Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Michigan Focused Program Integrity Review

Final Report

February 2016

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Objective of the Review

The Centers for Medicare and Medicaid Services (CMS) conducted a focused review to determine whether Michigan has fully implemented the requirements of federal regulations at 42 CFR 455 Subpart E that implemented the enhanced provider screening and enrollment provisions of the Affordable Care Act. This review also determined the extent of program integrity oversight present in the state managed care program and assessed the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state. The review also included a follow up on the state's progress in implementing its corrective action plan (CAP) related to CMS's last program integrity review in 2013.

Background: State Medicaid Program Overview

The Michigan Department of Community Health (MDCH) administers the Medicaid program. As of July 1, 2014, enrollment in the program exceeded 1.8 million beneficiaries. The state's Medicaid expenditures in federal fiscal year 2013 were more than $12 billion; the Federal Medical Assistance Percentage for Medicaid was 66.39%. Approximately 73% of all beneficiaries are enrolled in one of thirteen risk-based MCOs performing Medicaid services in 83 counties within the state of Michigan.

Michigan also has 10 prepaid inpatient health plans (PIHPs), 22 waiver agents and 1 non-emergency medical transportation (NEMT) vendor that have waiver authority to operate under Sections 1115 or 1915(b) and (c) of the Social Security Act. These plans were beyond the scope of this managed care focused review. The MDCH Office of Inspector General (OIG) is the program integrity unit within MDCH that is responsible for providing oversight to the program integrity activities in the Michigan Medicaid program.

Methodology of the Review

In advance of the onsite visit, CMS requested that Michigan complete a review guide that provided the review team detailed insight into the operational activities of the areas that were subject of the focused review. The team also obtained a copy of Michigan's State Plan Amendment (MI SPA 12-003) attesting to compliance with the enhanced provider screening and enrollment requirements of 42 CFR 455 Subpart E, which became effective on June 1, 2012. A six-person team reviewed the responses and materials that the state provided in advance of the onsite visit.

During the week of Jan 5-9, 2015, the CMS review team visited MDCH and other state agencies, as well as program integrity staff from four MCOs. The team conducted interviews with MDCH staff involved in program integrity, provider enrollment, and managed care. The MCOs interviewed included: Molina Healthcare of Michigan; HAP Midwest Health (a subsidiary of Health Alliance Plan) Plan; UnitedHealthcare Community Health Plan, Inc.; and McLaren Health Plan. Additionally, the team sampled provider enrollment applications, managed care investigations, and other primary data to validate Michigan's enhanced provider screening and enrollment practices and the selected MCO program integrity practices.

Results of the Review

The review team identified areas of concern and instances of regulatory non-compliance in the state's provider enrollment operation along with its program integrity activities and managed care oversight, thereby creating risk to the Medicaid program. These issues and CMS's recommendations for improvement are described in detail in this report. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved.

As detailed throughout the report, Michigan is in the process of implementing modifications to its Medicaid Management Information System, which it expects to be operational in state fiscal year 2016. In addition to its Medicaid Management Information System modifications, the state reported that modifications to the Community Health Automated Medicaid Processing System (CHAMPS) are responsible for the delays in implementing many of the enhanced provider screening and enrollment provisions.

Section 1: Affordable Care Act Provider Screening and Enrollment

Overview of the State's Provider Enrollment Process

The MDCH is the primary agency responsible for provider enrollment and screening within the Medicaid program, as well as their respective waiver programs. Michigan reports that over 90% of its managed care network providers are centrally enrolled in CHAMPS. Providers enrolling in Michigan are required to complete online provider enrollment applications.

42 CFR 455.410: Enrollment and screening of providers
The regulation at 42 CFR 455.410 requires that the State Medicaid agency: (a) screen all enrolled providers; and (b) enroll all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan as participating providers; and (c) the State Medicaid agency may rely on the results of the provider screening performed by any of the following: (1) Medicare contractors. (2) Medicaid agencies or Children's Health Insurance Programs of other states.
The state is in compliance with this regulation.
Michigan requires all ordering and referring providers to enroll in Medicaid as participating providers.
Recommendation: None
42 CFR 455.412: Verification of provider licenses
The regulation at 42 CFR 455.412 requires that the State Medicaid agency: (a) have a method for verifying that any provider purporting to be licensed in accordance with the laws of any state is licensed by such state; and (b) confirm that the provider's license has not expired and that there are no current limitations on the provider's license.
The state is in compliance with this regulation.

At enrollment, all provider licenses are screened through the Provider Credential Screening process which is contracted through a vendor. If a provider license is not active, the provider is not enrolled. The MDCH currently contracts its provider license verification process to a vendor that provides a daily interface with Licensing and Regulatory Affairs, which updates provider records. When a provider loses licensure, the system end dates the enrollment the same business day. In addition, if there is a limitation of the licensure, a request is made for documentation from the provider with consultation with the OIG if there are any questions regarding actions taken against the provider.

For licensure that is expiring, the provider receives a letter 45 days prior to the expiration of a license. If an update is not received within the 60 day grace period the provider is dis-enrolled.

Recommendation: None

42 CFR 455.414: Revalidation of enrollment

The regulation at 42 CFR 455.414 requires that the State Medicaid agency revalidate the enrollment of all providers regardless of provider type at least every 5 years.

The deadline has been revised according to *Sub Regulatory Guidance for SMAs: Revalidation (2016-001).* The purpose of this guidance is to align Medicare and Medicaid revalidation activities to the greatest extent possible. The new requirement is now a two-step deadline under which states must notify all affected providers of the revalidation requirement by the original March 24, 2016 deadline, and must have completed the revalidation process by a new deadline of September 25, 2016.

The state is potentially at risk of non-compliance with this regulation for both the March 25, 2016 and September 25, 2016 deadlines.

Michigan indicated all providers were initially revalidated in 2008 and the state is currently in its second cycle of revalidation that started April 1, 2014 and will conclude by the end of state fiscal year 2017. Therefore, Michigan runs the risk of not being compliant, unless the current revalidation schedule is accelerated and all remaining providers actually get revalidated by September 25, 2016. Michigan indicated they intend to accelerate the revalidation schedule in order to fully comply with the regulation.

All providers will be required to revalidate their Medicaid enrollment information a minimum of once every five years, or more often if requested by MDCH. The MDCH will notify providers when revalidation is required. Providers are reminded that they must notify MDCH within 35 days of any change to their enrollment information.

MDCH provides 90 days notice to the revalidate. If a provider does not meet the deadline, the provider's enrollment status is changed to incomplete. Thereafter, the provider is responsible for completing the application, verifying the information provided, and submitting it for review before their cycle end date. Another reminder notification is sent 30 days prior to the end date. If the provider does not revalidate, then their enrollment status is end dated.

Recommendation: Develop and implement a process that will meet the revalidation requirements for all eligible providers by the stipulated deadline of September 25, 2016.

42 CFR 455.416: Termination or denial of enrollment
The regulation at 42 CFR 455.416 describes several conditions under which a State Medicaid agency must terminate or deny enrollment to any provider. These include situations in which the Medicare program or another state Medicaid or Children's Health Insurance Program (CHIP) has terminated a provider for-cause on or after January 1, 2011 unless the State Medicaid Agency determines that denial or termination of enrollment is not in the best interests of the Medicaid program and documents that determination in writing.
The state is in compliance with this regulation.
The MDCH provided the review team with its policies and procedures to deny or terminate providers who have been denied or terminated by Medicare or another state's Medicaid or CHIP as required by the regulation. Furthermore, the state has access to the CMS server, which lists for-cause terminations taken by Medicare and other states and reports their state initiated actions to CMS for inclusion on this list.
Recommendation: None

42 CFR 455.420: Reactivation of provider enrollment
The regulation at 42 CFR 455.420 requires that the State Medicaid agency, after denial or termination of a provider for any reason, require the provider to undergo rescreening and pay the associated application fees pursuant to 42 CFR 455.460.
The state is in partial compliance with this regulation.
The state requires providers who have been deactivated or terminated to resubmit the enrollment documents required for an initial enrollment and undergo rescreening. However, the state does not have a process to collect the associated application fees. The state indicated that a process to collect application fees for reactivated Medicaid-only institutional providers will be implemented with the new modifications to CHAMPS.
Recommendation: Ensure the state collects the appropriate application fees from any applicable providers during the reactivation process.

42 CFR 455.422: Appeal rights
The regulation at 42 CFR 455.422 requires that the State Medicaid Agency give providers terminated or denied pursuant to 42 CFR 455.416 any appeal rights available under state law or regulations.
The state is in compliance with this regulation.
Michigan provides appeal rights to providers denied enrollment pursuant to 42 CFR 455.416 as evidenced by state statute and regulatory citations as well as policies and procedures for provider appeal rights.
Recommendation: None

42 CFR 455.432: Site visits
The regulation at 42 CFR 455.432 requires that the State Medicaid agency conduct pre-enrollment and post-enrollment site visits of providers who are designated as ''moderate'' or ''high'' categorical risks to the Medicaid program.
The state is in partial compliance with this regulation.
The state is conducting site visits for newly enrolled, high risk durable medical equipment providers, home health agencies, and laboratories. This constitutes only high risk level

providers and is not an all-inclusive list of providers who should have site visits conducted or should be identified as "moderate" or "high" risk. Therefore, due to the state's inability to conduct all moderate level site visits, the state is only partially in compliance with this regulation.

Recommendation: Develop and implement a process to conduct pre and post-enrollment site visits of all providers categorized as "moderate" and "high" risk. Or, where appropriate, the state can either verify that a site visit was performed within the prior 12 months by Medicare using the Medicare Provider Enrollment Chain and Ownership System, or confirm that a visit was completed by another state.

42 CFR 455.436: Federal database checks

The regulation at 42 CFR 455.436 requires that the State Medicaid Agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on 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 (DMF), the National Plan and the Provider Enumeration System (NPPES) upon enrollment and reenrollment; and check the LEIE and EPLS no less frequently than monthly.

The state is in compliance with this regulation.

In 2013, the state procured an online database system (CHAMPS) that includes checking all federally required data bases upon enrollment and re-enrollment. Verifications of the LEIE and EPLS/SAM are completed monthly thereafter.

Recommendation: None

42 CFR 455.440: National Provider Identifier

The regulation at 42 CFR 455.440 requires that the State Medicaid Agency must require all claims for payment for items and services that were ordered or referred to contain the NPI of the physician or other professional who ordered or referred such items or services.

The state is not in compliance with this regulation.

The state claim forms for items ordered, referred or prescribed are required to have the ordering, referring or prescribing provider's NPI on it. However, the state does not have system edits in place to edit for claims that do not contain the NPI.

Recommendation: Develop and implement systems edits to deny claims that do not contain the NPI of ordering, preferring or prescribing providers.

42 CFR 455.450: Screening levels for Medicaid providers

The regulation at 42 CFR 455.450 requires that the State Medicaid Agency must screen all initial applications, including applications for a new practice location, and any applications received in response to a reenrollment or revalidation of enrollment request based on a categorical risk level of ''limited,'' ''moderate,'' or ''high.''

The state is partially in compliance with this regulation.

The state designated ''limited,'' ''moderate,'' or ''high'' screening levels for its Medicaid providers. The state's process also meets the denial or termination of enrollment provision of

the regulation. However, the state does not have a process to elevate the risk level actually in place when any of the following occurs: • The State Medicaid agency imposes a payment suspension on a provider based on credible allegation of fraud • The provider has an existing Medicaid overpayment • The provider has been excluded by the OIG or another State's Medicaid program within the previous 10 years. • A provider who was denied enrollment due to a temporary moratorium imposed on that particular provider type by the State Medicaid agency or CMS, reapplies within 6 months of the moratorium being lifted.
Recommendation: The state must develop a process to elevate the category of risk level (i.e. from "limited" to "moderate") due to payment suspension based on credible allegation of fraud, Medicaid overpayment status, OIG/Medicaid Program exclusion status, or after lifting of a temporary moratorium.
42 CFR 455.460: Application fee
The regulation at 42 CFR 455.460 requires the State Medicaid agency to collect the applicable application fee prior to executing a provider agreement from certain prospective or re-enrolling Medicaid-only providers as stipulated in the regulation.
The state is not in compliance with this regulation.
The state does not have a process to collect the applicable application fees from enrolling or re-enrolling Medicaid-only providers. The MDCH anticipates collecting application fees by March 2016 when the online CHAMPS provider enrollment modifications are completed.
Recommendation: Develop and implement a process to collect the appropriate application fees for enrolling or re-enrolling Medicaid-only providers.
42 CFR 455.470. Temporary moratoria
The regulation at 42 CFR 455.470 requires the State Medicaid agency to impose temporary moratoria on enrollment of new providers or provider types identified by the Secretary as posing an increased risk to the Medicaid program unless the State Medicaid agency determines that imposition of a temporary moratorium would adversely affect beneficiaries' access to medical assistance.
The state is in compliance with this regulation.
The moratoria imposed in the state are those placed by CMS. The state currently has a federally-imposed moratorium on home health agencies.
Recommendation: None

Provider Enrollment and Screening in Managed Care

Michigan's managed care program is exposed to the same vulnerabilities and risks that are addressed in the fee-for-service (FFS) program, since nearly all MCO providers are enrolled by the state. In addition, the remaining 10% of providers not centrally enrolled by the state would be exposed to additional risks as the state relies on the MCOs or sister agencies to ensure that

excluded providers are not operating within their networks. These vulnerabilities continue to be tracked through the CAP currently in place and are summarized at the end of this report.

The state's contract does include provisions related to some of the regulations at 42 CFR 455 Subpart E, but does not directly require the contractor to conform to all of the regulations within this subpart. Below are the CMS review team's observations:

- Provider Enrollment and Credentialing: Only two of the plans require that all of their network providers be enrolled by the state. One plan currently does have all its providers enrolled in CHAMPS, but it is not a contract requirement to do so. The other plan reported that a small percentage is not enrolled in CHAMPS. All plans are re-credentialing their network providers at least every three years. All plans are checking licenses of their providers for each state where the provider is licensed, and they have systems established to continue to monitor these monthly.

- Provider Risk Levels and Site Visits: None of the plans assign low, medium, or high risk designations to all providers, as federal regulations require in the FFS Medicaid program. All of the plans rely on National Committee for Quality Assurance standards for credentialing. The lack of assignment of risk screening levels, a process to elevate the risk screening levels, and performance of the necessary provider site visits puts the plans' Medicaid dollars at risk.

- Provider Terminations: All MCOs report terminated providers on the state's "Quarterly Managed Care Activity Report." Terminations for any reason are included in this report. In turn, the state will notify MCOs of any terminated providers in FFS or from other MCOs.

- Federal Database Checks: All of the plans are checking the LEIE and the EPLS/SAM at credentialing and recredentialing. Two of the plans reviewed are conducting ongoing monthly checks of the LEIE and EPLS/SAM for all persons with an ownership or controlling interest, agents, and managing employees. The other two plans are only checking the provider's name on a monthly basis. One plan did not have the capacity to store all the names of persons with an ownership or controlling interest, managing employees, and agents in their system. All plans but one are checking the NPPES at credentialing and recredentialing to confirm the NPI of the provider. One plan is checking this site on a monthly basis after the provider was enrolled in their network. Only one plan was checking applicants against the DMF, although this is required by the state in its contract with the MCOs.

Section 2: Managed Care Program Integrity

Overview of the State's Managed Care Program

Michigan's Medicaid program consisted of approximately 1.8 million beneficiaries. In federal fiscal year 2013, Michigan had annual expenditures (total Medicaid dollars) exceeding $12.3 billion. 73% of all beneficiaries are enrolled in one of thirteen risk-based MCOs performing

Medicaid services in 83 counties within the state of Michigan. As mentioned previously, Michigan also has 10 PIHPs, 22 waiver agents and 1 NEMT vendor that have waiver authority to operate under Sections 1115 or 1915(b) and (c) of the Social Security Act. Approximately 90% of all Michigan Health Plan providers are currently enrolled in CHAMPS, with the goal of reaching 100% of the network providers in CHAMPS in the near future.

All MCOs are paid a pre-determined capitation rate to manage all enrolled beneficiary healthcare services, while the MCO providers are paid by the MCOs under a FFS arrangement, a capitation rate arrangement, or a combination of both (with the exception of NEMT, which is paid for on a FFS basis by the state). In October 2013, the MI Choice program that offers home and community-based personal-care services through the 22 waiver agencies, and pays those agencies a capitated rate, transitioned from FFS to managed care.

Summary Information on the Plans Reviewed

The CMS review team interviewed staff from MDCH, as well as the program integrity staff from the OIG. The CMS review team also conducted interviews with four MCOs and detailed the highlights of these visits within this summary.

The CMS review team focused on the MCOs contracted in Michigan. As mentioned earlier, the state has thirteen MCOs. This CMS review team selected four of these plans to review in more depth. At the time of the review, the Medicaid beneficiary and provider enrollment totals for these four MCOs were as depicted in the table below. This table also includes each MCO's expenditures for 2013.

MCO	Beneficiaries	Providers	CY 2013 Expenditures
Molina	223,769	21,118	$701,648,305
HAP	91,936	65,597	$273,816,735
United	257,029	9,758	$751,870,000
McLaren	161,000	35,193	$426,447,191

Molina Healthcare, Inc. is a national company, and Molina Healthcare of Michigan is its local plan that provides services in Michigan for Medicaid, Medicare, CHIP, and the Marketplace. Molina has contracted with Michigan since 1997. It pays the majority of its providers FFS with a Pay-for-Performance component for primary care physicians.

HAP Midwest is a local plan. It provides services for both Medicaid and Medicare in Michigan. The plan has contracted with Michigan since 1998. HAP pays its providers in a combination of FFS and capitation, although it did note that it is moving away from capitation and more to FFS due to not receiving all the data needed under the capitated fee schedule.

UnitedHealthcare Community Health Plan is the local plan within Michigan for UnitedHealth Group, which is a national company. Within Michigan, United provides Medicaid, Medicare,

and CHIP services. It has contracted with the state since 1996. United primarily reimburses its providers FFS, although it does have capitated arrangements with a small number of primary care physicians and some ancillary vendors, such as vision, non-emergency transportation, and dental.

McLaren Health Plan is a local plan that provides Medicaid, Medicare, and commercial services in Michigan. McLaren Health Plan has held a Medicaid contract with the state of Michigan since 1998. McLaren pays it providers in a combination of FFS and capitation.

State Oversight of Managed Care

The MDCH Managed Care Plan Division is principally responsible for providing contractual oversight of the managed care program. The MDCH/OIG has the responsibility for providing program integrity oversight for the State Medicaid agency, including but not limited to, the managed care program and all FFS Medicaid services. In accordance with the state's managed care contract, the Managed Care Plan Division performs annual compliance reviews of the MCOs. The state also contracts with an independent External Quality Review Organization that validates the state's compliance reviews. The External Quality Review Organization also conducts independent reviews for the PIHPs.

The OIG, Michigan's program integrity unit, has not historically been actively involved in the managed care contracting process. The OIG is comprised of approximately 40 full-time equivalent positions allocated to program integrity activities. During the review, the team was informed that currently the OIG has only one half of a full-time equivalent position dedicated to program integrity within the managed care program. The OIG indicated a need for additional staff in order to perform all of the necessary program integrity oversight activities. Since approximately 73% of Michigan's Medicaid beneficiaries are enrolled in the managed care program, additional program integrity positions may be warranted. The OIG has had some input recently into the state's managed care contract requirements, but they do not participate in periodic MCO readiness reviews or evaluations. Although encounter data is reported to the state in accordance with the contract, MDCH relies primarily on the MCOs to identify aberrant claims by network providers.

MCO Compliance Plan

In accordance with the MCO contract, the MCOs are required to have a compliance plan that meets the requirements of 42 CFR 438.608. All MCOs reviewed had the required compliance plans in place. The CMS review team found that all compliance plans meet the requirements of 42 CFR 438.608. In addition, the MDCH reviews the MCO compliance plans as part of their annual MCO compliance reviews.

MCO Program Integrity Activities

Investigations of Fraud, Waste, and Abuse

The MCOs in Michigan have either a Special Investigations Unit (SIU) or a compliance office that conducts preliminary investigations. The contract states, "At the time of suspicion, the contractor must report/refer all (employees, providers, and members) suspected of fraud or abuse to OIG via email, online, or through mail delivery. The report/referral must include, at minimum, all of the data elements as described in the CMS Performance Standard for Referrals of Suspected Fraud from the Single State Agency to a Medicaid Fraud Control Unit (MFCU)."

The MDCH monitors the MCOs' program integrity activities through the use of quarterly reports. Beginning in FY13, the MCOs summarized their suspected fraud or abuse and audit activities in quarterly reports to MDCH. This process allows MDCH to track the managed care program integrity activities and provides the state with the opportunity to determine whether or not the same provider is under investigation by MDCH or another MCO. Furthermore, it allows the MCO's investigation to proceed or to enter into a joint investigation with MDCH. The MDCH could also disapprove of the MCO's request to investigate and begin its own investigation of the provider without the assistance of the MCO.

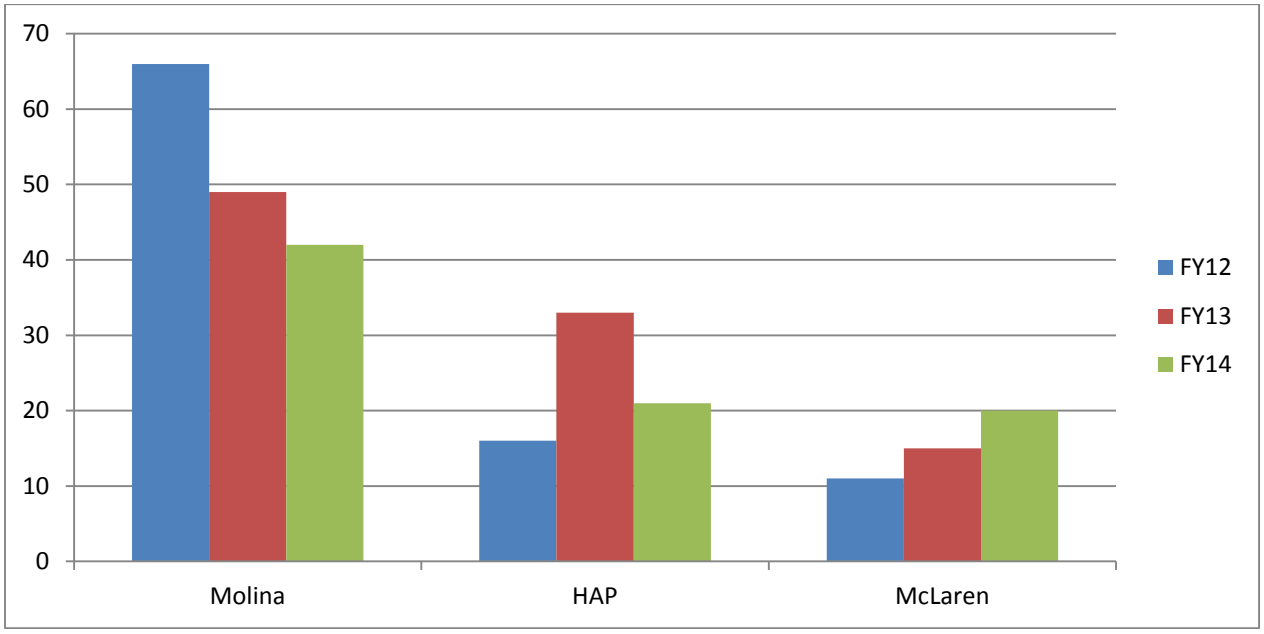
The MCOs do contractually maintain the responsibility for auditing and investigating their own providers. Only one of the four MCOs interviewed had an SIU overseeing all Medicaid lines of business, while the other MCOs relied on their compliance departments, often in collaboration with other departments within the plan, to monitor provider activity. Several MCOs indicated that they made referrals of suspected fraud directly to the MFCU instead of to the state. This demonstrates the lack of a clear understanding of the contract requirement regarding referrals by all of the MCOs and a need for additional training. In addition, the review team was informed that three of the MCOs did not notify the state's OIG after the MCOs' preliminary investigations revealed possible fraud or abuse. Instead, the MCOs would continue to conduct their own full investigation and make a determination whether they felt fraud existed. This is particularly evident with one MCO that only received referrals to investigate further from other internal components of the company.

For the past three fiscal years, the average number of investigations handled by Molina was 53, while McLaren handled 15. The review team received the HAP information on a calendar year basis with an average of 23 cases each year. United reported 117 cases. However, the review team was unable to ascertain if this was a one year total or a cumulative total of all cases handled by United and therefore not included in this report. The low number of annual investigations completed by McLaren and HAP indicates that these plans are in need of more investigators in order to decrease the risks to the Medicaid line of business detailed in this report. Both plans have more providers than United and Molina, yet report about the same number of investigations on average.

The current outlook concerning MCO program integrity activities in Michigan, along with the lack of OIG involvement in managed care program integrity activities, highlights this area as a potential risk to the Medicaid program. Therefore, the MDCH, in collaboration with the OIG,

should perform a thorough analysis of the full range of MCO program integrity activities to determine whether or not the MCOs have put forth an adequate level of effort towards identifying fraud and abuse by reviewing the full range of audit activities, pre-payment reviews, and other data analysis activities and ensuring that MCO work plans are developed to address specific issues/trends in Michigan.

The chart below shows the number of investigations that each plan reported as handled by its compliance department or SIU in the past three fiscal years.



Meetings and Training

The MDCH Managed Care Plan Division and OIG have not participated on any joint investigations with the MCOs. In addition, although bi-monthly meetings are scheduled, the meetings do not occur on a routine basis and do not always include representation from the program integrity staff from the OIG. The state mentioned that the MDCH OIG has participated in the bi-monthly meetings on occasion and it was during these meetings that the OIG learned that MCOs were making direct referrals to the MFCU.

The state also meets monthly with the MFCU. The state plans to involve the OIG in writing managed care contract language on fraud and abuse for the other MCOs in Michigan (PIHP, waiver, dental and NEMT programs) to ensure an effective program integrity model is transferred across the board. The state has not implemented any MCO program integrity related training to date.

Reporting of Overpayments and Recoveries

The MDCH contract does not specifically address prepayment reviews or the MCO performing any extensive billing audits. No other overpayment or recoupment language exists in the managed care contract. The MDCH informed the review team that recoveries are to be tracked by the MCO, but it is not a contract requirement for recoveries to be returned to the state. In addition, MDCH does not confirm or validate recovered overpayments by the MCOs.

As part of the focused review, the team asked the MCOs interviewed how much in overpayments they recovered over the three previous FFYs, as a result of program integrity activities conducted.

The plans were only able to report the overpayment recoveries by calendar year as seen in the table below.

Selected MCOs	Total Medicaid Expenditures*	Overpayments Collected 2011	Overpayments Collected 2012	Overpayments Collected 2013
United	$751,870,000	$0	$0	$91,200
Molina	$701,648,305	$13,637,558	$13,887,038	$12,264,787
McLaren	$426,447,191	$1,186,101	$1,202,962	$1,995,250
HAP	$273,816,735	$278,540	$361,429	$395,081
Total	**$2,153,819,231**	**$15,102,199**	**$15,451,429**	**$14,746,318**

**Total 2013 Medicaid expenditures reported by the MCO's.*

The United health plan reported expenditures over $751 million with total recoveries of $91,200 in 2013 only. The data depicted for United is from OptumInsight activities only. In addition, United indicated that it had cost avoidance results of $20,939,935 in prospective savings and $5,371,656 in retrospective savings. However, for vision services, the delegated entity that provides program integrity oversight indicated that its SIU has recovered overpayments made to providers, but does not share recovery amounts. While Molina had over $701 million in Medicaid expenditures in 2013, the plan reported average total program integrity recoveries of just over $13 million in the past three years (2011 – 2013). Across the same years, McLaren reported expenditures over $426 million, while total recoveries averaged just over $1.4 million. HAP reported expenditures over $273 million and average total recoveries of $345,017.

CMS is concerned about the Michigan overpayment information depicted above. Although the expenditures reported by Michigan's MCOs exceeds $2B annually, the MCOs' recoveries have only averaged approximately $15M for the past three years. The overpayments collected are not commensurate with expenditures related to managed care, since overpayments in the industry typically are between one to ten percent of total expenditures paid out.

Terminated Providers

The MDCH contract states the MCO must report any adverse actions taken against a provider due to fraud, quality, or integrity issues, during enrollment or any time thereafter, within 20 working days of the action, to the Inspector General of HHS and MDCH.

The table below depicts the number of terminated providers reported by each of the MCOs.

MCO	Providers	Providers disenrolled or terminated, not for-cause, in last 3 completed FFYs	Providers terminated for-cause in last 3 completed FFYs
Molina	21,118	FY13 468 FY12 428 FY11 250	FY13 20 FY12 7 FY11 3
HAP	65,597	FY13 447 FY12 320 FY11 332	FY13 9 FY12 1 FY11 0
United*	9,758	FY13 468 FY12 43 FY11 N/A	FY13 83 FY12 43 FY11 0
McLaren	35,193	FY13 1,092 FY12 506 FY11 293	FY13 6 FY12 2 FY11 0

**United data does not conform to the data requested for this table.*

Overall, the reporting of terminations appears to vary among the MCOs and there is no indication that the state has taken any measures to ensure that the provider is terminated from all plans. Also, as reflected in the chart above, the MCOs in Michigan have reported a disproportionately low number of for cause terminations relative to the number of providers terminated not for cause during the last three FFYs. This finding indicates a potential weakness in the state's Medicaid program.

Payment Suspensions

The managed care contract does not specifically address 42 CFR 455.23. The Federal regulation at 42 CFR 455.23(a) requires that upon the State Medicaid Agency determining that an allegation of fraud is credible, the State Medicaid Agency must suspend all Medicaid payments to a provider, unless the agency has good cause to not suspend payments or to suspend payment only in part. Under 42 CFR 455.23(d) the State Medicaid Agency must make a fraud referral to either a MFCU or to an appropriate law enforcement agency in states with no certified MFCU. The referral to the MFCU must be made in writing and conform to the fraud referral performance standards issued by the Secretary.

The state notified the review team that the standard MCO contract does not preclude the enactment of Medicaid provider payment suspensions at the direction of the State Medicaid Agency. As long as the state does not request a suspension of a payment, the MCO contract does not require the MCOs to suspend payment. The standard MCO contract stipulates that MCOs must report credible allegations of fraud directly to the state via the online web portal, although some MCOs were identified to be sending referrals directly to the MFCU. Ultimately, none of the Michigan health plans were suspending provider payments in response to any internal program integrity activities.

All MCOs indicated that they would suspend payments to providers at the direction of the state, even though they were not initiating payment suspension on their own. At least three of the MCOs indicated that they did have the ability to suspend payments if directed. In addition, at least two MCOs indicated that problem providers, specifically "those engaged in fraud," would have their payments suspended and be immediately terminated from their network. One MCO also indicated that it can flag a provider's claims in its system for a prospective review, thus temporarily suspending payments.

Summary Recommendations:

- The state should continue to move toward having all network providers enrolled in the CHAMPS system, and establish this as a mandatory requirement for all MCOs. This will allow for consistency in the screening and enrollment of providers and minimize the risks associated with having varying degrees of screening among the MCOs.

- The state should require MCOs to develop audit work plans that are proactive in identifying potential fraud, waste, or abuse, where such work plans do not exist. These audit work plans could be developed in collaboration with the OIG to address specific issues/trends in Michigan.

- The state should establish guidelines for MCOs to report the outcomes of their preliminary investigations prior to engaging in a full investigation. This should include time frames for reporting and what constitutes a preliminary investigation versus a full investigation. This will allow the state to assume responsibility for the investigation, if it so chooses, and to be able to better determine if the case needs to be referred to the MFCU. Also, the state and/or MFCU will be able to determine whether further MCO involvement could jeopardize an ongoing criminal investigation. It will also allow the state to determine whether a payment suspension is in order. These guidelines should be communicated to the MCOs in their contracts.

- The state should monitor MCOs' compliance with contractual requirements for checking the Social Security Administration's DMF and the NPPES when credentialing and re-credentialing providers.

- The MDCH should determine whether or not the MCOs have put forth an adequate level of effort towards identifying fraud and abuse by reviewing not merely potential fraud

cases, but also the full range of audit activities, pre-payment reviews, and other data analysis activities.

The current outlook concerning MCO program integrity activities in Michigan, along with the lack of OIG involvement in managed care program integrity activities, highlights this area as a potential risk to the Medicaid program. Therefore, the MDCH in collaboration with the OIG should perform a thorough analysis of the full range of MCO program integrity activities to determine whether or not the MCOs have put forth an adequate level of effort towards identifying fraud and abuse by reviewing the full range of audit activities, pre-payment reviews, and other data analysis activities and ensuring that MCO work plans are developed to address specific issues/trends in Michigan.

- Contractually require MCEs to suspend payment to providers against whom an MCE or the state can document a credible allegation of fraud. The payment suspension requirements in the federal regulation at 42 CFR 455.23 should be consulted in designing this provision. The state should provide training to its contracted MCEs on the circumstances in which payment suspensions are appropriate pursuant to 42 CFR 455.23 and should further require the reporting of plan-initiated payment suspensions based on credible allegations of fraud.

- The state's program integrity oversight in managed care could be improved with more OIG input into contract requirements and participation in joint state/MCO trainings. In addition, program integrity oversight may be enhanced through better communication and coordination of information across the program units that have oversight roles in managed care and the MCOs.

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:

- 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 can help address the risk areas identified in this report. Courses that may be helpful to Michigan based on its identified risks include those related to provider enrollment and 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.
- Access the annual program integrity review summary reports on the CMS's website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-

Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html. 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.

- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf.
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.104 Disclosures of Ownership and Control website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf.

Conclusion

CMS supports Michigan's efforts and encourages the state to look for additional opportunities to improve overall program integrity. The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

The CMS review team concluded that Michigan's managed care program may be vulnerable to many inefficiencies and risks related to core program integrity activities and program integrity oversight of managed care, which could expose the state to potential fraud, waste, or abuse. As a result, Michigan's managed care program is exposed to the same vulnerabilities and risks that are addressed in the FFS program. The review team based this conclusion on the identification of areas of non-compliance within the Affordable Care Act section of this report, as well as, the other managed care areas of risk, such as the lack of MCO program integrity training and the payment suspension policy and procedures. All of these issues together do not allow for Michigan to meet even the minimum program integrity requirements outlined within the Federal regulations contained within 42 CFR 455. Furthermore, CMS is concerned that some of the issues described in this review remain uncorrected from the CMS's 2013 Program Integrity Review.

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 plan should identify those corrections as well.

CMS looks forward to working with Michigan to build an effective and strengthened program integrity function.

Review of Corrective Action Plan

As part of the focused review, the CMS Review Team reviewed the state's CAP from the last Medicaid Comprehensive Program Integrity Review conducted in February 2013, which was not yet completed or fully addressed in the CAP. The state's 2013 program integrity review CAP was submitted on December 1, 2014. The state responded to the bulleted CAP concerns identified below:

- The 2013 Program Integrity Review Final Report cited the state for not having a program integrity work plan for all components of program integrity such as investigations and audits. The OIG FY15 Program Integrity work plan is still being approved and expected to be completed by April 1, 2015.

- The 2013 Program Integrity Review Final Report cited the state for not having policies and procedures for key program integrity functions and operations. The OIG Policy manual will capture thirty three individual policies to address procedures and protocols for individual core operational areas and is expected to be completed by the end of Feb 2015.

- The 2013 Program Integrity Review Final Report cited the state for not having NEMT policies in the contract addressing fraud and abuse monitoring and data analysis. Michigan's NEMT policies addressing fraud and abuse monitoring and data analysis will be added to the contract and the Interagency Agreement by April 1, 2015. The policy promulgation process may take a minimum of 120 days. This may push the expected completion date out to the end of the state fiscal year 2015.

- The 2013 Program Integrity Review Final Report cited the state for not providing program integrity training for other components within the state agency, such as managed care, NEMT, and waiver program staff. The state indicated the first investigative team program training would occur by April 1, 2015.

- The 2013 Program Integrity Review Final Report concluded that the state had made several improvements to their provider enrollment system to collect all the required elements outlined in 42 CFR 455.104. However, the system did not allow for the collection of the enhanced business address as required by the regulation. As mentioned in this report, modifications to the state's provider enrollment system, CHAMPS, are underway and the state expects to be in compliance with this regulation by year end 2015. The 2013 report also concluded that the state was not in compliance with the requirement to collect disclosures of ownership and controlling interest from MCOs and special programs. The state indicated that resolution of this issue was also dependent on the modifications to CHAMPS.

- The 2013 Program Integrity Review Final Report indicated that the state is not collecting health care related criminal conviction disclosures to the specificity as required by the regulation at 42 CFR 455.106. The state responded that the required 42 CFR 455.106 modifications to CHAMPS would occur by May 2015.

- The 2013 Program Integrity Review Final Report found that the state is not collecting health care-related criminal conviction disclosures from its NEMT, MCO, and PIHP providers as required by the regulation at 42 CFR 455.106. The state indicated collection of the required 42 CFR 455.106 disclosures for its NEMT, MCO, and PIHP providers will occur by the end of 2015.

- The 2013 Program Integrity Review Final Report found that the state is not collecting business transaction disclosure obligations as required by the regulation at 42 CFR 455.105 in the state's "Home Help" and NEMT programs. The state indicated the required 42 CFR 455.106 modifications to CHAMPS would occur by the end of 2015.

- The 2013 Program Integrity Review Final Report found that the state is not conducting all the required federal database exclusion searches in the state's "Home Help" and NEMT programs. The state indicated the "Home Help" providers are now captured in CHAMPS, and the required exclusion searches will be completed by July 2015. The requirement will be added to the NEMT broker contract by the end of 2015.

- The 2013 Program Integrity Review Final Report found that the state was not utilizing its permissive exclusion authority as outlined in 42.CFR 1002.210. The state indicated that policies and procedures will be developed to comply with this regulation by April 1, 2015.

- The 2013 Program Integrity Review Final Report found that the state did not have clear policies and procedures for reporting adverse actions to the HHS-OIG. The state indicated that policies and procedures would be developed for all Medicaid programs by April 1, 2015.

- The 2013 Program Integrity Review Final Report found that the state was not complying with its compliance review protocol in accordance with its State Plan on False Claims Act education requirements. The state indicated that compliance will be met by April 1, 2015.

- The 2013 Program Integrity Review Final Report found that the state was not collecting the required application fee for 592 Medicaid-only enrolled providers. The state responded that modifications to CHAMPS, expected by the end of 2015, would enable them to collect the fees.

Official Response from Michigan
March 2016

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42 CFR 455.410: Enrollment and screening of providers
The regulation at 42 CFR 455.410 requires that the State Medicaid agency: (a) screen all enrolled providers; and (b) enroll all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan as participating providers; and (c) the State Medicaid agency may rely on the results of the provider screening performed by any of the following: (1) Medicare contractors. (2) Medicaid agencies or Children's Health Insurance Programs of other states.
The state is in compliance with this regulation.
Michigan requires all ordering and referring providers to enroll in Medicaid as participating providers.
Recommendation: None

42 CFR 455.412: Verification of provider licenses
The regulation at 42 CFR 455.412 requires that the State Medicaid agency: (a) have a method for verifying that any provider purporting to be licensed in accordance with the laws of any state is licensed by such state; and (b) confirm that the provider's license has not expired and that there are no current limitations on the provider's license.
The state is in compliance with this regulation.
At enrollment, all provider licenses are screened through the Provider Credential Screening process which is contracted through a vendor. If a provider license is not active, the provider is not enrolled. The MDCH currently contracts its provider license verification process to a vendor that provides a daily interface with Licensing and Regulatory Affairs, which updates provider records. When a provider loses licensure, the system end dates the enrollment the same business day. In addition, if there is a limitation of the licensure, a request is made for documentation from the provider with consultation with the OIG if there are any questions regarding actions taken against the provider. For licensure that is expiring, the provider receives a letter 45 days prior to the expiration of a license. If an update is not received within the 60 day grace period the provider is dis-enrolled.
Recommendation: None