Department of Health and Human Services

Centers for Medicare and Medicaid Services

Center for Program Integrity

Pennsylvania Focused Program Integrity Review

Final Report

March 2016

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review to determine the extent of Pennsylvania's program integrity oversight of the managed care program at the state level and assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state. This review focused primarily on efforts by the state and MCOs to prevent and detect fraud and abuse on the part of managed care network providers. The review also included a follow up on the state's progress in implementing its corrective action plan (CAP) that resulted from CMS's last program integrity review in August 2011.

Background: State Medicaid Program Overview

The Pennsylvania Medicaid program, often referred to as the Medical Assistance (MA) program, provides an array of health and long-term care services to beneficiaries. These benefits are provided to persons of all ages including adults, children, pregnant women, low-income families, people with disabilities, and seniors. Currently one out of every six people in Pennsylvania receives Medicaid benefits. Pennsylvania's Medicaid program enrolled approximately 2.2 million beneficiaries in federal fiscal year (FFY) 2014 and had total computable Medicaid expenditures of approximately $23.5 billion (Federal share – approximately $12.7 billion).   The MA program provides care for approximately 1.7 million beneficiaries enrolled in their HealthChoices program which is administered through seven MCOs.

Pennsylvania is a Medicaid expansion state, which, in calendar year 2014 sought approval   from CMS to implement the Affordable Care Act's Medicaid expansion.. The Medicaid expansion plan sought benefit package changes for current and newly eligible beneficiaries, which were made through a state plan amendment. The Medicaid expansion demonstration was implemented on January 1, 2015.

In February 2015, Pennsylvania transitioned from a Medicaid expansion waiver to a traditional Medicaid expansion through the HealthChoices section 1915(b) waiver. The transition is expected to mostly affect newly eligible adults ages 21 to 64 in Pennsylvania with income up to 138% of the federal poverty level. Under the new plan, all newly eligible Medicaid beneficiaries enrolled in the new MCOs created by the waiver will transition to the state's pre-existing Medicaid MCOs and the three adult benefit packages will be replaced with one adult benefit package. The transition to the new expansion plan is scheduled to be completed by September 30, 2015.

Methodology of the Review

In advance of the onsite visit, CMS requested that Pennsylvania and the MCOs selected for the focused review complete a review guide that provided the CMS 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, 2015, the CMS review team met with staff from the Bureau of Program Integrity (BPI) and the Special Investigation Unit (SIU) of three MCOs selected for review. As part of the onsite review, the team conducted interviews with agency staff involved in program integrity, provider enrollment, and managed care, along with staff from sister agencies that provide specialty services. To validate Pennsylvania's and the selected MCOs' program integrity practices, the team also reviewed a sample of provider enrollment applications, MCO investigations, actions against providers, and other primary data.

Results of the Review

The CMS review team identified one area of concern in provider enrollment and screening requirements that have an impact on the state's managed care program. In addition, there were other areas of concern with the state's managed care program integrity activities and managed care oversight, thereby creating risks 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 soon as possible.

Section 1: Managed Care Identified Risks

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, the Social Security Administration's Death Master File (SSADMF), 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 fully in compliance with this regulation.
As part of the provider and enrollment and screening process, the state assigns a Medicaid number which the provider must provide to the MCOs in order to apply to be a part of an MCO's network. However, despite the required enrollment by the state, they do not perform all of the required federal database checks for providers during initial enrollment, re-enrollment, reactivating or revalidating, or when there is a requested change of ownership.   Neither the state nor the MCOs are checking providers against the SSADMF upon enrollment and re-enrollment. The state checks the LEIE and EPLS upon initial enrollment and reenrollment only and does not conduct monthly checks of providers, owners, agents, and managing employees against the LEIE and EPLS. This responsibility is delegated to the MCOs.   Therefore, the MCOs are checking the LEIE and EPLS on a monthly basis; however, they are not checking owners, agents, and managing employees. In addition, the state does not ensure that the MCOs check the SSADMF at the time of initial enrollment and re-enrollment.

> **Recommendations:**
> - Access and utilize the SSADMF during provider enrollment and re-enrollment.
> - Develop policies and procedures that comply with 42 CFR 455.436.
> - Ensure that MCO contract language stipulates that MCOs are required to check the SSADMF at the time of initial enrollment and re-enrollment as well as providers, owners, agents, and managing employees against the LEIE and EPLS on a monthly basis.

Section 2: Managed Care Program Integrity

Overview of the State's Managed Care Program:

In calendar year 2009, the BPI was moved to the Office of Administration. There are three divisions within the BPI: the Division of Provider Review, Division of Program and Provider Compliance and the Division of Third Party Liability. The BPI is the office for the state's program integrity activities for fee-for- service (FFS) program and the Managed Care program integrity operations all operating under the same administration.

The Bureau of Managed Care Operations (BMCO) is in the Department of Human Services, Office of Medical Assistance Programs. BMCO is responsible for the administration and oversight of the mandatory physical health managed care programs that provide MA benefits to beneficiaries in Pennsylvania. The BPI is a member of each of the BMCO Contract Management Teams (CMT) which collectively monitors the MCOs. The BPI is responsible for ongoing monitoring, prevention, and detection of fraud, waste, and abuse and the recoupment of overpayments in the HealthChoices programs. The BPI is in the process of conducting reviews of its current agreements, language, monitoring policies and practices.

The BPI performed physical health MCO compliance reviews in calendar years 2009 and 2012. As of this review there were no outstanding CAPs. State staff indicated that they were waiting the outcomes and requirements of this CMS review in order to incorporate them into its next round of reviews slated for the state fiscal year (SFY) 2015-2016.

The BPI is focusing on building and strengthening program oversight in the managed care environment. They are preparing a managed care proposal which will focus on agreement language, MCO network provider reviews, triennial MCO reviews, and RAC procurement to include managed care.

Summary Information on the MCOs Reviewed:

During the week of the onsite review, the CMS review team met with the program integrity staff from three MCOs to discuss their program integrity activities at length: AmeriHealth Caritas Pennsylvania/AmeriHealth Northeast (ACP/AHN), Keystone First, and Aetna Better Health.

All three of the MCOs interviewed had a compliance program with an SIU and dedicated staff for the oversight of their program integrity activities. All three MCOs had a Compliance Officer.

However, there is concern that one of the MCOs interviewed does not have any investigators present in the state and does not conduct any onsite visits of providers.

ACP/AHN and Keystone First are Pennsylvania's largest MCOs, serving nearly 500,000 beneficiaries combined, and share the same SIU. Aetna Better Health provides managed care services for people enrolled in Pennsylvania's MA program and Children Health Insurance Program. Aetna's membership is expanding in 2015 as a result of the Medicaid expansion program in Pennsylvania.

Below is the summary data for the MCOs reviewed:

Table 1: Summary Data for Pennsylvania MCOs.

MCO	Medicaid Enrollees	Medicaid Contracted Providers	Size and Composition of SIU	Average Medicaid Expenditures (SFY12-14)
ACP/AHN	185,882	22,155	20.5 SIU FTEs:** 1 Director 2 Managers 1 Support Supervisor 1 Intake Specialist 4 SIU analysts 8 Investigators (physical health) 3 Investigators (behavioral health)	$2.2 Billion*
Keystone First	311,498	28,971	20.5 SIU FTEs:** 1 Director 2 Managers 1 Support supervisor 5 SIU analysts 8 Investigators (physical health) 3 Investigators (behavioral health)	$5.6 Billion*
Aetna Better Health	149,734	25,856	12 SIU FTEs: 6 Investigators 3 Analysts 1 Program Manager 1 RN 1 Systems programmer	$334.3 Million*

MCO's fiscal year is the calendar year.
***ACP/AHN and Keystone First share the same SIU.*

State Monitoring of MCOs:

The CMTs are responsible for monitoring agreement compliance by using performance standards, which include those for fraud, waste, and abuse. The state uses an electronic monitoring system known as the Systematic Monitoring Access Retrieval Technology (SMART). BPI is responsible for completing SMART standards for each of the seven physical health MCOs relative to provider and beneficiary fraud, waste, and abuse activities. By measuring performance against the standards, the team can assess the MCO's compliance with agreement requirements.

BMCO and the BPI regularly monitor the MCOs' program integrity activities through:

- CMTs assigned to each MCO
- Monthly and quarterly calls
- Trainings and conferences
- Weekly or monthly updates and quarterly reports

The MCO contract requires that all MCOs make referrals of suspicious provider activity to the state and the Medicaid Fraud Control Unit (MFCU) simultaneously. During interviews with the three MCOs, it was learned that they differed on how they notified the MFCU and the state after their preliminary investigations revealed possible fraud. The ACP/AHN and Keystone First SIU stated that their referrals were typically made to the state, but there have been circumstances where dual referrals were made to the state and the MFCU simultaneously.

This process allows the BPI to track the managed care program integrity activities and to determine whether or not the same providers are under investigation by the state or another MCO. However, the state reported that when an MCO does not report referrals to them and the MFCU simultaneously then the state will receive the information from MFCU. Referrals from MCOs to the MFCU are tracked in the BPI MFCU referral database.

Section 3: Fraud, Waste, and Abuse, and Audit Activities

State Oversight of MCO Program Integrity Activities:

The Pennsylvania MCO contract, dated January 1, 2015, addresses fraud and abuse issues under different sections throughout the contract; however, the sections of the contract that deal with program integrity should contain a regulatory citation. The regulatory requirements such as data base checks, suspensions, exclusions, risk levels, etc., are part of the fraud and abuse oversight responsibility and the state should ensure that the contract fully addresses them.

In addition, the state conducts onsite reviews of the MCOs to verify compliance with fraud, waste, and abuse contract requirements, including Third Party Liability data, cost avoidance, and post-payments recoveries. The BPI is expected to begin its next onsite reviews in the SFY 2015-2016, timing the reviews to incorporate any findings from CMS's program integrity review.

Fraud, waste, and abuse referrals are submitted to BPI using the online referral process. When the BPI discovers or receives information, which suggests potential fraudulent activities related to the Medicaid program, it is required to make referrals of enrolled providers, individuals, and entities to the MFCU for further investigation. During the review period the BPI received the following referrals from the three MCOs interviewed over a four year period.

Table 2: Referrals from MCOs.

MCO	Number of Referrals SFY 2010 – 2014
ACP/AHN	39
Keystone First	95
Aetna	27

State Monitoring of MCO Network Provider Activities:

The state does not conduct oversight of the MCOs' network providers. The state reported they can only do reviews of MCO network providers when an operations memo is approved. Previously, the state initiated a retrospective review of outpatient services performed during an inpatient stay and durable medical equipment rented after purchase that were all provided by MCO network providers. The MCOs preempted the state's review and focused on these areas themselves; therefore, voiding the state's outcomes. The state is in the process of preparing another operations memo to open up the scope of their review of MCO network providers. The state should coordinate audits, reviews, and/or investigations of network providers with the MCOs to avoid duplication of effort. The state MCO contracts should specify that the state does have authority to review the MCOs network providers.

Compliance Plans:

The managed care regulation at 42 CFR 438.608 requires that MCOs have specific administrative and management procedures designed to guard against fraud and abuse, which must include: written policies, procedures, and standards of conduct regarding the MCO's commitment to compliance, the designation of a compliance officer, training and education for all employees, effective lines of communication, enforcement of standards through well-publicized disciplinary guidelines, internal monitoring and auditing, and prompt response to detected offenses and corrective action.

The ACP/AHN, Keystone First, and Aetna have the required administrative and management procedures to guard against fraud and abuse in place. The CMS review team reviewed Pennsylvania's compliance plan for its MCOs and confirmed that the three MCOs interviewed are meeting the plan's requirements. All Pennsylvania MCOs are required to have a compliance program that includes investigating fraud, waste, and abuse. Each MCO maintains the contractual responsibility for auditing and investigating its own providers.

Meetings and Training:

MCO staff and state managed care staff meet regularly on issues related to program integrity. Meetings include but are not limited to:

- Quarterly Fraud and Abuse Meeting,
- Annual Provider Compliance Meeting,
- Multidisciplinary Team Meeting to include MFCU,
- CMT and MCO Meeting,
- Program Integrity Monthly Staff Meeting,
- Managed Care Operations Management Meeting,
- Quarterly calls with MCOs and SIUs, and
- Provider Review Committee Meeting.

The BPI offers training for the MCOs throughout the year. Training for SIU personnel is usually offered during the quarterly fraud and abuse meetings.

All ACP/AHN and Keystone First staff, including managers, directors, and the Board of Directors, who are involved with the administration or delivery of the Medicaid program, complete new hire training within 30 days of start date, and annually thereafter. The training program includes education and guidance on:

- Ethics and legal compliance policies,
- The code of conduct,
- Fraud, waste, and abuse issues and procedures,
- The reporting and investigation of compliance issues,
- The SIU's mission and purpose, and
- The SIU referral process.

Additionally, ACP/AHN and Keystone First make their compliance and fraud, waste, and abuse training available to first tier, downstream, and related entities. During the interview, the CMS review team discovered that contractors attest to completing the trainings, but there is no oversight to validate completion.

As a condition of their employment, Aetna Medicaid employees are required to take Medicaid compliance, and fraud, waste, and abuse training, upon hire and annually thereafter.

Encounter Data:

The contract between the state and the MCOs specifies the certification and submission requirements for reporting encounter data, including timeliness, accuracy, completeness, format, sampling, data validation/verification, penalties, and monetary sanctions. However, the state reported that the data is not consistent and sometimes contains inaccurate information (e.g., service location).

On March 6, 2015, a Managed Care Operations Memorandum was issued on the reporting of encounter data at the service location level. The purpose of the memorandum was to provide the MCOs with updated information on the state's expectations for reporting encounter data at the service location level. Beginning on April 1, 2016, the MCOs will be required to submit encounter data at the service location level using the correct National Provider Identifier (NPI)/Taxonomy/Zip Code for the billing provider and to drill down to the correct NPI/Taxonomy for the rendering provider.

However, if the MCOs choose not to follow the guidance issued by the state, then according to the MCO contract, the state may impose penalties when MCOs do not provide complete, accurate, and timely encounter data. Continued or repeated failure to submit accurate encounter data may result in the application of penalties and may be considered a breach of the MCO contract. To date, the state has not imposed any penalties on the MCOs for inaccuracy of encounter data.

Overpayment Recoveries and Audit Activity:

The state's MCO contracts specify the state's ability to recoup overpayments as a result of managed care network provider investigations or audits by the state. However, the MCO has the right to recover any overpayments from provider audits, reviews, or investigations conducted solely by the MCO. Overpayments and recoveries resulting from audits, reviews or investigations conducted solely by the state will be recouped from the MCO. In addition, when joint reviews, audits, or investigations are conducted, it specifies that recoveries are to be shared equally between the MCO and the state.

According to the contract, recoveries are to be tracked by the MCO and reported to the state monthly or quarterly. The state verifies and validates all recoveries. All of the overpayment recoveries solely by the MCO are reported to the state for rate setting purposes. The CMS review team found that the MCOs reviewed during this period adhered to the contract and policy manual regarding procedures for properly processing and managing all claims and provider overpayments.

The ACP/AHN and Keystone First reported overpayment and recoveries in the amount of $109,519,959 and $331,972,999, respectively, in the last four FFYs. Aetna had a savings of $185.34 and had no recoveries for the last four FFYs.

The tables below indicate the number of investigations by the Pennsylvania MCOs reviewed and the overpayments identified and collected by each of the MCOs for the past four years.

Table 3A: Investigations and Overpayments collected by ACP/AHN.

SFY	Number of Preliminary Investigations (Not referred to BPI)	Number of Full Investigations (Referred to BPI)	Amount of Overpayments Identified and Collected
2011	6	6	$19,192,486
2012	7	7	$15,564,552
2013	18**	2	$28,952,978*
2014	30**	1	$45,809,943*

Overpayments identified for both ACP and AHN. (Numbers were not separated.)
**Please note that AHN became operational on March 1, 2013.*

Table 3B: Investigations and Overpayments collected by Keystone First.

SFY	Number of Preliminary Investigations (Not referred to BPI)	Number of Full Investigations (Referred to BPI)	Amount of Overpayments Identified and Collected
2011	34	10	$72,566,268
2012	19	13	$65,539,981
2013	41	8	$99,122,239
2014	94	2	$94,744,511

Table 3C: Investigations and Overpayments collected by Aetna.

SFY	Number of Preliminary Investigations (Not referred to BPI)	Number of Full Investigations (referred to BPI)	Amount of Overpayments Identified and Collected
2011	0	0	0
2012	0	0	0
2013	0	0	0
2014	30	10	0

Aetna staff indicated that low or no overpayments can be attributed to successful front end edits, however, this is simple and not plausible. No evidence has been provided by Aetna to support that a front end edit system they have developed is 100 percent successful.

Furthermore, during the interview, ACP/AHN and Keystone First staff indicated that they took measures to establish a comprehensive fraud and abuse operation. They utilize internal resources and an external vendor to run claims through electronic pre-payment edits. This increases the likelihood that claims are paid appropriately. Medical Directors as well as Provider Network Management review all clinical cost avoidance edits and approve them prior to payment. There
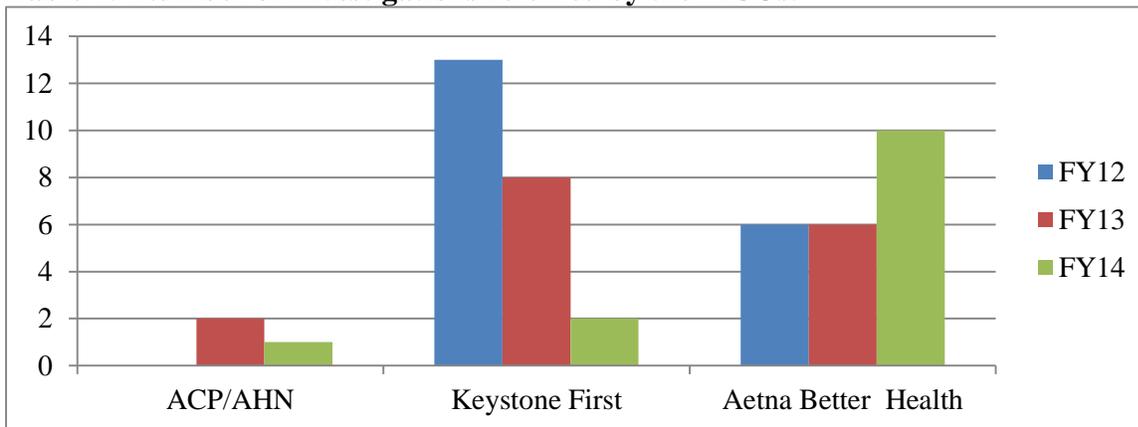
is an internal claims cost management process that is a post-adjudication, pre-check run, internal data mining system that runs twice a week and more frequently if needed.

The majority of Aetna's SIU activities are done nationally. Every allegation that comes into the national SIU is cross-checked against all Medicaid plans and other lines of business. Data mining is conducted at a national level as well as at the local level. Reporting is done locally by the MCO compliance officer.

The table below shows the number of cases that each MCO reported in the past three federal fiscal years:

Table 4: Number of Investigations referred by the MCOs.

Payment Suspensions:

According to the MCO contract, the state has the right to request the MCO to withhold payment to a provider in its network as a result of the state's audits, reviews, or investigations of managed care claims. However, the MCO contract does not contain the exact language in 42 CFR 455.23. The state reported that the MCOs are not obligated to suspend payments; it is at their discretion to suspend a claim or put it in prepayment review. Therefore, the MCO may treat requests from the state to suspend payments as an option to suspend or not.

The MCO contract does require MCOs to report any activity it has with providers, which is reported via the quarterly compliance report. The referrals must conform to the CMS fraud referral performance standards outlined in 42 CFR 455.23. Based on interviews and the MCO contract, the payment suspension procedures are either directed by the state or by the MCO. When the MCOs initiate payment suspensions due to a credible allegation of fraud, they are to report simultaneously to the state and MFCU. The state initiates all payment suspensions in the FFS program.

The ACP/AHN and Keystone First indicated that they suspend all payments to a provider after the state determines that there is a credible allegation of fraud for which an investigation is pending under the Medicaid program. The CMS review team sampling revealed there were no

payments suspended. In cases where the MCO identified suspected fraud, the cases were referred to the state in which they set an expectation that the MCOs' not pursue recoupment in the case of fraud but rather have them refer the case to the state.

The ACP/AHN and Keystone First staff indicated that the SIU did not initiate payment suspensions. The SIU employs a prepayment review process, on a case by case basis, for providers with suspected abusive and/or potentially fraudulent billing behaviors or patterns. The SIU requires the submission of medical records for review to validate services prior to payment. The case is reported to the state at the point a provider is suspended via the standard quarterly report submission.

Aetna providers are placed on "provider watch/provider hold" on an as needed basis. If a "provider watch/provider hold" is due to a fraud, waste, or abuse investigation, the state is notified via the referral process. The "provider watch/provider hold" stops claims from being paid rather than suspending payments. The claim's department needs to gain approval prior to releasing any claim if a provider is on "provider watch/provider hold."

Terminated Providers and Adverse Action Reporting

The MCOs are required by the contract to immediately notify the state in writing if a provider, subcontractor, or employee is suspended, terminated, or voluntarily withdraws from participation in the program as a result of suspected or confirmed fraud or abuse. It also requires that the MCOs' provider agreements must carry notification of the prohibition against false claims and statements. An MCO who fails to report is subject to sanctions, penalties, or other actions.

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

Table 5: Provider Terminations in Managed Care

Selected MCOS	No. Providers Disenrolled or Terminated in Last 3 Completed FFYs		No. Providers Terminated for Cause in Last 3 Completed FFYs	
ACP/AHN	2012	501	2012	0
	2013	572	2013	3
	2014	408	2014	3
Keystone First	2012	938	2012	1
	2013	1,051	2013	0
	2014	523	2014	1
Aetna	2012	600	2012	3
	2013	1,181	2013	0
	2014	2,361	2014	0

Section 4: Status of Corrective Action Plan

Pennsylvania's last CMS program integrity report was issued in FFY 2012 and contained three findings and five vulnerabilities. During the current on-site review, the CMS review team conducted a thorough review of the corrective actions taken by Pennsylvania to address all issues reported in FFY 2012.

Regulatory Compliance Issue #1:
The state has not implemented the new provisions of the regulation to suspend payments in cases of credible allegations of fraud.

The state supplied their policy that addresses this regulation and reflects the requirements for payment suspension under 42 CFR 455.23. The state's CAP indicated that since the implementation of this policy and procedure all referrals for suspected provider fraud dating back to March 25, 2011 were reviewed for the applicability of payment suspension.

Regulatory Compliance Issue #2:
The state does not capture all required ownership and control disclosures from disclosing entities. (Uncorrected Partial Repeat Finding)

The state indicated that they were in the process of finalizing the required new Ownership and Controlling Interest form for the remaining group provider applications during the CMS MIG Comprehensive Program Integrity review the week of August 22, 2011. Based on the state's CAP they revised the Provider Disclosure and Statement form to now include both the date of birth for listed individuals and enhanced address information for business entities on the form. In addition, the state's CAP indicated that prior to posting the disclosure forms to Pennsylvania's website, the Department of Human Services (DHS) enrollment staff requested the disclosure information for newly enrolled providers manually, but did not have a way of entering the information in the MMIS. The data entry windows for recording ownership and control interest information in the MMIS and the system changes for monthly checks have now been implemented.

In addition, the non-emergency medical transportation (NEMT) program is in the process of modifying disclosure forms to capture DOB, SSN, and enhanced address information on persons with an ownership or control interest and managing employees. The NEMT program has also begun making the necessary changes to policies and grant agreements to reflect the requirements. The requirements include that grantees notify DHS in a timely manner on such disclosures.

Regulatory Compliance Issue #3:
The state does not conduct complete searches for individuals and entities excluded from participating in Medicaid.

The state is continuing to look at the information they are collecting from providers and is working with their provider enrollment contractor to refine the information they are collecting

from the providers as well as to do some of the automated database checks. The provider portal is not up and running yet, but is expected to go live be by the end of January 2016.

NEMT providers are not enrolled in Pennsylvania's MA program. They are paid by direct contracts with NEMT brokers in counties of Philadelphia and Northumberland and via grants in the other 65 counties. To address this finding, as stated in compliance issue # 2 the DHS's NEMT program will modify its grantee agreements and policies to require searches of the LEIE and the EPLS at least monthly, to ensure that the state does not pay federal funds to excluded persons or entities pursuant to 42 CFR 455.436.

Vulnerability Issue #4
Not verifying with managed care and NEMT enrollees whether services billed were received.
(Uncorrected Partial Repeat Vulnerability).

On March 13, 2012, the state sent out a memorandum to all their MCOs clarifying what is expected of them to be in compliance with 42 CFR 455.20. Onsite reviews are being performed to verify that services billed were received by the beneficiaries.

The state also mentioned that meetings were held with each MCO to discuss their specific deficiencies and identify what corrective action is necessary to ensure their future compliance.

Vulnerability Issue #5
Not adequately addressing business transaction disclosures in NEMT commercial network provider contracts. (Uncorrected Repeat Vulnerability)

The state made changes to their grant agreements to make sure sub-contractors amended their sub-contract agreements as well to require disclosures upon request of the information identified in the provision.

Vulnerability Issue #6
Not maintaining adequate controls to deactivate sanctioned providers in the MMIS.

The BPI has been and continues to be notified any time the Office of Long Term Living has dis-enrolled, terminated, or sanctioned a provider. This addresses notification across sister agencies, but doesn't address whether these providers are subsequently deactivated in the MMIS system.

Recommendations for Improvement in Managed Care

- The state should develop policies and procedures that comply with 42 CFR 455.436.
- The state should coordinate audits, reviews, and/or investigations of network providers with the MCOs to avoid duplication of effort.
- The state should ensure that MCO contract language stipulates that MCOs are required to check the SSADMF at the time of initial enrollment and re-enrollment as well as providers, owners, agents, and managing employees against the LEIE and EPLS on a monthly basis.
- The state should ensure that the sections of the MCO contract that deal with program integrity should contain a regulatory citation. The regulatory requirements such as data base checks, suspensions, exclusions, risk levels, etc., are part of the fraud and abuse oversight responsibility and the state should ensure that the contract fully addresses them.
- Even though 42 CFR 455.23 is not currently a requirement for the MCOs, the state should ensure that the MCO contract fully addresses the complete regulatory requirements of specified at 42 CFR 455.23 to ensure there is consistency with payments suspensions from the state level as well as the MCO level.
- The MCO contract needs to include language as specified at 42 CFR 455.23 to strengthen the compliance requirement and stress the importance of a timely action and that it is not an option. The MCOs need to have a mechanism in place to suspend payments when the state asks them to, and to specifically when they determine that there is a credible allegation of fraud and to explain the options available to providers.
- The state should conduct a review of all MCOs who claim the reason for low or no overpayments is due to successful front end system edits to determine how it works. Once this review is complete the state should have a better understanding as to whether or not the MCOs have a successful front end edit system that would explain low or no overpayments.

Technical Assistance Resources

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

- Consult with the provider enrollment and screening workgroup of the Medicaid Technical Assistance Group to work with states that have developed automated monthly EPLS/ System for Award Management database checks.
- Consult with the provider enrollment and screening workgroup of the Medicaid Technical Assistance Group for suggestions on how to complete out-of-state site visits.
- 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.
- 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 Pennsylvania based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.

- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- 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 Pennsylvania review the effective and noteworthy 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.

Conclusion

CMS supports Pennsylvania's efforts and encourages it 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.

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 Pennsylvania to build an effective and strengthened program integrity function.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

Mr. Mark Majestic, Director
Department of Health & Human Services
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

Dear Mr. Majestic:

On behalf of the Pennsylvania Department of Human Services (DHS), thank you for the opportunity you provided through your review process in identifying areas we can strengthen to enhance our program integrity efforts. Additionally, we appreciate that you provided a series of technical assistance resources to assist the state in strengthening its program integrity operations.

Enclosed you will find the DHS response to the March 2016 Final Report from the Focused Program Integrity Review conducted by the Medicare and Medicaid Services' (CMS) Investigations and Audits Group. These responses contain details for each of the state's corrective actions and were formulated using the Corrective Action Plan Development Tool templates provided by CMS. These responses will address both the Regulatory Compliance Issue as well as the Vulnerabilities identified in the report.

A. <u>REGULATORY COMPLIANCE ISSUE</u>

1. The state should develop policies and procedures that comply with 42 CFR 455.436.

B. <u>VULNERABILTIES</u>

1. The state should ensure that MCO contract language stipulates that MCOs are required to check the SSADMF at the time of initial enrollment and re-enrollment as well as providers, owners, agents, and managing employees against the LEIE and EPLS on a monthly basis.

2. The state should coordinate audits, reviews, and/or investigations of network providers with the MCOs to avoid duplication of effort.

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3. The state should ensure that the sections of the MCO contract that deal with program integrity should contain a regulatory citation. The regulatory requirements such as data base checks, suspensions, exclusions, risk levels, etc., are part of the fraud and abuse oversight responsibility and the state should ensure that the contract fully addresses them.

4. Even though 42 CFR 455.23 is not currently a requirement for the MCOs, the state should ensure that the MCO contract fully addresses the complete regulatory requirements of specified at 42 CFR 455.23 to ensure there is consistency with payments suspensions for the state level as well as the MCO level.

5. The MCO contract needs to include language as specified at 42 CFR 455.23 to strengthen the compliance requirement and stress the importance of a timely action and that it is not an option. The MCOs need to have a mechanism in place to suspend payments when the state asks them to, and to specifically when they determine that there is a credible allegation of fraud and to explain the options available to providers.

6. The state should conduct a review of all MCOs who claim the reason for low or no overpayments is due to successful front end system edits to determine how it works. Once this review is complete the state should have a better understanding as to whether or not the MCOs have a successful front end edit system that would explain low or no overpayments.

As noted in our exit conference and in the Preliminary findings report, DHS is pleased that the CMS review team conducted a thorough review of the corrective actions taken by Pennsylvania to address all issues reported in 2012 and determined that all Correction Action Plan items from Pennsylvania's previous review have been satisfactorily addressed by the state.

Thank you and your staff for sharing this valuable information with us so that we can strengthen our program. If you have any questions regarding this response, please do not hesitate to contact me at (717) 787-3422 or jbausch@pa.gov.

Sincerely,

Jay Bausch
Deputy Secretary for Administration