Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Minnesota Focused Program Integrity Review

Final Report

December 2015

Submitted By:
LaShonda Mazique, Review Team Leader
Margi Charleston
Mark Rogers
Edward Sottong
Sean Johnson, Review Manager

Table of Contents

Objective of the Review

The Centers for Medicare and Medicaid Services (CMS) conducted a focused review to determine whether Minnesota 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 (ACA). 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 entities (MCEs) under contract with the state. The review also included a follow up on the state's progress in implementing its corrective actions related to CMS's last program integrity review in 2011.

Background: State Medicaid Program Overview

The Provider Enrollment Section of the Minnesota Department of Human Services (DHS) is responsible for enrolling all State Plan and waiver providers including pharmacies, dentists, personal care attendants (PCAs), and non-emergency medical transportation providers into the Minnesota Health Care Programs (MHCP). With a few exceptions, the MCEs are responsible for enrolling and screening managed care network providers. DHS is responsible for enrolling and screening certain provider types, like personal care attendants, on behalf of the MCEs. There are a total of 988,113 Medicaid beneficiaries, of that total 778,942 or 79% are enrolled in managed care plans. The total Medicaid annual expenditures for the fiscal year ending June 30, 2014 were approximately $10 billion. Of that, approximately $4.3 billion or 41% was paid to MCEs. Minnesota is a Medicaid expansion state.

Methodology of the Review

In advance of the onsite visit, CMS requested that Minnesota complete a review guide that provided the review team detailed insight to the operational activities of the areas that were subject to the focused review. A four-person team reviewed the responses and materials that the state provided in advance of the onsite visit.

During the week of July 21, 2014, the CMS review team visited DHS, and the Surveillance Integrity Review Section (SIRS) of DHS's Office of the Inspector General. The team conducted interviews with DHS staff involved in program integrity, provider enrollment, and managed care. The team also did onsite interviews of the compliance or Special Investigation Units (SIUs) at Itasca Medical Care (IMCare), Metropolitan Health Plan (MHP), PrimeWest Health (PWH), and HealthPartners (HP). In addition, the team conducted sampling of provider enrollment applications, MCE program integrity cases, onsite screening visit files, and other primary data to validate Minnesota's and the selected MCEs program integrity practices.

Corrective Action Plan Status

As part of the focused review, the CMS review team evaluated the status of the state's corrective action plan (CAP) submitted in response to CMS's last review of the state in 2011. The

Minnesota DHS staff was interviewed specifically to cover each regulatory compliance issue and vulnerability identified during the FFY 2011 review; the CAP letter was also addressed. Prior to the onsite review, the review team researched each regulatory compliance issue and vulnerability. The review team identified one remaining issue from the FFY 2011 final report that had not been resolved. The issue remains that the state only checks the Excluded Parties List System (EPLS) upon initial credentialing. The state does not check for debarments on a monthly basis as required after March 25, 2011. Based upon the interview with state staff and research conducted prior to the interview it has been determined that (excluding the aforementioned remaining issue) all other regulatory compliance issues and vulnerabilities have been satisfied from the FFY 2011 review.

Results of the Review

The review team identified areas of concern and instances of regulatory non-compliance in the state's provider enrollment and managed care program integrity activities, thereby creating a risk to the Medicaid program.

CMS will work closely with the state to ensure that all issues are satisfactorily resolved as soon as possible. These issues and CMS recommendations for improvement are described in detail in this report.

Section 1: Affordable Care Act Provider Screening and Enrollment

Overview of the State's Provider Enrollment Process

Again, all state plan and waiver providers are enrolled into the MHCP by the Provider Enrollment Section of the DHS. Managed care network providers are enrolled by the individual MCEs. In assigning risk levels for each MHCP provider type, DHS was guided by the risk levels assigned by Medicare for categorization. The state also has a State Plan Amendment approved in 2013 by the Consortium for Medicaid and Children's Health Operations for Provider Screening and Enrollment specifically in reference to 42 CFR 455 Subpart E.

42 CFR 455 Table 1

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.
Minnesota requires all ordering and referring providers to enroll in Medicaid. A provider news bulletin posted on Minnesota DHS website stating the requirement was reviewed by the team. However, the state does not have system edits in place to edit for claims that do not

42 CFR 455.410: Enrollment and screening of providers
contain the National Provider Identifier (NPI). This issue is further explained in 42 CFR 455.440.
Recommendations: 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.
The provider enrollment staff checks the applicable licensure databases and websites such as the Medical Board of Minnesota website. The effective date of the license is input into the provider file along with a "valid value" along with any limitations placed on the license. Monthly licensing board orders and in-state license files are sent to the enrollment section to update the provider file. When an out-of-state provider's, license is up for renewal, a monthly report is sent to the appropriate enrollment specialist to verify with the licensing board whether the license is active or has been terminated.
Recommendations: 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 state is potentially at risk of being out of compliance with this regulation by March 24, 2016.
While the state has re-enrolled over 100,000 PCAs, every waiver provider since FFY 2011, and annually every PCA agency; a work plan is still being developed to place all other providers on a revalidation schedule. As part of this plan, the enrollment section is attempting to combine this effort with other needs in the agency to accomplish portions of the revalidation together. In addition, now that the enrollment unit has access to the Provider Enrollment and Chain Ownership System, it will rely on Medicare actions and possibly get on the same revalidation schedule as Medicare.
Recommendations: Complete the development and implement a provider revalidation work plan to ensure the March 2016 revalidation deadline is met for all providers.
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 Title XXI program or state Children's Health Insurance Program has terminated a provider for-cause on or after Jan. 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 not in compliance with this regulation.

42 CFR 455.410: Enrollment and screening of providers
The state does not have policies and procedures in place to ensure providers terminated for cause by other states or Medicare are not allowed to enter or remain providers in MHCP. At the time of our review, the state did not have access to the CMS terminations database that contains Medicare and state reported Medicaid for-cause provider terminations. While no terminated providers were identified as participating in MHCP, without the ability to check at the time of enrollment, or routinely thereafter, the probability of enrolling a terminated provider remains. In addition, the state was not submitting its final for-cause terminations to CMS. The CMS review team assisted the state in gaining access to the server while on-site.
Recommendations: Develop and implement a procedure to check the CMS provider termination database to ensure the state terminates or denies enrollment to any provider that has been terminated for cause by Medicare or another state's Medicaid or Child Health Insurance Program. Submit all final for-cause provider terminations to CMS on an ongoing basis.
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 partially in compliance with this regulation.
Providers that have had their provider numbers deactivated must go through the complete enrollment process. However, as evidenced by the vulnerabilities mentioned in this report that reenrollment is not fully compliant with Subpart E as the state is not collecting application fees or conducting all required screenings like the Social Security Administration Death Master File (DMF) and obtaining disclosure information from agents of the provider.
Recommendations: Upon reactivating a provider that was denied or terminated for any reason, the state should ensure the provider enrollment screening process is fully compliant with Subpart E including collection of application fees.
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.
The state has appeal statutes and administrative rules that further outline or establish the providers appeal rights. In addition, a review of the state's denial and termination letters confirmed that the state provides the provider with appeal rights.
Recommendations: 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 not in compliance with this regulation.

42 CFR 455.410: Enrollment and screening of providers
The SIRS is responsible for conducting site visits. Minnesota statute allows for unannounced on-site inspections of any provider location. The review team was told by program integrity management that no pre-enrollment site visits have been conducted because the provider enrollment unit had not completed programming needed to collect fees and implement new screening requirements. Only nine post-enrollment site visits to eight PCA agencies and one non-emergency medical transportation provider have been conducted due to limited staffing. Minnesota has developed a detailed Onsite Visit tool that has been used for these visits. The review team was told that Minnesota has received legislative approval to hire four staff to conduct pre and post-enrollment site visits and hopes to have them on board by August 2014.
Recommendations: Implement a process to begin conducting pre and post-enrollment site visits with the newly appointed staff.
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 EPLS on the System for Award Management, the DMF, the National Plan and the Provider Enumeration System upon enrollment and reenrollment; and check the LEIE and EPLS no less frequently than monthly.
The state is not in compliance with this regulation.
Upon provider enrollment and re-enrollment, the state checks the name of the provider, persons with ownership or controlling interests in the provider, and managing employees of the provider against the LEIE, EPLS, and the National Plan and the Provider Enumeration System. It also checks these names against the LEIE on a monthly basis. However, the EPLS on the System for Award Management is not checked monthly as required in the regulation, which is a repeat finding from CMS's 2011 review of Minnesota. The state is also not searching the DMF at any point. In addition, the Ownership and Control Interest form does not solicit disclosure of agents of the provider. Further, individual providers are not required to complete the Ownership and Control Interest form which prevents the state from searching the names of parties affiliated with the individual providers against the required databases. Finally, during the provider enrollment demonstration and the interview with provider enrollment staff, the CMS team observed that the completeness of an entity's disclosure of managing employees was taken at face value even if only one managing employee was listed for a large entity. Therefore, it is possible that not all managing employees from entities are known to the state or are being searched against federal databases at enrollment or monthly thereafter.
Recommendations: Revise the Ownership and Control Interest form to require disclosure of agents of the provider. Implement procedures for the appropriate collection of disclosures from individual providers so that the state is able to conduct the full range of federal database

42 CFR 455.410: Enrollment and screening of providers
searches required by 42 CFR 455.436. Search the DMF upon enrollment and the EPLS on a monthly basis in accordance with the requirements of the regulation.
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 does not have system edits in place to edit for claims that do not contain the National Provider Identifier (NPI).
Recommendations: Develop and implement systems edits to deny claims that do not contain the NPI of ordering, referring, 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 re-enrollment or revalidation of enrollment request based on a categorical risk level of ‘‘limited,’’ ‘‘moderate,’’ or ‘‘high.’’
The state is not in compliance with this regulation.
The state has established screening levels for limited, moderate, and high risk providers, but is not performing site visits for moderate and high risk providers as required by the regulation. Further, the state does not have a process to adjust a provider’s risk level in instances where the provider has an existing overpayment, when the state imposes a payment suspension based on a credible allegation of fraud, or when the provider has been excluded by HHS-OIG or by another State Medicaid agency within the previous 10 years, in accordance with the requirements of the regulation.
Recommendations: Perform site visits on moderate and high risk providers as required by regulation. Develop a process to adjust the risk level of providers who have an existing overpayment; providers who have had payments suspended in cases with a credible allegation of fraud, and providers who have been excluded by HHS-OIG or another State Medicaid agency within the previous 10 years.
42 CFR 455.460: Application fee
The regulation at 42 CFR 455.460 requires the State’s 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 in place to collect application fees from Medicaid only institutional providers. However, the state legislature granted authority for the state to begin

42 CFR 455.410: Enrollment and screening of providers
collecting application fees. At the time of the review, the state hoped to have had this process in place by October 2014.
Recommendations: Develop policies and procedures with the newly granted authority to begin the collection of application fees from Medicaid only institutional 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 a position to comply with this regulation.
The state has passed legislation providing them authority to impose a temporary moratorium; however the state has not imposed a moratorium at this time.
Recommendations: None

Section 2: Managed Care Program Integrity

Overview of the State's Managed Care Program

DHS contracts with eight risk-based managed care plans to provide services for its Prepaid Medical Assistance Program. Four of these risk-based MCEs also do commercial business. Three of the health plans provide services to Medicare and Medicaid beneficiaries only. The state contracts with one Medicaid-only managed care plan.

Through these eight risk-based plans, the state offers eight contracts for Families and Children, Minnesota Senior Health Options, and Minnesota Senior Care Plus options and five contracts for Special Needs Basic Care options for its Medicaid beneficiaries.

Summary Information on the Plans Reviewed

The CMS team met with staff from the compliance unit or SIU of the four selected MCEs and detailed the highlights of these visits within this summary. The four MCEs use as variety of payment methods which include, but are not limited to capitation, fee for service, capacity development grants, Diagnosis Related Groups, and pay for performance bonuses.

Three of the four MCEs, (IMCare, MHP, and PWH) are local, county-based plans.

The national plan is HP. This MCE is one of the organizations that piloted the Prepaid Medical Assistance Program. The MCE offers both Medicare and commercial products in addition to its Medicaid line of business.

Only one of the three MCEs selected for this review has a distinct SIU. The other plans selected to house their program integrity operations in compliance units. Regardless of the operational structure, each organization performs various functions that contribute to investigations completed by the MCEs.

As of July 2014 enrollment information in each plan is summarized as follows

	IMCare	MHP	PWH	HP
Beneficiary enrollment total	7,790	12,982	33,338	112,690
Provider enrollment total	305	8,453	6,295	28,733
Year originally contracted	1982	1986	2002	1985
National/Local plan	Local	Local	Local	National

Managed Care Organization's Program Integrity Oversight

State Oversight of Managed Care

Oversight of the Medicaid Managed Care Program falls under the umbrella of Health Care Administration (HCA), and within the Purchasing and Service Delivery Division (PSD) of DHS. Many divisions within HCA impact the oversight of the Medicaid managed care program. However, direct oversight is accomplished through the Managed Care Contracting and Service Implementation Department. The department has Contract Managers that are assigned to each MCE. The Contract Manager is responsible for overseeing the contract between the MCE and the state.

The state has an interagency agreement with the Minnesota Department of Health to provide onsite reviews of specific contract obligations. The SIRS staff also goes onsite to each MCE every two years and meets with the plan to discuss program integrity issues. The state provided the review team with several agendas for the meetings which focused on various program integrity topics such as, ACA screening requirements, Annual Program Integrity Reports, review of referral processes, notification of terminations and withholds, adverse action reporting to HHS-OIG, services during inpatient stays, etc.

The state confirmed that there is no specific statute, regulation, or policy that requires MCEs to return to the state overpayments recovered from providers as a result of MCE fraud and abuse investigations or audits. MCEs retain the overpayments collected and they are used to provide other services covered under their risk-based contracts. However, the term "other services" raises some concerns as to how the MCEs utilize the overpayments that are collected since the state does not require the recovered overpayments be returned.

The MCEs must maintain patient encounter data to identify the physician who delivers services or supervises services delivered to enrollees as required by 1903(m)(A)(xi) of the Social Security Act. The SIRS and MCEs conduct data mining for aberrant billing patterns from the MCE payment/encounter data. SIRS has confirmed that MCEs perform data mining by reviewing data reports during the SIRS bi-annual site visits to the MCEs. The MCEs also report data mining activities in their annual reports to the state. When SIRS performs data mining it includes fee-for-service (FFS) and managed care claims.

For the years under review, the MCEs were required to submit a Reporting of Adverse Actions quarterly and Reporting of Provider Fraud and/or Abuse Log monthly per contract requirement. These reports were submitted to DHS Contract Managers and a representative of the SIRS Unit for review. The MCE must also provide an Annual Report to the state in writing, by August 31st of the contract year. The report details the MCE's integrity program, including investigative activity, corrective actions, fraud and abuse prevention efforts and results, according to guidelines provided by the state. The report must describe implementation of the requirements of the contract section 9.9.1(A), and must include descriptions of any activities it has undertaken to safeguard against fraud and abuse. The report must also delineate the activities of the previous state fiscal year and provide information about reports of provider fraud and abuse investigated by the MCE.

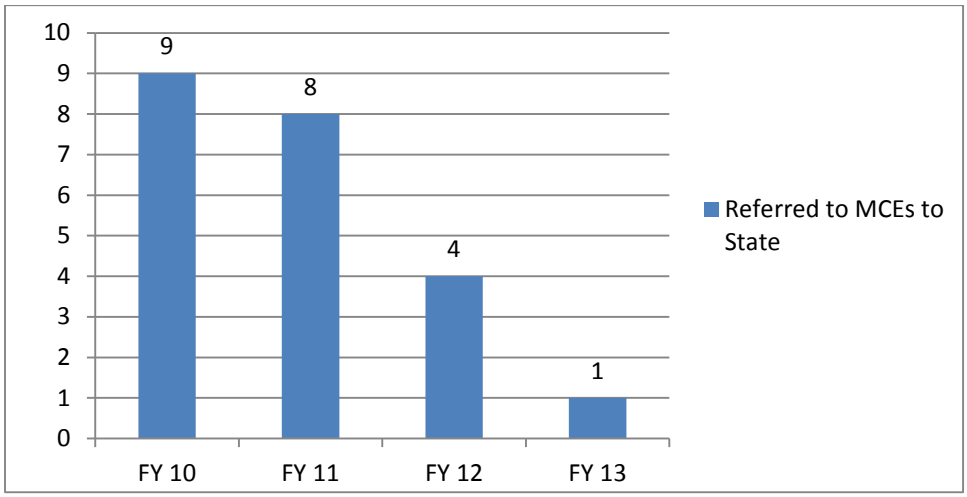
The state contract requires the MCE to report in writing to the state, and its Medicaid Fraud Control Unit (MFCU), any fraud the MCE knows or has reason to believe has been committed by a provider within 24 hours after the MCE learns of or has reason to believe a credible allegation of fraud exist.

MCE Program Integrity Activities

In Minnesota, all MCEs and their subcontractors are required by contract to cooperate with Minnesota MFCU investigations. Of the four organizations that the team interviewed only one has a Memorandum of Understanding (MOU) with the MFCU. It is important to note that half of the state's eight MCEs have MOUs with the MFCU.

As reflected in the chart below, there was a significant decrease in the number of suspected network provider fraud or abuse cases from FFY10 to FFY13. Of the four MCEs interviewed, one MCE has referred only one case of suspected provider fraud or abuse in the last four FFYs. This MCE does not have an SIU and only has a compliance officer who handles all program integrity activity. The following chart shows a dramatic drop over the four FFYs highlighted by a 75% reduction in referrals by the four MCEs interviewed from FFY12 to FFY13. There is concern about the lack of cases being referred by MCEs to the MFCU and the state.

Fraud and Abuse Referrals from the Interviewed MCEs to the State



Trainings and Meetings

The state does not have any formal training that has occurred between the SIRS and MCEs. However, on occasions the two areas have consulted on specific issues, such as whether counties are required to follow disclosure requirements when contracted with the MCE to provide direct services.

The state hosts the Anti-Fraud Task Force Meeting which is held quarterly. The SIRS/MCE SIU Meeting is held semi-annually, all four MCEs reported attending each meeting. Mentoring of SIU staff is one component of these semi-annual meetings held between SIRS and the MCEs. Each of the four MCEs in this review reported attendance at several national association trainings and CMS webinars/meetings. The PSD also has a quarterly meeting with all MCEs.

Overpayments Identified and Recoveries

Each MCE has a variety of pre and post-payment review efforts that are utilized to detect fraud, waste, and abuse prior to claims payment including but not limited to:

- review of high dollar claims.
- review of claims submitted for services rendered without the required prior authorization.
- review of member eligibility, other insurance coverage, excluded services, and possible submission of duplicate claims; and
- pre and post-payment review edits – procedure to procedure, procedure to provider, procedure to gender, frequency to time, and diagnosis to procedure.

The table below illustrates the overpayments identified and collected by each MCE in the past 4 FFYs as a result of fraud and abuse investigations

MCE Recoveries	FFY 2010	FFY 2011	FFY 2012	FFY 2013
IMCare	$1726.56	$0.00	$488.30	$0.00
MHP	$118,784.38	$58,200.27	$1,883.82	$960.23
HP	$313,944.18	$492,581.67	$575,261.12	$375,336.22
PrimeWest	$3605.15	$950.40	$22,944.20	$0.00

Of the four MCEs interviewed, three reported low recoveries of overpayments as a result of fraud and abuse investigations in the last few fiscal years. Based on estimated 2014 MCE expenditures, the MCEs recovered only 0.01% approximately. There is concern that overpayments identified and recovered are not commensurate to the size of state expenditures related to managed care.

Terminated Providers

Each MCE is contractually required to report quarterly to the state a provider whose participation has been denied at enrollment, credentialing or, re-credentialing, and providers whose active participation status the MCE has taken action to terminate or not renew during the previous quarter. The state is responsible for reporting all adverse action to HHS-OIG.

The table below reflects the number of providers in each MCE, the number of providers enrolled over the past three complete FFYs, the number dis-enrolled or terminated, and the number terminated for cause.

MCE	# of providers in FFY 2013	# of providers enrolled in the last 3 completed FFYs	# of providers dis-enrolled or terminated in the last 3 completed FFYs	# of providers terminated for cause in the last 3 completed FFYs
IMCare	265	FFY13 - 265 FFY12 - 309 FFY11 - 315	FFY13 - 24 FFY12 - 68 FFY11 - 23	FFY13 - 0 FFY12 - 1 FFY11 - 0
MHP	7,510	FFY13 - 7,510 FFY12 - 7,446 FFY11 - 6,009	FFY13 - 4 FFY12 - 10 FFY11 - 4	FFY13 - 0 FFY12 - 1 FFY11 - 3
HP	38,111	FFY13 - 38,111 FFY12 - 35,726 FFY11 - 33,327	FFY13 - 1,661 FFY12 - 1,976 FFY11 - 1,947	FFY13 - 18 FFY12 - 9 FFY 11 - 1
PrimeWest	6,825	FFY13 - 6,825 FFY12 - 6,101 FFY11 - 5,262	FFY13 - 233 FFY12 - 402 FFY11 - 405	FFY13 - 4 FFY12 - 10 FFY11 - 17

Overall, the reporting of terminations appears to vary among the MCEs. Upon termination from a plan, no effort is made to ensure that the terminated provider's information is communicated to the other plans where the provider may be participating. Communication of termination information would allow other plans to also audit the provider's billing practices. In addition, not checking whether terminated network providers are participating in FFS leaves the state vulnerable to ongoing abuses of the Medicaid program by fraudulent providers.

MCE Compliance Plan

The state contractually requires the MCEs to include a mandatory compliance plan that is designed to guard against fraud, abuse, and improper payments. Each MCE has designed and implemented a compliance plan.

The PSD has Contract Managers that are assigned to each MCE. The Contract Manager is responsible for overseeing the contract between the MCE and the state. However, the state has not reviewed all of the MCE compliance plans. The state plans to remedy this by delegating the responsibility of reviewing MCE compliance plans to a new hire in SIRS.

Payment Suspension

The state's managed care contract requires that each MCE must suspend all Medicaid payments to a provider (1) after the state has notified the MCE that it has suspended all Medicaid payments to the provider or (2) the MCE determines there is a credible allegation of fraud against the provider for which an investigation is pending under the Medicaid program. The payment suspension requirement in each MCE's contract mirrors the language in federal regulation 42 CFR 455.23.

The provider sampling revealed that the majority of payment suspensions were derived from notification the MCEs received from the state to suspend provider payments. The provider sampling noted all payment suspensions that were enacted also resulted in various payment recoupments. The fact that the MCEs reviewed are not initiating any payment suspensions on their own initiative is of concern.

Summary Recommendations:

- Conduct a root cause analysis to determine why there has been a significant decrease in the number of referrals of suspected network provider fraud or abuse cases. Develop corrective actions based on the findings of the root cause analysis.
- Conduct a root cause analysis of why recoveries made by the MCE appear to be very low. Develop corrective actions based on the findings of the root cause analysis.
- Develop and enhance procedures that facilitate the sharing of termination information among plans and the state so that all parties can take appropriate action.

- Develop a training plan to educate the MCEs on payment suspension pursuant to 42 CFR 455.23. This is an issue due to the lack of suspensions of provider payments initiated by the reviewed MCEs.

Noteworthy Practice

As part of its focused review process, the CMS review team identified a practice that merits consideration as a noteworthy or "best" practice. CMS recommends that other states consider emulating this activity.

Minnesota DHS Use of Stipulated Provider Agreement

Under Minnesota regulations, one of the administrative sanctions available to DHS is imposition of a provider agreement that stipulates specific conditions of participation. This sanction is an option when a provider is found to be in violation of program rules, but the violation (e.g., billing aberrancies) is not severe enough to warrant the provider being terminated from the program. In addition to recouping an overpayment from a provider, DHS will often require the provider to sign a “Stipulated Provider Agreement.” This document sets forth terms that are in addition to the legal requirements that the provider agrees to upon enrollment. Stipulated provisions include such things as waiver of notice prior to an onsite visit by SIRS, reporting requirements over and above what is in statute or rule, and mandatory training. In addition, the Stipulated Provider Agreement often repeats legal obligations that the provider was found to have violated. The Stipulated Provider Agreement is of limited duration – usually two years – and is signed by the provider as well as DHS. The agreement puts the provider on notice that if they fail to comply with its terms, DHS will seek suspension of the provider’s participation.

DHS has found that Stipulated Provider Agreements are valuable in providing education to providers and assuring that providers pay closer attention to their legal obligations. Also, SIRS tracks the date of expiration of Stipulated Provider Agreements. Before an agreement expires, SIRS will conduct another onsite visit to assess compliance with the terms of the agreement. If violations have continued, the agreement and the provider’s signature of acquiescence to its terms are good evidence to support a more severe sanction. In a few cases, Minnesota’s MFCU has used a Stipulated Provider Agreement combined with the provider’s continued non-compliance as evidence supporting intent to commit fraud.

Effective and Innovative Practices

As part of its focused 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.

Beneficiary Lock-In Program

Minnesota's Medicaid Recipient Restriction Program (MRRP) was cited as an effective practice by the Medicaid Integrity Group review teams in both 2008 and 2011. MRRP staff continues to work closely with MCEs to bring about universal restriction. Universal restriction means that regardless of whether beneficiaries are initially restricted by an MCE or the FFS Medicaid program, the restriction will follow the beneficiaries if they change plans, move from FFS to managed care, or vice versa. The MRRP staff enters such restrictions into the Medicaid Management Information System so that tracking edits can be created. These edits automatically prevent payment to all providers who are not the beneficiaries' designated providers. The MRRP program has continued to reduce the abuse of services by beneficiaries and unnecessary costs to the program by decreasing the amount of unnecessary services used.

According to SIRS, the MRRP program had 2,305 active beneficiaries in the program in 2013 and generated $42,458,307 in savings from CY 2011 through 2013. Of this total, DHS estimated that it saved an average of $7,413.28 per restricted beneficiary during the first year of restriction and $11,006.29 during the second year of restriction per restricted recipient. Approximately 77% of the savings was due to the impact of reduced utilization under the MRRP. Roughly 23% resulted from the denial of unallowable claims for services rendered by providers other than those assigned to MRRP participants. As of July 1, 2014 there were 3,599 active MRRP recipients with an estimated savings of $66.2 million dollars in savings over the restriction period.

Innovative Practice in Minnesota's Personal Care Attendant Program

The Medicaid Integrity Group's 2008 and 2011 program integrity reviews identified Minnesota's management of PCAs as an effective practice. The following elements of the program, which are still in use, were cited:

- the requirement that PCAs be enrolled with the state Medicaid agency and have individual provider numbers;
- the affiliation of individual PCAs with home health and PCA agencies;
- the requirement that services be billed through an affiliated agency;
- the requirement to bill by individual service date rather than by date span
- employment data matches with the state Department of Employment and Economic Development, to find conflicting employment;
- daily and monthly service limits;
- edits for conflicting claims;
- PCA agency three day training; and
- PCA on-line training.

DHS has built upon these practices through collaboration with its contracted MCEs. When an MCE investigates billings by an individual PCA and determines that inappropriate billings have

occurred, the MCE will prohibit that PCA from submitting claims to the organization. However, because PCAs are required to enroll with DHS, the MCEs also refer the investigative information to DHS. The SIRS unit will then initiate action to suspend or terminate the PCA as a provider. Once suspended or terminated, that PCA cannot work for other PCA agencies or other MCEs during a period of suspension or termination. In addition, the PCA is identified on the state's public exclusion list, which all provider types are required to check to identify individuals who cannot participate in Minnesota Medicaid.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Minnesota 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 Regional Information Sharing Systems for information provided by other states including best practices and managed care contracts.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and assistance as needed to conduct exclusion searches and training of managed care staff in program integrity issues.
- 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 Minnesota based on its identified risks include those related to provider enrollment and oversight of managed care. More information can be found at http://www.justice.gov/usao/training/mii/training.html.
- 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 Minnesota 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 the ACA section of this report.

Conclusion

Minnesota applies noteworthy and effective practices that demonstrate program capabilities and the state's commitment to program integrity. CMS supports Minnesota's efforts and encourages it to look for additional opportunities to improve overall program integrity.

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. In addition, 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 Minnesota to build an effective and strengthened program integrity function.

Minnesota Department of **Human Services**

January 20, 2016

Mark Majestic, Director
Investigation and Audits Group
Division of Field Operation
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop AR-21-55
Baltimore, Maryland 21244-1850

Dear Mr. Majestic:

Thank you for the thorough review of Minnesota's Medicaid program integrity processes by the Investigations and Audits Group (IAG). We appreciate the review team's efforts to identify strengths and vulnerabilities in the state's implementation of the enhanced provider screening and enrollment provisions of the Affordable Care Act and oversight of integrity activities in our managed care program. The recommendations for improvement in the IAG's final report has provided a roadmap for Minnesota's corrective action plan, which is attached.

Soon after the review team's visit, Minnesota completed correction of several areas of identified noncompliance and vulnerability. In the area of enhanced screening, implementation plans were underway at the time of review, following passage of essential state legislation and appropriation of funding. Minnesota is also working extensively on the development of an online provider enrollment screening portal, in cooperation with CMS. In the area of managed care, we have implemented significant changes since the date of the IAG's visit. For example, the development of a comprehensive reporting tool has strengthened oversight of the managed care organizations' integrity activities in several areas mentioned in the final report. Minnesota will actively work to implement the remaining corrective actions, based on the final report recommendations.

Please contact Jennifer Hasbargen, Manager of the Surveillance Integrity Review Section, in the Office of Inspector General, at 651-431-4356, if you have any questions.

Sincerely,

Julie A. Beck

Julie A. Beck, Federal Audit and RAC Supervisor
Surveillance and Integrity Review
Office of Inspector General