaints concerning suspected or alleged MCE provider fraud are submitted by MCEs either directly to the Program Integrity Section or through the contract managers. In some instances, the Program Integrity Section were not made aware of important program integrity activities that may not be reported or performed appropriately or may not be performed outright. Therefore, the Audits and Compliance Division must effectively communicate and coordinate program integrity requirements with the contract managers from the Health Programs Office. The CMS review team identified insufficient communication and oversight of managed care program integrity operations, and a need for more comprehensive program integrity contract requirements that are clearly understood by each MCE.

In regards to the state's lack of communication and oversight of its managed care program, the state's program integrity personnel do not have sufficient policies and procedures specifically governing MCE program integrity oversight activities. The HCPF involves many various organizational staff in the program integrity process, but does not effectively designate and

define clear roles of program integrity responsibility. Some program integrity responsibilities are delegated to the other units within the organization, such as the staff involved in rate setting, provider enrollment staff, contract managers and other staff from the Health Programs Office. The CMS review team identified that the Program Integrity Section within the Audits and Compliance Division is not always aware of some of the more significant MCE program integrity activities as well as the program integrity activities that these other state staff may be handling. Therefore, the Audits and Compliance Division is not aware of important program integrity functions that may not be performed appropriately or may not be performed outright.

Also, the MCEs are contractually required to verify that reimbursed services were actually provided to enrollees by providers. However, the Program Integrity Section is neither involved in reviewing the verification plans or the compliance plans and programs submitted by the MCEs. The MCEs interviewed have not verified that services billed by providers were received by their plans' beneficiaries. The state should ensure that beneficiary services have been verified by their MCEs. This issue was cited during the last CMS onsite review and remains uncorrected as of the date of this onsite review.

In addition, the Program Integrity Section within the Audits and Compliance Division appears to lack the final authority to oversee all program integrity responsibilities, regardless of where the function is performed within the department. This structure may be hindering effective program integrity communications from filtering through the entire state Medicaid agency as well as allowing the following inefficiencies to exist: not verifying receipt of services with beneficiaries; not reviewing the MCE compliance plans; and not having input into the MCE compliance monitoring tool used by the EQRO. The MCEs also mentioned to the CMS review team, the need for improved communication between the Program Integrity Section and the MCEs, primarily regarding investigations of credible allegations of fraud and some of the other regulatory program integrity requirements.

The CMS review team evaluated the program integrity provisions of the general contract language, along with the feedback from the MCEs, and identified a need for the inclusion of more comprehensive contract language regarding program integrity requirements. The MCEs also reported that the program integrity contract requirements are sometimes vaguely stipulated in the contract, such as not having a specific requirement regarding the collection of business transaction disclosures. The Denver Health MCE was unaware as to whether the general MCE contract contained the appropriate language for supplying business transaction information upon request or if they were requiring providers to disclose this information. In March 2017, the state's implementation of a new Medicaid Management Information System (MMIS) provided resolution to this program weakness, since all providers must now enroll with the state prior to participating in the Medicaid managed care program.

The CMS review team also identified instances of inconsistent interpretation of the program integrity requirements by the MCEs, as a result of not having clear contract requirements outlined in the general MCE contract. Although the contract requires the MCEs to verify receipt of services with beneficiaries, none of the MCEs were verifying receipt of services directly with the beneficiary as specified in the MCE contract. In addition, the general MCE contract does not specify requirements for: provider enrollment; program integrity meetings and/or program

integrity trainings; encounter data or claims data submissions to the state for analysis; identification, investigation, referral, and reporting guidelines for investigations of credible allegations of fraud; and provider termination and adverse action (for-cause and not for-cause) situations.

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. However, the complete process is not always in writing and, as previously referenced, the contract is not always clear and comprehensive in nature.

Colorado's managed care contract language covering the MCEs' reporting requirements states the following:

1.1.1.1. Contractor shall immediately report known confirmed intentional incidents of fraud and abuse to the Department's contract manager and to the appropriate law enforcement agency, including, but not limited to, the Colorado Medicaid Fraud Control Unit (MFCU).

1.1.1.2. Contractor shall immediately report indications or suspicions of fraud by giving a verbal report to the Department's contract manager. Contractor shall investigate its suspicions and shall submit its written findings and concerns to the contract manager within three Business Days of the verbal report. If the investigation is not complete in three Business Days, Contractor shall continue to investigate. A final report shall be submitted within fifteen Business Days of the verbal report. The contract manager may approve an extension of time in which to complete the final report upon a showing of good cause.

This language is not found in the PCCM or BHO contracts. In this contracted process, the Program Integrity Section is absent from all of the reporting activities previously detailed.

Colorado Access' Compliance Department is responsible for investigating referrals that may be forwarded by the state, providers, or internal sources, including a hotline and claims review. Colorado Access reviews each referral on a case by case basis, and conducts audits or other investigations for non-claim issues as necessary. In certain instances, the Compliance Department has identified erroneous billing by reviewing charts and verifying codes. Colorado Access only notifies the state when they discover an allegation of fraud, the majority of cases reviewed by Colorado Access did not rise to the level of suspected fraud required for reporting to the state, which has led to a low number of referrals to the state in the last three fiscal years.

The BHI's current fraud and abuse prevention plan consists of a provider auditing program. The providers selected for audits are chosen using the following criteria: random selection; overutilization; billing anomalies; suspected fraud, waste, and abuse; and new providers who joined the network in the last 12 months. The compliance specialist conducts two audits every other week. On occasion, the Compliance Department may receive a tip of suspected fraud and

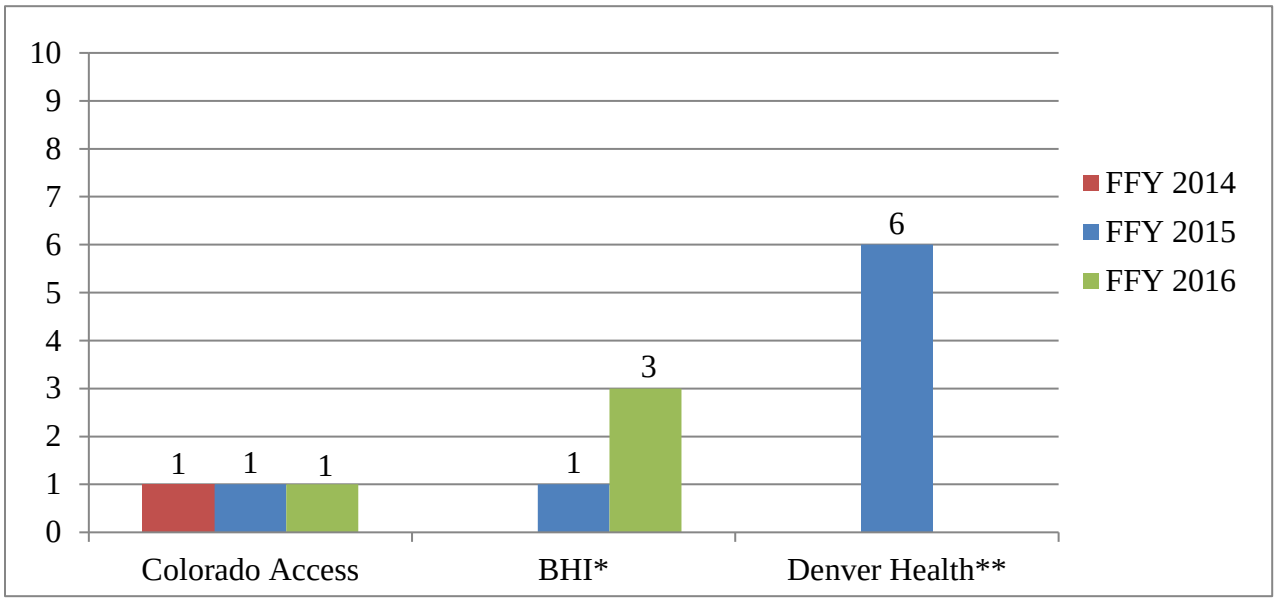
abuse from the HCPF, and/or community members, regarding possible fraudulent activities from providers. Once the tip is received, the Compliance Department will first review the claim to see if evidence of fraud exists; if any indication of fraud is found, an internal meeting is held to determine the next steps. Before submitting any cases to HCPF, a preliminary audit is conducted, which typically involves a review of 20 to 50 claims.

Denver Health's SIU is responsible for investigating referrals that may come from the state, providers, or internal sources such as their hotline. Denver Health utilizes current fraud detection software, audits, data analysis, hotline tips, and other tools to identify and investigate improper, deceptive, and fraudulent billing. Denver Health performs audits to verify allegations of fraud, such as verification of medical necessity and appropriateness of services, proper billing, and eligibility for coverage. Claim management tools assist with the identification of inconsistent and illogical relationships among claims data, while data mining tools are used to identify providers and members who may be involved in fraud. The Denver Health SIU director makes a determination as to whether to refer the case to the MFCU and/or the contract manager at HCPF, once a preliminary and a full investigation have been completed. Denver Health makes a complete determination as to whether or not there is a credible allegation of fraud, prior to referring a case to the state or the MFCU, in accordance with its Medicaid contract.

The MCEs do not submit monthly reports of fraud, waste, and abuse activity to the Program Integrity Section for review. The contract does include language requiring the MCEs to report suspected provider fraud, waste, and abuse to the Colorado MFCU.

Table 3 lists the number of referrals that Colorado Access, BHI, and Denver Health made to the state in the last three FFYs.

Table 3.



*The BHI did not refer any preliminary investigations to the state during FFY 2014.
**Denver Health did not refer any preliminary investigations to the state during FFYs 2014 and 2016.

Table 3 lists the number of referrals that Colorado Access, BHI, and Denver Health made to the state in the last three FFYs. Overall, the number of Medicaid provider investigations and referrals by each of the MCEs is low, compared to the size of the Colorado Medicaid program and the size of the plans reviewed. The level of MCE investigative activity among the MCEs reviewed has not changed over time.

As previously discussed, the CMS review team identified the state as having a lack of effective policies and procedures regarding MCE investigations, referrals, and reporting requirements for preliminary investigations and overpayments. During the onsite review, it was learned that the state did not require overpayments to be reported to the Program Integrity Section for verification, and did not have written policies and procedures for MCE audits and investigations. The Program Integrity Section appears to rely on the contract managers to review the program integrity activities of the MCEs and subcontractors. In addition, the Audits and Compliance Division has been operating without complete and accurate managed care provider encounter data, and has not initiated or completed any MCE investigative cases. Colorado Access and BHI also do not conduct data mining; however, Colorado Access does contract with an outside vendor to data mine diagnosis-related group claims for potential overpayments and to conduct documentation reviews.

The Program Integrity Section performs no audits, reviews, and/or investigations of network providers independently or in conjunction with the MCEs, nor do they maintain reliable tracking of MCE referrals. The Program Integrity Section could not provide the CMS review team with the number of cases referred by the MCEs, since they do not track the source of the MCE referrals. As a result, the MCEs may not be referring all potential credible allegations of fraud to

the state. During the onsite interviews, the state often appeared to be uninformed about the MCE program integrity activities.

While conducting a random sampling of cases, the CMS review team reviewed a report from Denver Health that identified possible billing issues in a particular case that has an estimated potential overpayment of approximately $70,000. The case was from 2014 and had not yet been referred to the state. The MCE stated this was a unique case and is still being worked out internally with Denver Health legal officials regarding actual billing and reimbursement issues between the parties and the true estimated overpayment amount.

The MCEs appear to perform preliminary and/or full investigations to determine if fraud exists, prior to referring cases to the state. The MCEs' responsibility and authority to determine whether or not there is a credible allegation of fraud directly impacts potential investigations and, consequently, provider terminations. In addition, the MCEs predominately rely on conducting provider education aimed at changing aberrant billing patterns, which has resulted in a low number of for-cause terminations.

As previously mentioned, the general contract language does not address the state conducting program integrity meetings and/or program integrity trainings. The Program Integrity Section stated that meetings had not been occurring regularly, but they have recently initiated bi-annual meetings with the MCEs. During onsite interviews, the CMS review team identified that these re-established meetings did not have a formal agenda. These meetings were initiated for information sharing purposes among those involved in program integrity activities. There has not been any training or collaboration among MCEs and the program integrity staff or MFCU. The MCEs reviewed agreed that the meetings could be improved and trainings would be a worthwhile addition. The MCEs also mentioned they would like to have more discussions regarding providers that may be of concern across the plans to assist in identifying suspect providers.

MCE Compliance Plans

The state does require its MCEs to have a compliance plan to guard against fraud and abuse in accordance with the requirements at 42 CFR 438.608. The state does not have a process that allows for the Program Integrity Section to review the compliance plans and programs.

The contract with the MCEs states, "The Contractor shall create a compliance program plan documenting Contractor's written policies and procedures, standards and documentation of practices. The Compliance Program Plan shall be approved by Contractor's Chief Executive Officer and Compliance Officer. The Compliance Program Plan shall be submitted to the Department for review and approval." As required by 42 CFR 438.608, the contract managers at HCPF receive and review the compliance plan and communicates approval/disapproval with the MCEs. However, prior to the FFY 2017 onsite review, the Program Integrity Section was not involved with reviewing the compliance plans.
Colorado's contract with its EQRO, Health Services Advisory Group, calls for a review audit of the MCEs using a compliance site review audit tool annually. Within a 3 year period the EQRO reviews extensive program integrity criteria to monitor MCE compliance and internal

discussions to review program integrity annually are being conducted. The site review audit tool was provided by the Quality Health and Improvement Section within the Client and Clinical Care Office of the HCPF. The purpose of the operational review audit is to assess each contractor's compliance with HCPF's contract standards, which include the program integrity sections of the contract. The CMS review team makes no determination as to the validity of the evidence submitted by the health plans necessary to fulfill the requirements of the annual audit.

The CMS review team identified no regulatory issues with the compliance plan received from the MCEs. The CMS review team identified a concern that the compliance plans were not being reviewed by the Program Integrity Section and the state was not providing feedback to the MCEs regarding the content of the compliance plans. All of the MCEs provided the CMS review team with a copy of their compliance plans that have been submitted to the state. A review of these plans revealed the MCEs were in compliance with 42 CFR 438.608.

Encounter Data

The state does collect and review encounter data from the MCEs, but do not have the ability to run program integrity related analysis of that data. This collection and review action is performed by the Rates Section within HCPF. However, as previously mentioned, the Program Integrity Section has not performed data analysis of managed care encounter data as the accuracy and completeness of the data has not supported overpayment recoveries, but will in the future. The new MCE contract contains a requirement for the MCEs to provide access to claims data. Therefore, the Program Integrity Section has not initiated or completed any cases on services provided by the MCE network providers.

Overpayment Recoveries, Audit Activity, and Return on Investment

The state does not require MCEs to return to the state overpayments recovered from providers as a result of MCE fraud and abuse investigations or audits, since expenditures are adjusted at rate setting. The state mentioned that the rate setting team is involved in the overpayment process, since the overpayments are tracked and ultimately reflected in the rates. As mentioned previously, the MCEs perform very minimal audit activities and the state has not determined the return on investment for its managed care program integrity activities.

The table below shows the respective amounts reported by Colorado Access for the past three FFYs.

Table 4-A.

FFY	Preliminary Investigations*	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered**
2014	4	4	$785	$785
2015	3	3	$0	$0
2016	6	6	$33,554	$33,554

*The RCCOs and Access KP investigations were not included, since they are paid the same as the FFS delivery system.
**Recoveries are offset against future claims resulting in total recovery of the overpayments identified.

The Access KP program started on July 1, 2016. There was one claims validation review conducted by Colorado Access from September 26 to 27, 2016. There were no fraud or abuse issues identified, and there were no referrals made to the state.

The table below shows the respective amounts reported by BHI for the past three FFYs.

Table 4-B.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered*
2014	7	0	$716	$716
2015	20	1	$8,069	$8,069
2016	28	1	$20,602	$20,602

*Recoveries are offset against future claims resulting in total recovery of the overpayments identified.

The BHI's full investigations and overpayments identified and recovered are extremely low respectively. However, the amount of overpayments identified and recovered has steadily increased annually for the three FFYs reviewed, which demonstrates positive progress.

The table below shows the respective amounts reported by Denver Health for the past three FFYs.

Table 4-C.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2014	0	0	$0	$0
2015	10	6	$16,308	$0
2016	0	0	$0	$0

There were no preliminary or full investigations being conducted in FFY 2014, due to the MCE's transition to a new subcontractor. During FFY 2016, Denver Health had no preliminary or full investigations, again due to their transition to another new subcontractor. The conversion and time involved in changing subcontractors twice during the three FFYs reviewed also accounts for the low volume of overpayments identified and the lack of monies recovered.

Overall, the amount of overpayments identified and recovered by the MCEs is improving for two of the three MCEs reviewed, however, the full investigations are either low or nonexistent for a managed care program of Colorado's size. The CMS review team identified the state as having a lack of effective policies and procedures regarding MCE investigations, referrals, and reporting requirements for preliminary investigations and overpayments. During the onsite review, it was learned that the state did not require overpayments to be reported to the Program Integrity Section for verification, and did not have written policies and procedures for MCE audits and investigations. Although MCEs are not required to report on overpayments from their network providers to the state, it is important that the state obtain a clear accounting of any recoupments, since these dollars are factored into establishing annual rates. Without these adjustments, the rates paid to these MCEs may be inflated per member per month.

Payment Suspensions

In Colorado, 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 MCE contract states that the contractor shall suspend payments to any network provider that is actively under investigation for a credible fraud allegation. The state may suspend payments by MCEs to a network provider when an individual network provider is under investigation based upon a credible allegation of fraud.

The review revealed the MCEs were not actively suspending provider payments in conjunction with the state and in accordance with the state's payment suspension process. Since the MCEs are not conducting payment suspensions in the Medicaid managed care program, the state is at risk by failing to suspend payments to providers against whom there is a credible allegation of fraud.

Terminated Providers and Adverse Action Reporting

The state MCE contract states, "The Contractor shall notify the Department, in writing, of its decision to terminate any existing Participating Provider agreement where such termination will cause the delivery of Covered Services to be inadequate in a given area. The notice to the Department shall include a description of how the Contractor will replace the provision of Covered Services at issue. In the event that the Contractor is unable to adequately replace the affected services to the extent that accessibility will be inadequate in a given area, the Department may impose limitations on Enrollment in the area or eliminate the area from the Contractor's Service Area."

The contract also states that, "The Contractor shall make a reasonable effort to provide written notice of the termination of Participating Provider agreements to Members. This shall occur within fifteen (15) calendar days after receipt, issuance of, or notice of such termination to all Members receiving Covered Services on a regular basis from or through a Provider whose agreement is terminating with the Contractor, regardless of whether the termination is for cause or without cause. Where a termination involves a Primary Care Physician, all Members that receive Covered Services through that Primary Care Physician shall also be notified. Such notice shall describe how services provided by the Participating Provider will be replaced, and inform the Members of Disenrollment procedures. The Contractor shall allow Members to continue receiving care for sixty (60) calendar days from the date a Participating Provider is terminated without cause when proper notice as specified in this section has not been provided to the Members." Consequently, the MCEs are allowed to terminate a provider from the Medicaid program as long as they properly notify HCPF.

The MCEs reviewed stated that for cases where there is an indication of fraud, waste, or abuse, their provider relations department contact both the compliance department and the government products department to notify them that the termination will take place. The provider relations department then terminates the provider as per the contract. There have been few provider terminations as depicted in the table below.

Table 5:

MCEs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		Total #of Providers Terminated for Cause in Last 3 Completed FFYs	
Colorado Access	2014	0	2014	0
	2015	1	2015	0
	2016	0	2016	0
BHI	2014	20	2014	0
	2015	45	2015	2
	2016	65	2016	0
Denver Health	2014	107	2014	0
	2015	112	2015	0
	2016	123	2016	0

Overall, the number of providers terminated for cause by each of the MCEs appears to be either nonexistent or very low, compared to the number of providers in each of the MCE's networks and compared to the number of providers disenrolled or terminated for any reason. In addition, the number of providers disenrolled or terminated for any reason by Colorado Access is low, compared to the other MCEs reviewed and considering the number of providers participating in the MCEs networks.

Federal Database Checks

The regulation at 42 CFR 455.436 requires that the state Medicaid agency must check the exclusion status of the provider or persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE); the Excluded Parties List System (EPLS) on the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); the National Plan and Provider Enumeration System upon enrollment and reenrollment, and check the LEIE and EPLS no less frequently than monthly.

The HCPF contract states that the contractor shall not knowingly have any relationship as described in 42 CFR 438.610 and defined as follows: "An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549."

The state complies with all regulatory requirements regarding all database checks, except the SSA-DMF prior to March 2017. In addition, the state was not checking the Medicare Revocation Database and the TIBCO system prior to the implementation of the state's new MMIS system in March 2017.

Recommendations for Improvement

- The state should identify ways that program integrity oversight and communication could be enhanced within its organizational structure, or look into restructuring, so that the Program Integrity Section can be better informed of all managed care program integrity activities.
- The state should develop and implement policies and procedures to facilitate stronger oversight of MCE program integrity activities. The policies and procedures should also address measures necessary to increase oversight for MCEs identified as not expending sufficient effort towards identifying and recovering overpayments to providers, including but not limited to the MCEs that participated in the review.
- The state should ensure the MCEs meet their contract requirements in regards to verifying services rendered with the beneficiary. In addition, the Program Integrity Section should be involved with reviewing the verification plans submitted by the MCEs.
- The state should modify its model contract to ensure all federal regulations are included and appropriately cited. Based on the size of the managed care program, the state should address low referral numbers and the lack of reporting of all suspected fraud cases to the state Medicaid agency and/or MFCU by strengthening its contract language and/or the policies which promote MCE participation in the identification of fraud and abuse.
- The state should develop a mechanism to track all cases referred to the state and/or MFCU by the MCEs. The state should also have a method to track overpayments identified and recovered by MCEs and consider tracking MCE investigations that may potentially develop into a referral, to ensure that MCEs are not failing to report potential credible allegations of fraud.
- The state should schedule frequent meetings with the MCEs to review program integrity activities and contract performance. The state should provide Medicaid program integrity training as a routine part of their meetings with the MCEs.
- The state should develop a process for the Program Integrity Section to review the MCEs' compliance plans and programs. This process should also include providing feedback to the MCEs regarding the content of the compliance plans.
- The state should ensure encounter data is complete and accurate to support overpayment determinations by the Audits and Compliance Division and coordinate audits, reviews, and/or investigations of network providers with the MCEs to avoid duplication of effort.
- Given the limited audit work performed by the MCEs, along with the low number of overpayments and terminations that the MCEs reported, the state should ensure that any MCE with which it contracts has an established and functioning program integrity infrastructure that includes adequate systems and staff to prevent, detect, and investigate provider fraud.
- The state should consider each case referred by the MCEs on its own merits in order for the state agency to identify where it can safely suspend Medicaid managed care payments to problem providers, without jeopardizing further investigation of those providers. Ensure that in the absence of a written good cause exception, provider payments are suspended after determination of a credible allegation of fraud in accordance with the requirements at 42 CFR 455.23. If or where necessary, update and strengthen the state's policies and procedures to suspend payments to managed care providers after determination of a credible allegation of fraud in the absence of a documented good cause exception, and follow these procedures.

Refer to the technical assistance resources section of this report for further recommendations to address this area of risk.

- The state should implement oversight methods aimed at ensuring all managed care providers and contractors safeguard the Medicaid managed care program against employing or contracting with an individual who is debarred, suspended, or otherwise excluded. The Medicaid managed care program methods should include, but not limited to, checking the Medicare Revocation Database and the TIBCO system and all federal database checks as required by the regulation at 42 CFR 455.436. In addition, the state should confirm that its Program Integrity Section is reporting managed care providers terminated for cause to CMS.

Section 2: Status of Corrective Action Plan

Colorado's last CMS program integrity review was in May 2012, and the report for this review was issued in January 2013. The report contained six findings and six vulnerabilities. During the onsite review in February 2017, the CMS review team conducted a thorough review of the corrective actions taken by Colorado to address all issues reported in calendar year 2013. The findings of this review are described below.

Findings -

1. ***The state does not suspend all payments in a timely manner for cases with credible allegations of fraud.***

   Status at time of the review: Corrected

   The state corrected this finding in 2014 and provided the CMS review team with a 2014 email with documentation with revisions that were made to the contract language, which now contains language to comply with 42 CFR 455.23.

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

   Status at time of the review: Corrected

   The state corrected and cleared this item prior to the onsite review and provided the CMS review team with a copy of their new provider application.

The state does not adequately address business transaction disclosure requirements in its provider agreement or contracts. (Uncorrected Partial Repeat Finding)

Status at time of the review: Corrected

- The state made the necessary revisions to the NEMT provider agreement in 2014.
- The state corrected this finding as of October 1, 2014, when revisions were made to the contract language which now require the MCEs to comply with all elements contained in the regulation at 42 CFR 455.436.

3. ***The state does not capture all required criminal conviction disclosures from providers or contractors. (Uncorrected Repeat Finding)***

   Status at time of the review: Corrected

   The state corrected and cleared this item prior to the onsite review and provided the CMS review team with a copy of their new provider application.

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

Status at time of the review: Corrected

The state corrected and cleared this item as of March 2017 with its new procedure to centrally enroll all providers and with the implementation of their new MMIS.

4. ***The state does not provide notice of exclusion consistent with the regulation at 42 CFR 1002.212.***

Status at time of the review: Not corrected

The state is currently developing a policy and procedure for giving public notice of state-initiated terminations.

Vulnerabilities -

1. ***Not capturing ownership and control disclosures from network providers.***

Status at time of the review: Corrected

The state corrected and cleared this item as of March 2017 with its new procedure to centrally enroll all providers and with the implementation of their new MMIS.

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

Status at time of the review: Corrected

The state corrected and cleared this item as of March 2017 with its new procedure to centrally enroll all providers and with the implementation of their new MMIS.

3. ***Not capturing criminal conviction disclosures from network providers.***

Status at time of the review: Corrected

The state corrected and cleared this item as of March 2017 with its new procedure to centrally enroll all providers and with the implementation of their new MMIS.

4. Not conducting complete searches for individuals and entities excluded from participating in Medicaid. (Uncorrected Repeat Vulnerability)

Status at time of the review: Corrected

The state corrected and cleared this item as of March 2017 with its new procedure to centrally enroll all providers and with the implementation of their new MMIS.

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

Status at time of the review: Not corrected

The state has not corrected this item as of the date of the onsite review, although there is a contract requirement that calls for beneficiary verification of services billed.

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

Status at time of the review: Corrected

The state corrected the contract language and guidance on reporting adverse action to HHS-OIG.

Technical Assistance Resources

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

- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the Regional Information Sharing Systems for information provided by other states including best practices and managed care contracts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which may help address the risk areas identified in this report. Courses that may be helpful to Colorado 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.
- The CMS annual report of program integrity reviews includes highlights of states that have been cited for noteworthy and effective practices in managed care. These reports can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html.
- CMS provides a fraud prevention toolkit located on CMS.gov that includes:
    - The 4Rs (Record, Review, Report, and Remember) brochure
    - Fact sheets on preventing and detecting fraud
    - Frequently Asked Questions
    - The CMS.gov website also contains information regarding the Center for Program Integrity and fraud prevention efforts in Original Medicare (FFS), Part C and Part D, and Medicaid. For more information on the fraud prevention toolkit, visit CMS.gov/outreach-and-education/outreach/partnerships/fraudpreventiontoolkit.
    - For the latest news and information from the Center for Program Integrity, visit CMS.gov/about-cms/components/cpi/center-for-program-integrity.html.

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 Colorado to build an effective and strengthened program integrity function.