Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Michigan Comprehensive Program Integrity Review

Final Report

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Introduction and Executive Summary

The Centers for Medicare & Medicaid Services (CMS) regularly conducts reviews of each state's Medicaid program integrity activities to assess the state's effectiveness in combating Medicaid fraud, waste, and abuse. Through state comprehensive program integrity reviews, CMS identifies program integrity related risks in state operations and, in turn, helps states improve program integrity efforts. In addition, CMS uses these reviews to identify noteworthy program integrity practices worthy of being emulated by other states. Each year, CMS prepares and publishes a compendium of findings, vulnerabilities, and noteworthy practices culled from the state comprehensive review reports issued during the previous year in the *Annual Summary Report of Comprehensive Program Integrity Reviews*.

The purpose of this review was to determine whether Michigan's program integrity procedures satisfy the requirements of federal regulations and applicable provisions of the Social Security Act. A related purpose of the review was to learn how the State Medicaid agency receives and uses information about potential fraud and abuse involving Medicaid providers and how the state works with the Medicaid Fraud Control Unit (MFCU, known in Michigan as the Health Care Fraud Division, or HCFD) in coordinating efforts related to fraud and abuse issues. Other major focuses of the review include but are not limited to: provider enrollment, disclosures, and reporting; pre-payment and post-payment review; methods for identifying, investigating, and referring fraud; appropriate use of payment suspensions; and False Claims Act education and monitoring.

The CMS review team found the state's Medicaid program has risks in both its fee-for-service (FFS) and managed care program integrity activities. The areas of risk are related to program integrity oversight, fraud detection and investigation, and provider enrollment practices. All the issues identified and CMS's recommendations for improvement are described in detail in this report. CMS is concerned that some of the issues described in this review were also identified in CMS's 2010 review and are still partially uncorrected. CMS will work closely with the state to ensure that all issues, particularly those that remain from the earlier review are satisfactorily resolved as soon as possible.

Methodology of the Review

In advance of the onsite review, the review team requested that Michigan complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment, managed care, and relationship with the HCFD. The team also reviewed managed care contracts to determine whether managed care organizations (MCOs) were complying with contract provisions and federal regulations related to Medicaid program integrity. A four-person team reviewed the responses and materials that the state and MCOs provided in advance of the onsite visit. The team also conducted in-depth telephone interviews with representatives from the HCFD and three MCOs.

During the week of September 9, 2013, the CMS review team visited the Michigan Department of Community Health (MDCH) and conducted interviews with numerous MDCH officials as well as the dedicated program integrity staff in the Office of Health Services Inspector General

(OHSIG), which is part of the MDCH. Interviews also included staff from the Michigan Department of Human Services (MDHS), a sister agency, with whom MDCH coordinates one of Michigan's personal care services (PCS) programs, known as Home Help[1], and a statewide, county-based non-emergency medical transportation (NEMT) system. The team also conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate Michigan's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the OHSIG but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment and contract management, especially in the provision of managed care, waiver, and NEMT services. Michigan operates its Children's Health Insurance Program (CHIP) as a stand-alone Title XXI program. The stand-alone CHIP program operates under the authority of Title XXI and is beyond the scope of this review. Unless otherwise noted, Michigan 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 that the OHSIG provided.

Medicaid Program Integrity Unit

In Michigan, program integrity operations, oversight and surveillance and utilization review activities are principally located in the OHSIG although many program units have oversight roles in managed care. At the time of the review, the OHSIG had 40 full-time equivalent positions allocated to Medicaid program integrity functions and was led by an Acting Health Services Inspector General.

The table below represents the total number of preliminary and full investigations, and the amount of identified and recouped overpayments related to program integrity activities in the last four state fiscal years (SFYs). From SFY 2010-13 the number of preliminary investigations increased substantially due to multiple factors, including the greater use of data mining and audits, an increase in hiring in SFY 2013, and the use of streamlined processes to increase employee productivity. On the other hand, the increase in preliminary investigations has not resulted in a corresponding increase in overpayments collected for the same time period. The overpayments identified as a result of increased audit and data mining activity have resulted in an increased number of appeals, delaying actual recoupments.

Table 1

SFY	Number of Preliminary Investigations*	Number of Referrals to HCFD**	Amount of Overpayments Identified***	Amount of Overpayments Collected***
2010	561	65	Was not tracked	$10,205,026
2011	776	82	Was not tracked	$6,604,880
2012	1,308	41	$4,142,703	$1,685,831
2013	1,875	43	$878,780	$689,751

[1] Home Help is the term for the one of the personal care services programs in Michigan. See pages 4-5 below.

* 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. The OHSIG indicated that full investigations are conducted by the HCFD. As a proxy for full investigations by the state agency, this report has listed the number of referrals made annually to the HCFD.
***Figures do not include global settlements.

Results of the Review

The CMS review team found a number of risks related to program integrity in Michigan's Medicaid program. These issues fall into three areas of risk and are discussed below. To address these issues, Michigan should improve oversight and build more robust program safeguards.

Risk Area 1: Risks were identified in the state's oversight of program integrity activities.

Program Integrity Oversight of Personal Care Services

The delivery of PCS in Michigan is largely consumer directed with services principally offered through two programs: Home Help, which is part of the Medicaid State Plan, and MI Choice, a 1915(c) waiver program. MDCH does not sufficiently focus on fraud and abuse prevention and detection in its oversight of PCS for either program.

Home Help

Home Help operates in coordination between MDCH and MDHS. MDCH is responsible for overall administration of the Home Help program while MDHS has responsibility for day-to-day operations. Neither MDHS nor MDCH has adopted basic fraud and abuse safeguards in its oversight procedures. For example, neither performs exclusion checks or reports sanctioned providers. Nor has either agency provided fraud and abuse training to participants. Furthermore, very few fraud referrals originate from the Home Help program.

The payment system for the Home Help program also lacks adequate safeguards. Home Help claims are paid through the Adult Services Authorized Payment System (ASAP), which is separate from Michigan's Medicaid Management Information System (MMIS), known as Community Health Automated Medicaid Processing System (CHAMPS). The ASAP does not fully track personal care attendant activities and has limited edits to prevent duplication or other erroneous payments. This was demonstrated by the OHSIG's Surveillance and Utilization Review Subsystem unit when it compared Home Help claims data processed by ASAP to claims data processed by CHAMPS and found improper payments, including payments for PCS that overlapped with institutional stays and payments for services to deceased beneficiaries.

MI Choice

Program integrity oversight was also limited in the MI Choice program that offers home and community-based PCS through agencies and individual personal care attendants. MI Choice is administered by 20 regional waiver agencies that are located throughout the state. Although the waiver agencies compare claims with the authorization limits in a beneficiary's plan of care, time

sheets are not required to pay the claim. Furthermore, while waiver agencies are required by contract to report fraud and abuse to MDCH to initiate an investigation, there is no fraud and abuse guidance in the waiver agency contracts. The MDCH staff found cases where a beneficiary was hospitalized but a personal care attendant continued to bill. In these particular cases, the state reconciled with the waiver agency and money was recouped, but the case was not referred for investigation as there is not a process in place to share investigation/tracking sheets with the OHSIG. Although MDCH requires waiver agencies to report any fraud and abuse to OHSIG, during interviews, the state indicated that only one case was referred to the OHSIG in the last four years.

Comprehensive Program Integrity Work Plan, Policies and Procedures

The OHSIG SFY 2013 work plan focuses on data-mining scenarios but does not include a broad array of program integrity functions and activities, such as investigations and audits, which may have contributed to the low number of fraud referrals as further discussed in Risk Area 2. Although the OHSIG increased the number of staff from 25 to 40 from SFY 2012-13, the work plan was not revised to include specific training goals or work load targets for core program integrity activities. The lack of an adequate work plan creates a risk to the Medicaid program considering the state's status as a focal point of the U.S. Department of Health & Human Services – Department of Justice Health Care Fraud Enforcement Action Team (HEAT Strike Force).

Further, Michigan does not have policies and procedures for key program integrity functions and operations. In Michigan's FFS program, these areas include conducting services after death data matches, recovering overpayments, and performing sampling and extrapolation in audit and review activities where possible even though permitted by the state. The lack of written policies and procedures may lead to inconsistent operations and ineffective functioning in the event the state loses experienced program integrity or provider enrollment staff.

In the Michigan managed care program, 14 MCOs provide physical health services across the state, and managed behavioral health services are administered by 18 prepaid inpatient health plans (PIHP) using dual waiver authority under Sections 1915(b) and (c) of the Social Security Act. While the three MCOs interviewed by the team all had the required compliance plans in place, it is not clear if this is the case in the behavioral health services program. The PIHP contract requires a program integrity compliance plan that meets the specifications of 42 CFR 438.608; however, MDCH does not retain a copy of the compliance plans for any of the 18 PIHPs. Although there are procedures to review MCO compliance plans, MDCH does not have similar procedures to review the compliance plans submitted by the PIHPs.

Michigan's NEMT program is a joint endeavor between MDCH and MDHS. The current NEMT policies describe detailed service verification requirements and payment authorization procedures, as well as the need for review of whether transportation was being provided appropriately. However, these policies do not address actual fraud and abuse monitoring and data analysis. For instance, MDCH and MDHS NEMT policies do not have standard operating procedures for post-payment reviews based on an analysis of NEMT encounter data.

Recommendations:

- Implement comprehensive program integrity oversight of all PCS programs by ensuring that enrollment forms are revised to capture all the necessary information to perform complete exclusion searches. Provide training and guidance related to fraud and abuse detection and investigation, and implement procedures to track services to avoid duplicate or incorrect billing.
- Revise the program integrity work plan to include specific training goals or work load targets for all components of program integrity, such as investigations and audits. Share the work plan with other units in the state agency to facilitate coordination and incorporate program integrity within the mainstream of agency operations.
- Develop policies and procedures to facilitate stronger OHSIG oversight of essential program integrity activities such as conducting services after death data matches and obtaining overpayment recoveries. Ensure that contracted PIHPs have the required compliance plans in effect and that the state is reviewing the compliance plans. Include procedures for monitoring fraud, waste, and abuse in the comprehensive operational guidelines for the NEMT program.

Risk Area 2: Risks were identified in fraud detection and investigation.

Fraud Referrals

During the period SFY 2010-12, the OHSIG referred an average of 41 cases per year to the HCFD for investigation. These numbers appear low for a Medicaid program with annual expenditures totaling more than $10 billion and a program integrity unit with 40 FTEs. In SFY 2011-12, referrals from the OHSIG comprised 18% of all HCFD investigations and were primarily related to overprescribing activities.

At the time of the review, the HCFD was pursuing regulatory authority to conduct data mining activities and had filed an application with U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG), which has the potential to increase the number of cases for investigation.

Suspension of Payments in Cases of Credible Allegation of Fraud

Michigan is not in compliance with the requirements of the regulation at 42 CFR 455.23. Under Michigan's fraud referral procedure, the OHSIG is expected to send cases to the HCFD, which in turn is expected to determine whether a credible allegation of fraud exists within five days and indicate whether the OHSIG should suspend payments or invoke a good cause exception. The OHSIG indicated that cases sent to the HCFD are considered formal referrals while acknowledging that in many of these cases, the preliminary investigation has not established a credible allegation of fraud. While CMS encourages states to communicate frequently with the MFCU and does not limit who a state may consult with in order to determine that an allegation of fraud is credible, the regulation at 42 CFR 455.23(a) requires that upon the State Medicaid agency determining that an allegation of fraud is credible, the state must suspend Medicaid

payments to a provider, unless the agency has good cause to not suspend payments or to suspend only in part.

During the review, the review team examined thirteen case files from SFY 2011-12 involving referrals made to the HCFD after March 25, 2011. In seven cases, there was no communication from the HCFD regarding whether the state agency should suspend payments or invoke a good cause exception at the request of law enforcement. In four cases, the providers had either left the program or been suspended for prior infractions, so no payment suspension was necessary. The HCFD was working on the remaining two cases and had properly suspended payments in one of them. The number of referrals is quite low in a state that has been targeted by the HEAT Strike Force as a high-risk area.

The review team found the state agency to be out of compliance with other provisions in 42 CFR 455.23 as well. OHSIG staff indicated that they had not requested quarterly certifications of payment suspensions from the HCFD, although 42 CFR 455.23(d)(3)(ii) requires the state to obtain quarterly MFCU certifications for suspensions to remain in effect. In addition, the OHSIG has not reported annual summary information on payment suspensions to CMS as required by 42 CFR 455.23(g)(3). The state indicated that they have not obtained access to the web based portal through which these reports must be transmitted.

Fraud and Abuse Awareness Training

Although OHSIG staff has regularly obtained program integrity training through the Medicaid Integrity Institute, the benefits of this training have not always been reflected in cross-training for other components within the state agency, such as managed care, NEMT, or waiver program staff. This may contribute to the relatively low number of referrals to the HCFD as discussed above. The MDCH Managed Care Plan Division meets with MCOs bi-monthly but OHSIG only recently began to train MCO personnel on fraud, waste, and abuse prevention and detection. The only confirmed training was held in June 2013. The MDCH staff who oversee the MI Choice program also have not received formal training in how to report suspected fraud and abuse. Furthermore, the PIHPs who are responsible for providing behavioral health services to managed care beneficiaries have not received basic training regarding the statutory and regulatory requirements related to fraud and abuse prevention and detection. Michigan's FFS and managed care programs would benefit from more fraud and abuse awareness training.

Recommendations:

- Refine current payment suspension practices to ensure that OHSIG determines whether an allegation of fraud is credible. As soon as OHSIG's 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 and refer the cases to the HCFD. Ensure that all referrals to the HCFD comply with CMS Fraud Referral Performance Standards[2]. Work with the HCFD to obtain more timely updates on referred cases and document quarterly certifications for all ongoing payment suspensions. Obtain access to the web portal and report payment suspension information

[2] http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/downloads/fraudreferralperformancestandardsstateagencytomfcu.pdf

to CMS. More information on this process is located in the Technical Assistance Resources section of this report on page 14.

- Develop and schedule comprehensive program integrity training for MDCH, MDHS, and MCO staff, including topics such as developing case files and fraud and abuse detection. Engage the HCFD to assist in developing and delivering fraud and abuse training.

Risk Area 3: Risks were identified in the state and MCO provider enrollment practices and reporting.

Ownership and Control Disclosures

Michigan requires most FFS providers and, beginning in SFY 2013, all managed care providers to centrally enroll through the state via CHAMPS. As of the time of the review, the state indicated that all but ten managed care network providers were enrolled with the state in CHAMPS using an option to enroll as a managed care-only provider. The state has made several revisions and improvements in CHAMPS to comply with federal ownership and control disclosure requirements. However, CHAMPS does not collect the enhanced address information for disclosing entities as required by 42 CFR 455.104(b)(1)(i). The enhanced address must include the primary business address, every business location, and P.O. Box address (as applicable).

Further, the full range of ownership and control disclosures are not captured from the MCOs and providers in several of the state's other special programs. For example, in managed care the MDCH utilizes a state form (*Ownership Information Collection Form*) to collect ownership and control disclosure information from the MCOs and the remaining non-centrally enrolled network providers. However, the form is incomplete. It does not solicit three key areas of disclosure: enhanced address information; whether any of the disclosed persons, individual or corporate, are related to persons (individual or corporate) in another disclosing entity as spouse, parent, child, or sibling; and the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. Despite the missing elements on the form, two of the MCOs reviewed submitted all the required disclosure information voluntarily. However, one of the three did not. It only disclosed corporate ownership information while omitting information about agents, managing employees, board of director members, and relationships among the parties named.

Additionally, the NEMT broker's enrollment form for network providers who are not enrolled directly by the state does not require the disclosure of managing employees and their address, date of birth, and Social Security number. This issue remains uncorrected since the 2010 CMS review.

The state's contract with the PIHPs includes a requirement to provide the complete disclosure information specified in 42 CFR 455.104. However, at the time of the review, this information had not been collected or verified by the MDCH. Although required by contract, eight of 18 PIHPs do not require the full range of ownership and control disclosures from their network providers. The state indicated that it had only limited policies and procedures in place for

monitoring PIHP compliance with contractual obligations related to ownership and control disclosures.

In the Home Help program, MDHS enrolls both personal care services agencies and individuals as personal care attendants, but does not use an enrollment form that captures complete disclosure information necessary to conduct complete exclusion searches.

In the MI Choice program, the state advises waiver agencies to ensure provider compliance with the 42 CFR 455.104 requirements, but MDCH staff could not confirm that disclosure collection tools were in use or whether the state required use of a standard form. Furthermore, the state does not conduct a systematic look-behind of enrollment practices.

Lastly, as part of the contracting process, Medicaid agencies are required to collect ownership and control disclosures from fiscal agents. Michigan contracts with a fiscal intermediary for pharmacy services. The fiscal intermediary reported that it is owned by a parent company and included a list of indirect owners with its disclosures; however, the date of birth and Social Security number for disclosed names was not on file and no information was available on managing employees or agents.

Criminal Offense Disclosures

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 since the inception of those programs for each person with ownership or control interest in the provider, or who is an agent or managing employee of the provider. Michigan's enrollment forms lack a specific reference to requiring disclosures since the inception of Medicare, Medicaid, or Title XX programs. Additionally, no standard forms are used by waiver agents in the MI Choice program; consequently, the MI Choice providers they enroll are not uniformly asked to disclose criminal conviction history.

In the county-based NEMT program administered by MDHS, the state does not solicit criminal disclosure information at the NEMT broker level, nor are providers asked for these disclosures. In the broker program run by MDCH, the standard provider enrollment form is used and has the same deficiencies described above. These issues were also identified in the 2010 CMS review.

The contract between the MDCH and MCOs includes all of the elements required by 42 CFR 455.106; however, the language in the standard MDCH disclosure form which is used to solicit criminal disclosure information is not consistent with that of the contract. For example, none of the statements in the form reference the requirement for disclosure of convictions since the inception of Medicare, Medicaid, or Title XX programs or solicit criminal conviction history on agents or managing employees of the provider. The convictions section of the MDCH form only relates to felonies and specific misdemeanors and does not reflect the requirements of the federal regulation. In addition, the CMS review team studied the disclosure forms completed by three MCOs and found that one did not capture complete criminal history information on its managing employees, board of directors, and agents.

The MDCH requires PIHPs and their network providers to adhere to the requirements specified in 42 CFR 455.106; however, PIHPs do not complete a criminal history disclosure at the point of contracting or renewal. There are a variety of provider agreements used by the PIHPs to enroll providers, and the state does not conduct oversight to determine whether network providers in the PIHP are disclosing criminal conviction history.

Requesting Business Transaction Information

Business transaction disclosure obligations are missing from selected contracts and provider agreements that are executed outside of the CHAMPS system. For example, the provider agreement in the Home Help program does not include a requirement to provide business transaction information upon request as specified by 42 CFR 455.105. This issue was also identified in the 2010 CMS review. In addition, the CMS review team found that the MDCH contract with the NEMT broker does not require the contractor to furnish business transaction information, nor does the contract between the broker and its network providers contain language that requires them to disclose business transactions with wholly owned suppliers or any subcontractor upon request.

At the managed care network provider network level, only one of three MCO contracts reviewed contained a requirement that providers furnish information about their business transactions with wholly owned suppliers or any subcontractor upon request.

Exclusion Searches

During the provider enrollment walkthrough, MDCH staff demonstrated the ability to properly search all disclosed names in appropriate federal exclusion databases. However, during contract procurement with MCOs, the MDCH did not capture all required ownership and control disclosures as discussed earlier in this Risk Area. Accordingly, the MDCH is unable to verify the exclusion status of all persons with an ownership or control interest or who are agents or managing employees of MCOs through routine checks of federal databases.

Issues with exclusion verification also extend to MCO providers. Contractually, MCOs are required to perform regular checks on the exclusion status of network providers and any person with an ownership or control interest or who is an agent or managing employee of these providers. However, two of the three MCOs reviewed did not check the exclusion status of the managing employees of their network providers and subcontractors on a monthly basis.

In the Home Help program, the state reported that exclusion checking of individual providers is not performed as part of the enrollment process or monthly on either an entity or provider network level. In the MI Choice program, MDCH staff could not confirm whether exclusion checking at enrollment and monthly was conducted on any names disclosed.

These risks also extend to the NEMT program. The MDCH is not able to verify the exclusion status of persons with ownership or control interest, agents, or managing employees of the NEMT broker. In the county-based NEMT program, the CMS review team discovered that MDHS/MDCH does not check providers against any federal exclusion databases.

Permissive Exclusions

The regulation at 42 CFR 1002.210 requires that states institute administrative procedures to exclude a provider for any reason for which the HHS-OIG could exclude a provider under 42 CFR Parts 1001 and 1003. Although Michigan has permissive exclusion authority to exclude or terminate a provider from the Medicaid program for a variety of reasons (as documented in the provider agreement's terms and conditions), the state indicated that it does not initiate use of this authority. The only terminations it takes are the result of indictments or convictions ordered by a state or federal court, HHS-OIG exclusions, or license revocations by a state professional board.

Adverse Actions

The regulation at 42 CFR 1002.3 requires reporting to HHS-OIG any adverse actions a state takes to limit the ability of an individual or entity to participate in its program, regardless of what such an action is called. This includes, but is not limited to, suspension actions, settlement agreements, enrollment denials for cause, and situations where an individual or entity voluntarily withdraws from the program to avoid a formal sanction.

The OHSIG does not have clear policies and procedures on reporting adverse actions to the HHS-OIG. In addition, the state noted that it does not report "for cause" enrollment denials to the HHS-OIG. While the MDCH mandates Medicaid MCOs to report any adverse actions taken on providers, MDCH lacks standard operating procedures to document and track referrals resulting from actions taken. If MDCH does not document reported adverse actions it will not be in a position to report these to HHS-OIG as required.

One of three MCOs interviewed by the CMS review team did not report "for cause" enrollment denials of new providers in accordance with its contract. It was also determined that this MCO only considered for-cause sanctions against existing network providers to be adverse actions, although by contract, adverse action reporting expressly includes enrollment denials made for cause. This creates a risk because state and federal regulatory agencies must be made aware when excluded individuals are attempting to enter the Medicaid program.

Adverse action reporting was also an issue in the NEMT programs. MDCH's contract does not direct the NEMT broker to report all adverse actions taken on provider participation related to fraud, integrity, and quality to the state. Furthermore, the interagency agreement between the MDCH and the MDHS for transportation services does not require adverse action reporting so enrollment denials or adverse actions taken against a provider are not generally reported and, when reported, are informal. The interagency agreement requires that providers meet federal and state requirements but these requirements are not specified.

Application Fees

Michigan has enrolled 592 Medicaid-only providers since the provider screening and enrollment provisions at 42 CFR 455 Subpart E took effect on March 25, 2011. Providers who are not already enrolled in Medicare or with another state Medicaid program are subject to the collection of application fees; however, MDCH staff indicated fees were not currently being collected. A

procedure for using CHAMPS to collect application fees from these providers was in development at the time of the review.

False Claims Act Education

The state is not following its compliance review protocol in accordance with its State Plan on False Claims Act education requirements. The State Plan requires the state to annually determine what providers are covered entities following Section 1902(a)(68) of the Social Security Act [42 U.S.C. 1396a(a)(68)] and verify that providers are meeting the requirements of this statutory requirement. The OHSIG identified 619 providers during SFY 2010-12 that are subject to this reporting requirement and drafted provider attestation documents; however, the attestation documents were awaiting clearance from the State Medicaid agency, and the OHSIG had not implemented any look-behind activities as stipulated in the State Plan.

Recommendations:

- Resolve the limitations in CHAMPS to capture all required disclosure information at the time of enrollment of FFS and managed care providers, and to enable the collection of application fees from prospective or reenrolling Medicaid-only providers to help cover the cost of provider screening activities.
- Revise the state's *Ownership Information Collection Form* to ensure that complete ownership and control disclosure information is obtained from the MCOs and the remaining non-centrally enrolled network providers. Require the NEMT broker to revise their enrollment form for network providers not directly enrolled by the state to ensure it captures the full range of ownership and control disclosures
- Ensure that MCO and subcontractor enrollment applications solicit information about the criminal history of persons with ownership and control interests, agents or managing employees. Develop and implement a process to ensure that neither the state nor its MCOs are affiliated with any individual or entity prohibited from receiving federal funds. At a minimum, either the state or the MCOs should search any person with an ownership or control interest or who is an agent or managing of the provider against the Excluded Parties List System located on the System for Award Management and the List of Excluded Individuals and Entities during the enrollment process and monthly thereafter.
- All provider agreements used by MCOs and their subcontractors should require providers to furnish the state or HHS Secretary with information about certain business transaction information upon request. Update the business transaction disclosure obligations that are missing from selected contracts and provider agreements that are executed outside of CHAMPS.
- Utilize the state's permissive exclusion authority independently at the state agency's initiative as warranted.
- Review and revise the OHSIG, MDHS, MDCH, and MCO policies and procedures for reporting adverse actions to the HHS-OIG.
- Implement the compliance review protocol associated with the state's False Claims Act education requirements which is outlined in Michigan's approved State Plan.

Effective Practices

As part of its comprehensive review process, CMS also invites each state to self-report practices that it believes are effective and demonstrate its commitment to program integrity. CMS does not conduct a detailed assessment of each state-reported effective practice.

The state centrally enrolls all managed care entities and network providers in CHAMPS

The State Medicaid agency enrolled all FFS providers, MCOs, and almost all of their network providers in CHAMPS, Michigan's MMIS. The state has actively reached out to providers who have not enrolled and reported that only ten providers across all plans had not yet enrolled in the system at the time of the review. The MCOs have encouraged all their providers to register in the state's enrollment system and are working actively with the state to engage all providers. Registration in CHAMPS allows providers to indicate their status as managed care-only, yet requires the completion of the full Michigan enrollment application, which includes collection of comprehensive ownership and control information that mirrors FFS enrollment. The state is moving toward enrolling virtually all providers who serve Medicaid beneficiaries. Those still to be enrolled include the remaining providers in managed care, PCS, NEMT, and other home and community based waiver services.

Notwithstanding the effectiveness of centrally enrolling all providers in CHAMPS, the CMS review team identified risks in the provider enrollment process in Michigan, which are detailed in Risk Area 3.

The state has put into service a Medicaid claims screening system which identifies and flags Medicaid claims for billing irregularities

In February 2013, the MDCH implemented a claims screening system to proactively identify potential inaccurate billing scenarios before all FFS claims are paid through CHAMPS. This system identifies inaccurate billings, flags billings that deviate from statistical models, and ensures that only authorized providers and provider types are submitting specific types of billings.

If a claim is flagged as suspect, it is pended in CHAMPS until state staff can determine if it requires further review. If necessary, the state will request documentation and conduct a clinical review. The software system is designed to be self-learning. It will incorporate the logic behind denied claims in algorithms that are applied to future claims. The software is also programmed to identify sudden changes in provider billing patterns and to pend these claims or claim types for review.

According to the state, refinements in the software are still needed. At times there have been "false positives" which inappropriately held up claims. However, one area where the software has been most useful is in screening laboratory claims for unbundled services.

As of September 2013, the Michigan screening system had flagged a total of 26,456 claims with a total value of $110,615,472. These figures include 4,347 total claims denied with a potential

savings (or cost avoidance) of $6,324,578. An additional 2,695 claims worth $3,451,407 are awaiting additional documentation.

Technical Assistance Resources

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

- Consult with CMS and other states to develop a process to ensure the state has adequate controls in place to oversee the personal care services being provided in Michigan. Refer to the HHS-OIG's 2012 portfolio on personal care services for additional recommendations to improve the integrity of personal care services in Medicaid. More information can be found at https://oig.hhs.gov/reports-and-publications/portfolio/portfolio-12-12-01.pdf.
- Consult with other states that have large Medicaid managed care programs to discuss best practices for effective program integrity oversight of managed care to address the issues identified in Risk Area 1. These include areas such as training for managed care staff regarding program integrity issues, MCO contract compliance reviews, monitoring of MCO exclusion searches, and evaluation and mining of MCO encounter data.
- Consult CMS guidance on payment suspensions including the March 25, 2011 Informational Bulletin located at http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/payment-suspensions-info-bulletin-3-25-2011.pdf to develop a payment suspension process that is consistent with federal regulations and guidance. CMS can also refer Michigan to states that are further along in this process to address the areas of non-compliance identified is Risk Area 2. To gain access to website portal to facilitate annual reporting of payment suspension information to CMS, please follow these steps:
    - Go to: www.medicaid.gov
    - Select the "State Resources" tab near the top of the page
    - Select the "Medicaid and CHIP Program Portal" option
    - Medicaid Model Data Lab will appear as an option, select "Enter" on the right
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the provider enrollment folders in RISS for information provided by other states regarding provider enrollment applications to address the full range of disclosure requirements as outlined in Risk Area 3.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute, particularly those that relate to provider enrollment and managed care. More information can be found at http://www.justice.gov/usao/training/mii/training.html.
- Continue to 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.
- Access the annual program integrity review summary reports on CMS's website. These reports contain information on noteworthy and effective program integrity practices in states. We recommend that Michigan review the noteworthy practices on provider enrollment and disclosures and the effective practices in program integrity and consider

emulating these practices as appropriate. The state should also review effective practices related to the handling of terminated providers to address the issues identified in Risk Area 3.

Summary

The instances of risk and non-compliance with federal regulations are of great concern and should be addressed immediately, particularly related to oversight of personal care services. CMS is also concerned about uncorrected, repeat risks that remain from the time of the agency's last comprehensive program integrity review in 2010.

We require the state to provide a corrective action plan (CAP) for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place and identify which area of the State Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. Please 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 plan should identify those corrections as well.

CMS looks forward to working with Michigan to strengthen the effectiveness of its program integrity function.

Official Response from Michigan
November 2014

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

December 1, 2014

Peter Leonis
Director of the Division of Field Operations
Peter.Leonis@cms.hhs.gov

Dear Mr. Leonis:

I am in receipt of a letter from Mark Majestic dated October 17, 2014 as well as the Medicaid Integrity Program, Michigan Comprehensive Program Integrity Review Final Report date October 2014. The Michigan Department of Community Health appreciates the two effective practices highlighted and discussed in the Final Report as well as the opportunity to submit a corrective action plan in response to the regulatory compliance issues identified in the Final Report. As requested, we are also including a description of how the identified vulnerabilities will be addressed.

Please contact me if you have further questions. Thank you.

Sincerely,

Stephen Fitton
Medicaid Director

Enclosure

cc: Jackie Garner, CMCHO Consortium Administrator
Verlon Johnson, DMCHO Associate regional Administrator
David Tanay, MFCU Director
Gene Adamezyk, MDCH Inspector General
Pam Myers, MDCH Audit Liaison