Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Utah Focused Program Integrity Review

Final Report

June 2017

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Objectives of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of Utah to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected accountable care organizations (ACOs) under contract with the state Medicaid agency. The review also included a follow up on the state's progress in implementing corrective actions related to CMS's previous comprehensive program integrity review conducted in calendar year 2010.

Background: State Medicaid Program Overview

The CMS review team conducted the review at the offices of the Utah Department of Health (DOH). The Division of Medicaid and Health Financing (known as the Division) within the DOH is the organization that is responsible for implementing the Medicaid program, while the Bureau of Managed Health Care (BMHC) has programmatic oversight of all the managed care entities.

The state contracts with four ACOs, one managed care organization (MCO) called the Utah Healthy Outcomes Medical Excellence (HOME) program, and two managed care dental plans. In addition, there are 12 prepaid mental health plans which offer behavioral health services.

Utah is not a Medicaid expansion state and has nearly 90 percent of its Medicaid beneficiary population participating in its statewide mandatory managed care program and ten percent participating in its fee-for-service (FFS) program. The state's Federal Medical Assistance Percentage is 70 percent. The total Medicaid expenditures for state fiscal year (SFY) 2015 totaled nearly $1.2 billion. The managed care health plans in Utah deliver Medicaid managed care services to approximately 291,698 Medicaid beneficiaries.

Methodology of the Review

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

During the week of August 23, 2016, the review team visited with representatives from BMHC within the Division and the Office of the Inspector General (OIG) for Medicaid Services. The OIG is a state agency that is located within the Department of Administrative Services. The review team also conducted interviews with three Medicaid ACOs and their special investigations units (SIUs) or program integrity units (PIUs). The selected ACOs were Healthy U Medicaid Health Insurance (Healthy U), Molina HealthCare of Utah (Molina), and SelectHealth Community Care (SelectHealth). The review team also reviewed the program integrity activities performed by Premier Access, one of the two dental plans operating in the state. The program integrity review focused primarily on the activities of the DOH organizations with the responsibility of providing the program integrity oversight of all managed care plans. In

addition, the review team conducted sampling of program integrity cases and other primary data to validate the state's and the selected ACOs' program integrity practices.

Results of the Review

The CMS review team identified areas of concern with the state's managed care program integrity oversight, thereby creating risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible, particularly those that remain from the earlier review. These issues and CMS's recommendations for improvement are described in detail in this report.

Section 1: Managed Care Program Integrity

Overview of the State's Managed Care Program

As mentioned earlier, approximately 291,698 beneficiaries were enrolled in Medicaid managed care programs during FFY 2015. The state spent approximately $940 million on their four ACO contracts in FFY 2015. The DOH is responsible for evaluating the quality of care provided to eligible participants in contracted ACOs through the Utah Medicaid managed care program, which has been operational since June 1997. The state delegates the responsibility to detect, analyze, and investigate billing patterns from claims data for fraudulent activity to its ACOs in the Medicaid managed care program. They rely on the ACOs' SIU to control fraudulent activity. The Medicaid Single State Agency (SSA) also delegates certain program integrity activities through a memorandum of understanding to the OIG. The OIG also has additional statutory authority and responsibility to detect fraud, waste, and abuse in the Medicaid program. The OIG's investigative focus has been primarily on FFS claims. At the time of the review, the OIG had a total of 24 full time equivalent (FTE) positions dedicated to program integrity responsibilities; however, these program integrity responsibilities are dedicated primarily to Utah's traditional or FFS Medicaid program. The OIG expressed an interest for increasing their managed care program integrity efforts in the future.

The ACOs are contractually responsible to credential providers in their networks in compliance with 42 CFR 455. Although not yet required in 42 CFR 438, Utah requires managed care entities to also enroll their network providers directly with the state Medicaid program. This allows Utah to have a dual provider enrollment/credentialing process. Notwithstanding the noteworthy effectiveness of Utah's centralized and dual provider enrollment/credentialing process, the review team identified some issues with provider enrollment practices within Utah's managed care program that are reflected in this report and should be addressed in order to maximize the benefits from having a centralized and dual provider enrollment/credentialing process.

Summary Information on the Plans Reviewed

The CMS review team interviewed three ACOs as part of its review. The review team met with the program integrity or SIU staff of Healthy U, Molina, and SelectHealth to discuss their program integrity activities at length. In addition, the review team interviewed Premier Access to determine how program integrity is being conducted within the dental health plan.

Healthy U is part of the University of Utah Health Plan (UUHP). The UUHP is a local plan owned by the University of Utah Hospitals and Clinics (UUHC), which started in 1998 and provides services in Utah for Medicaid, Medicare and its commercial lines of business. Healthy U has a PIU that is housed at the Murray, UT location. The PIU informed the review team that 80 percent of its time was spent on its Medicaid line of business, while only 20 percent of its time was dedicated to its commercial line of business. Within the Medicaid line of business, approximately 20 percent of time is spent on fraud, waste, and abuse activities. Furthermore, UUHP has a government programs unit that assists with suspected fraud, waste or abuse cases that are reported to them. UUHP contracts with Verisk to utilize their Verisk (Nucleus) fraud and abuse detection application that is designed to score and profile provider billing behaviors and patterns. The UUHP provides a monthly claim file to Verisk. Verisk then returns the claim file to UUHP with their program integrity findings.

Molina's ACO became operational in 2004. Molina's compliance department is responsible for addressing suspected provider fraud and abuse. Complaints and provider oversight are administered by Molina's network management and operations department. The compliance department consists of a director of compliance, a chart review nurse, and a compliance specialist. Under the director of compliance there is a compliance committee and anti-fraud waste and abuse sub-committee to oversee Molina's fraud, waste, and abuse prevention, identification, investigation, and reporting activities, while maintaining consistency with the goals of Molina's program integrity compliance plan.

SelectHealth, which is a subsidiary of Intermountain Health Care, operates in Utah and Idaho, and conducts most of its business commercially. The government programs consist of approximately 40 percent of its overall business operations, with Medicare and Medicaid split evenly of approximately 20 percent each.

Premier Access is corporately based out of Sacramento, CA and operates in Utah. The SIU is operated by their parent company, Guardian Life, and maintains a staff of 12 personnel. The SIU staff works primarily on the commercial line of business and claimed it spent approximately five to ten percent of their time on Medicaid fraud, waste, and abuse. The SIU is located in Bethlehem, PA and mentioned they do not meet with the OIG on a regularly scheduled basis.

The external quality review organization (EQRO) contractor, Health Services Advisory Group (HSAG), reviews managed care contracts in Utah. The HSAG is the largest EQRO in the nation and provides quality review services for states that operate Medicaid managed care programs and FFS programs. As an EQRO, HSAG evaluates Utah's ACOs as required by the code of federal regulations (CFR). Specifically, HSAG reviews 42 CFR Part 438, Subpart E, and aggregates information on the timeliness, access, and quality of healthcare services furnished to Medicaid

enrollees. Utah delegates the monitoring of the ACOs' fraud and abuse policies and procedures to HSAG. HSAG's initial compliance reviews were conducted in calendar year 2015. Follow-up reviews were conducted in March through June 2016.

Enrollment information for each ACO as of June 2016 is summarized below.

Table 1.

	Healthy U	Molina	SelectHealth
Beneficiary enrollment total	49,030	88,788	99,067
Provider enrollment total	6,171	8,627	5,509
Year originally contracted	1998	2004	2013
Size and composition of SIU	6.0 FTEs	3.0 FTEs	3.0 FTEs
National/local plan	Local	National	Local

Table 2.

ACOs	FFY 2013	FFY 2014	FFY 2015
Healthy U	$277.2 million	$228.3 million	$208.4 million
Molina	$243.4 million	$213.9 million	$197.6 million
SelectHealth	$384.6 million	$360.9 million	$281.0 million

State Oversight of ACO Program Integrity Activities

The office responsible for governing Utah Medicaid is the Division, which is located within the DOH. The Division operates many program integrity activities. The Utah OIG is responsible, by state statute, for identifying and investigating fraud, waste, and abuse in the Medicaid program. The OIG partners closely with Division on their policy updates to ensure clarity and accuracy for Medicaid providers and consistency with existing policy. The OIG conducts annual provider training to encourage provider participation in Utah's Medicaid program, while increasing awareness and transparency of Medicaid policies and OIG compliance reviews. The OIG conducted 31 provider outreach trainings in SFY 2014. Currently, they meet with the Division on a monthly basis, and with the Division and ACOs on a quarterly basis. In addition, the OIG meets with each of the ACOs individually between the quarterly meetings. Therefore, the OIG has approximately eight meetings annually with the managed care program integrity partners in Utah. The OIG mentioned its staff spends approximately 40 percent of its program integrity activities on managed care operations. The OIG also mentioned that their goal is to raise this percentage to 60 percent.

Utah maintains fraud, waste, and abuse policies and procedures in a fraud manual detailing how the OIG should conduct their reviews and audits of providers. However, the OIG does not conduct routine investigations of managed care providers, but relies primarily on the SIUs of each ACO to do the initial investigations and refer credible allegations of fraud to them. The state expressed a desire to increase their program integrity efforts in managed care, largely due to the low number of case referrals resulting from ACO investigations.

ACO Investigations of Fraud, Waste, and Abuse

As stipulated in 42 CFR 455.13, 455.14, 455.15, 455.16, and 455.17, the state does have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and ACOs. The process is outlined in Utah's Model ACO Contract, Attachment B – Traditional, Effective July 1, 2015, Articles 6 and 6.1.1 through6.1.4.

Healthy U has a managed care coordinator who reviews potential fraud cases by utilizing claims audits, and reports, and will log the suspected fraud. If the coordinator suspects fraud, a letter is initially sent to the provider notifying them of their audit and investigation, and requests a response from the provider. A fraud investigation folder is then created for the specific provider fraud investigation. The coordinator saves a copy of the letter in this folder, along with any other information from the investigation. Following the receipt of the provider's response, if action is still deemed necessary, the coordinator will draft a letter requesting a refund of the payments made on the fraudulent claims or notify the provider of any action that will be taken and request a response within 60 days of the letter. A report of potential fraud will be reported to their provider relations/credentialing team, and cases of potential fraud are reported to the Utah fraud division. Their managed care coordinator will document all findings and action taken against the provider in their claims system and in their fraud, waste, and abuse log.

Molina uses IntegriLink to house all of the information for their investigations. Once a referral or tip is received, the compliance department will complete an initial review and pull a claims report for a fraud, waste, and abuse review. This is considered their preliminary investigation. If, during the preliminary investigation, the information gathered indicates the likelihood that suspect activity has occurred, the preliminary investigation may escalate into an extensive or full investigation; this step may include an audit of medical record documentation, validation that services occurred, and/or determination that services were medically necessary by the compliance department. At the conclusion of the audit, the results are prepared in a letter by Molina's compliance/legal departments and issued to the provider. The letter will identify the issues determined during the audit, any corrective action required by the provider, the resulting overpayment, and the provider's right to appeal if he/she is in disagreement with the findings.

SelectHealth's SIU works across multiple platforms including their commercial and Medicare/ Medicaid lines of business. Their SIU operates in an ad-hoc capacity, regarding any proactive approach in identifying instances of fraud, waste, and abuse. Their SIU depends on their billing/coding departments to identify potential cases of fraud, waste, and abuse. The SIU unit does not have any systems or measures in place to analyze the billing database for patterns of fraud, waste, and abuse. However, SIU staff runs structured query language (SQL) queries to search for instances of fraud, waste, and abuse, when time allows and only after a potential issue is identified. Based upon the SQL query results, the SIU may run the SQL query again at a later date. SelectHealth does not currently have a case tracking management system, but is exploring either developing one in-house or purchasing one from a third party vendor.

During FFY 2016, HSAG evaluated Utah's Medicaid ACOs, which included approximately 26 program integrity elements. Healthy U scored 86 percent in meeting its program integrity requirements; Molina scored 94 percent; and SelectHealth scored 96 percent. The EQRO

evaluation of Utah Medicaid ACOs did not include the dental plans. The HSAG identified corrective actions needed to address opportunities for improvement in the report. However, the EQRO report did not identify the actual program integrity activity which the ACOs did failed to meet.

Utah's ACOs were not verifying receipt services rendered with beneficiaries. Although this is not currently a regulatory requirement for the ACOs, the ACO contract specifically requires Utah ACOs to have a mechanism in place to meet the full requirements outlined at 42 CFR 455.20. SelectHealth was the only ACO verifying receipt of services with beneficiaries by randomly sending beneficiaries a service verification letter. During the interviews, the ACOs seemed to be unaware of the contract language at Article 6.1.2 (A)(6)(i), requiring them to verify receipt of services with beneficiaries, as a method to identify whether services are being rendered and billed correctly. In addition, Premier Access was not verifying receipt of services with beneficiaries, as required by their contract.

As mentioned previously, Utah has a dual provider enrollment process. The state has implemented new procedures in its provider enrollment process along with modifying provider enrollment documents and agreements. However, not all the ACOs are meeting the full provider enrollment requirements of their contract. Healthy U and SelectHealth were not checking the Social Security Administration's Death Master File (SSA-DMF). Molina checks the SSA-DMF at credentialing, recredentialing, and on a monthly basis thereafter. In addition, Premier Access does not check the SSA-DMF. This demonstrates a certain level of inconsistency among the ACOs and the dental plan; however, the state does not appear to be at risk of paying excluded persons or entities with federal funds, since the required SSA-DMF checks are performed for providers centrally by the state.

The ACOs submit monthly reports of fraud, waste, and abuse activity to the state, which is then sent to the OIG for review on a monthly basis. The contract does includes language that requires the ACO to report suspected provider fraud, waste, and abuse to the Utah Medicaid Fraud Control Unit (MFCU) or the OIG. The plans were in compliance with the contract regarding making referrals directly to the OIG or the MFCU, as stipulated in their contract. However, the review team found it difficult to track all cases that had been referred to the OIG or MFCU. The ACOs would refer arbitrarily to either the MFCU or the OIG. The review team had difficulty reconciling the number of cases the OIG claimed to have received with the number of cases that the ACOs claimed to have referred; this was due to the OIG not reporting cases that went to restriction, the Department of Workforce Services (DWS), or directly to the MFCU.

Table 3 lists the number of referrals that Healthy U, Molina, and SelectHealth made to the state in the last three FFYs. Overall, the number of Medicaid provider investigations and referrals by each of the ACOs is low, based upon the size of the plan. The level of investigative activity has not changed over time.

Table 3.

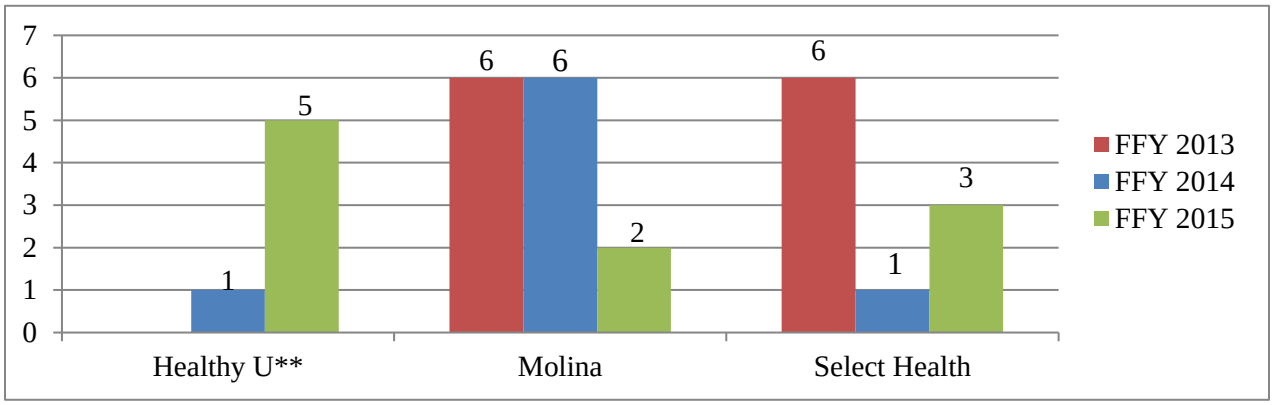

*Table includes one case referred in FFY 2014 and one case referred in FFY 2015 from an ACO that was not selected for this review.
**Healthy U did not refer any cases to the state during FFY 2013.

Although the case referral totals reported by the ACOs are slightly increasing, there are few cases of credible allegations of fraud being referred by the ACOs overall. In addition, Healthy U mentioned that interfering with providers was a sensitive matter. No referrals came from either of the dental plans operating in Utah.

During a sampling of preliminary investigation files, the review team identified cases where Medicaid services were provided not in accordance with Medicaid policy, but these cases were not viewed as a credible allegation of fraud by the ACO. The review team reviewed a UUHP case where the ACO determined that a provider was billing incorrect place of service (POS) code for emergency room visits. Claims data revealed that there were no emergency room visits on the date that the POS code was billed. According to the records, the office administrator was informed about the incorrect billings along with subsequent corrective measures in September 2013. In another note dated April 2014, the provider's office continued to bill incorrectly. There is no indication in the records that further actions were taken such as following up with the billing agent, placing the provider on prepay review, or referring the provider to the state OIG or MFCU. The overpayment amount of $4,686.16 was recovered.

ACO Compliance Plans

The state does require its ACOs to have a compliance plan to guard against fraud and abuse in accordance with the requirements at 42 CFR 438.608. The state does have a process to review the compliance plans and programs. All of the ACOs provided the review team with a copy of their compliance plans that were submitted to the state. A review of these plans revealed they were in compliance with 42 CFR 438.608; however, the Premier Access dental plan did not have a compliance plan. As required by 42 CFR 438.608, the state does review the ACOs' compliance plans and communicates approval/disapproval with the ACOs.

Encounter Data

The state does receive and review all encounter data from the ACOs and maintains the ability to run program integrity related analysis of that data. The OIG does not perform any data analysis, unless there is a complaint that calls for the OIG to specifically look into a managed care provider. Typically, the OIG will contact the ACO and request additional information in the event they need to look into a complaint.

Overpayment Recoveries, Audit Activity, and Return on Investment

The state does require ACOs to report on overpayments recovered from providers as a result of ACO fraud and abuse investigations or audits, but does not require the ACOs to return overpayments to the state. The state does not collect any overpayments from network providers. The overpayment amounts are offset on the ACOs financial reports for rate setting.

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

Table 4-A.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013*	N/A	N/A	N/A	N/A
2014	28	7	$292,639	$145,877
2015	25	12	$86,997	$54,095

*The UUHP began program integrity operations and organizing staff, during this time period.

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

Table 4-B.

FFY	Number of Preliminary Investigations	Number of Full Investigations	Amount of Overpayments Identified	Amount of Overpayments Collected
2013	11	7	$121,213	$65,000*
2014	10	8	$1,308,854	$0
2015	8	3	$12,952	$0

*Molina reported this amount was a settlement resulting from a FFY 2011 case.

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

Table 4-C.

FFY	Number of Preliminary Investigations*	Number of Full Investigations*	Amount of Overpayments Identified	Amount of Overpayments Collected
2013	15	15	$0	$0
2014	9	9	$0	$0
2015	20	20	$0	$0

*SelectHealth does not distinguish between preliminary and full investigations.

The above tables demonstrate that Utah's ACOs recover overpayments in small percentages. These low figures are likely the result in how the ACOs define and investigate credible allegations of fraud and the low number of fraud investigations being conducted by each ACO. Neither the SIUs nor the OIG were able to provide any return on investment figures for their Medicaid managed care program.

Payment Suspensions

Utah's ACOs are contractually required to suspend payments to providers at the state's request. The state confirmed that there is contract language addressing the payment suspension regulation at 42 CFR 455.23. However, the state relies on the contractor to develop policies and procedures for compliance with the regulation. At 6.1.5 Obligation to Suspend Payments to Providers, the Utah ACO contract states the following:

> (A) The Contractor shall develop policies and procedures to comply with 42 CFR 455.23.
> (B) The Contractor shall contact MFCU prior to suspending payments.

Although Utah's contract language delegates the responsibility to suspend provider payments to the ACOs, this does not remove the responsibility from the state to ensure that there is an effective process in place that meets full requirements of the regulation. 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.

Although the contract requires the contractors to develop a payment suspension procedure, the review team found that none of the ACOs had an active payment suspension process in place. The state does not routinely require the ACOs to suspend payments, although they have this requirement in the contract. Payment suspensions have only occurred in the managed care program when the state has initiated action directing the networks to suspend payments to a provider that may be operating in the Medicaid managed care program. Since the state does not

routinely analyze and investigate managed care claims data, payment suspensions do not happen frequently in the managed care program as outlined at 42 CFR 455.23.

Terminated Providers and Adverse Action Reporting

The state ACO contract does allow the ACOs to terminate a provider for quality of care issues, billing issues, suspected fraud or abuse, suspended licensure, or exclusion through federal or state database checks. The Utah ACO contract requires the ACOs to report terminations to the state. If the ACO is terminating the contract, the ACO shall electronically submit information relating to the termination (non-inclusion of providers) to the state within 30 calendar days of the termination (non-inclusion) action using the state-specified form. The state does require ACOs to provide them with the names and the National Provider Identifier numbers of providers that the ACOs have terminated; however, in the past, not all ACOs have been compliant with this requirement. The state will share this information with other plans when the state has been notified.

Since, the ACO contract does not require ACOs to report all adverse actions taken on provider participation, the ACOs were not reporting all adverse actions due to integrity or quality to the state. Therefore, the state should reiterate to ACOs their responsibility for reporting to the state whenever they deny enrollment of a provider into their network based on concerns related to fraud, integrity or quality. All ACOs indicated they have the authority to terminate providers for fraud or for business reasons and do not have to wait to be notified of actions taken at the state level before taking action against providers. Therefore, if the ACO made a general business decision to terminate a provider, the state would only know about it when they receive the monthly credentialing/decredentialing reports.

The state maintains its own state exclusion list and they share information on terminated providers across its managed care plan network. In addition, the state has the necessary access to the established CMS secure web-based portal, the MFT TIBCO server, which facilitates the sharing of information by states regarding terminated Medicaid providers and allows the state to terminate enrollment of providers terminated by Medicare or other state Medicaid or Children's Health Insurance Program in accordance with the regulation at 42 CFR 455.416.

Table 5.

ACOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		Total # of Providers Terminated For Cause in Last 3 Completed FFYs	
UUHP	2013	102	2013	5
	2014	92	2014	1
	2015	96	2015	2
Molina	2013	357	2013	4
	2014	10	2014	6
	2015	263	2015	0
Select Health	2013	29	2013	0
	2014	38	2014	0
	2015	27	2015	0

Overall, the number of providers terminated for cause by the plans appears to be low. Each of the ACOs mentioned that it was easier to let the provider contracts expire and not renew, rather than to get involved in lengthy litigation. Also, the low number of providers terminated for cause by the plans directly correlates to the low number of suspected fraud investigations being referred to the state or MFCU by the ACOs. Most of the plans expressed their impression that provider fraud was low in Utah and, as a result, opted to educate most of those providers instead of proactively referring these cases to the state for review. This is practice is evident in FFY 2015 where only two providers were terminated for cause for all ACOs reviewed. In addition, Premier Access dental plan had no terminations for cause over the past three FFYs.

Recommendations for Improvement

- The OIG should continue their program integrity efforts to increase their managed care oversight of administrative and management procedures. Specifically, the OIG should access ACO encounter data and ensure that it is sufficient, timely, accurate, and complete, and utilized to improve its program integrity oversight of its managed care program.
- The state should monitor ACO program integrity activities and ensure all ACOs have a case tracking management system, so that all Medicaid investigations of suspected fraud can be accurately tracked and reported to the state.
- The state should develop and implement procedures to verify that services billed by providers were received by ACO enrollees. The state should also ensure that the ACOs comply with their contractual requirement to verify with ACO enrollees whether services billed by providers were received.
- The state should ensure that all ACOs and contracted entities receiving Medicaid funding comply with their contract requirements to search the LEIE, EPLS, SSA-DMF, and NPPES upon contract execution, and check the LEIE and EPLS monthly thereafter by the names of any person with an ownership or control interest or who is an agent or managing employee. In addition, all Medicaid managed care providers should be informed and trained, if necessary, on how to search their employees for exclusions with federal programs to ensure the state does not enter a contract with a managed care contractor that has a prohibited affiliation.
- The state should develop ACO case referral policies and procedures to improve upon the case referral tracking discrepancies between the OIG and the ACOs. The OIG should increase the number of meetings with the ACOs to discuss and define what constitutes a suspected fraud case referral and ensure the ACOs identify cases where a credible allegation of fraud exits. Consider modifying the contract language so that referrals are submitted to the OIG, or to the OIG and the MFCU simultaneously.
- The state should review the contract requirements with ACOs, including the dental plans as well as all ACO delegates and sub-contractors who contract with ACOs, to ensure compliance with all the requirements of 42 CFR 438.608, such as verifying that all ACOs have effective compliance plans.
- The state should ensure that ACOs are allocating sufficient resources to the prevention, detection, investigation, and referral of suspected provider fraud, in light of the limited number of provider investigations being conducted by the ACOs and low number of overpayments identified and recovered. In addition, the state should monitor and track the overpayments reported by the ACOs, and verify that overpayments are accurately reported by the ACOs.
- The state should ensure the managed care program has a payment suspension process that covers all aspects of the federal payment suspension regulation found at 42 CFR 455.23. In addition, the state should ensure that the payment suspension process is implemented to include training for ACOs on the payment suspension process.
- The state should require contracted ACOs to notify the state when they take an adverse action against a network provider for program integrity-related reasons. Ensure procedures are developed and implemented for reporting these actions to U.S. Department of Health & Human Services (HHS)-Office of the Inspector General (OIG).

Section 2: Status of Corrective Action Plan

Utah's last CMS program integrity review was in October 2010, and the report for this review was issued in January 2012. The report contained five findings and 12 vulnerabilities. During the on-site review in August 2016, the CMS review team conducted a thorough review of the corrective actions taken by Utah to address all issues reported in calendar year 2010. The findings of this review are described below.

Findings

1. ***Utah does not collect all ownership and control disclosure from FFS providers, non-emergency medical transportation (NEMT) brokers, or MCEs. (Uncorrected Partial Repeat Finding)***

   Status at time of the review: Corrected

   Utah modified its FFS provider applications, NEMT contract, and MCE disclosure forms to capture all required ownership, control, and relationship information.

2. ***Utah's NEMT broker contract and certain MCE contracts do not require disclosure of business transaction information upon request. (Uncorrected Repeat Finding)***

   Status at time of the review: Corrected

   Utah's contracts with the NEMT broker and the ACOs were modified to meet the requirement of 42 CFR 455.105(b).

3. ***The state does not require the disclosure of healthcare-related criminal conviction information from the NEMT broker and one of the ACOs.***

   Status at time of the review: Corrected

   Utah modified the contracts with the NEMT broker and the non-risk ACO to meet the requirements of 42 CFR 455.106.

4. ***The state does not report to HHS-OIG adverse actions it takes on provider applications or actions taken to limit the ability of providers to continue participating in the Medicaid program. (Uncorrected Repeat Findings)***

   Status at time of the review: Corrected

   The state developed and implemented a policy and procedure to ensure that their OIG is notified of all negative actions taken on provider applications or against enrolled providers for program integrity reasons, and ensure that adverse actions are reported to the HHS-OIG as required by regulation.

5. ***The state's MCE contracts contain no provision for excluding managed care plans.***

Status at time of the review: Not corrected

The state has not incorporated 42 CFR 1002.203 language in the contracts with its ACOs. Utah will incorporate the language in its contracts with the physical health plans and prepaid mental health plans (PMHPs) in the next revision of the general contract.

Vulnerabilities

1. ***Inadequate oversight regarding the handling and referral of beneficiary fraud and abuse cases. (Uncorrected Repeat Vulnerability)***

Status at time of the review: Not corrected

The State has amended the agreement [between DOH and DWS] that was signed by both parties, but it has expired. The new agreement is in draft and should be signed soon. The state will provide a copy of the new agreement once it has been signed. The state has yet to develop and implement guidelines regarding the reporting format and frequency of reporting and expected response times for both components when dealing with inquiries and follow-up issues.

2. ***Lack of program integrity oversight, tracking and coordination across state Medicaid agency components.***

Status at time of the review: Corrected

Utah has an agreement as of June 2014, that establishes procedures for improving communication on program integrity issues among all components of the state agency and relevant sister agency components. The agreement includes procedures for disseminating information on handling and disposition of fraud and abuse cases.

3. ***Not using permissive exclusion authority***

Status at time of the review: Corrected

The state enacted a substantive amendment to its administrative rule with plans to implement when warranted.

4. ***Inadequate oversight of program integrity activities in managed care***

Status at time of the review: Corrected

The state developed and implemented policies and procedures with the managed care division (BMHC) that provides active oversight of program integrity and provider enrollment

activities during managed care compliance reviews. The ACO's compliance with all applicable program integrity and provider enrollment regulations are evaluated by the state.

5. Not collecting all ownership and control disclosure information from transportation and MCE network providers.

Status at time of the review: Corrected

The state modified the NEMT provider application and the MCE credentialing applications to capture all required ownership and control disclosure information and maintains it for federal data base checks at enrollment, re-enrollment and monthly thereafter.

6. Not requiring ACO and PMHP network providers and NEMT subcontracted companies and drivers to disclose business transaction information upon request.

Status at time of the review: Corrected

The state modified the MCE and NEMT provider agreements to meet requirements of 42 CFR 455.105 (b).

7. Not capturing the full criminal conviction information for all managed care providers.

Status at time of the review: Corrected

The state modified all ACO contracts and the NEMT provider agreement to include language in compliance with 42 CFR 455.106.

8. Not consistently collecting all required disclosure information from provider applicants.

Status at time of the review: Corrected

The state modified all its provider enrollment applications, agreement, and contracts used for the Medicaid program to ensure the consistent collection of all required disclosure information.

9. Not requiring the reporting of adverse actions taken against NEMT subcontracted companies and driver applications and providers applying for participation in MCE networks

Status at time of the review: Corrected

The state modified the contracts with the NEMT broker, PMHPs, and physical health plans to require the entities to notify the state when taking action against a driver's or provider's participation in the program, including when it denies credentialing for fraud related

concerns, and implemented policies and procedures to report all such adverse actions to the HHS-OIG.

10. Not requiring beneficiary verification of receipt of services in managed care, and home and community based services (HCBS) waiver programs.

Status at time of the review: Corrected

The state modified is managed care contract to include beneficiary verification of receipt of services as a requirement in managed care HCBS waiver programs.

11. Not conducting complete searches for individuals and entities excluded from participating in Medicaid.

Status at time of the review: Corrected

The state managed care contract refers to *Section 1* of the *Provider Manual* which addresses the responsibility for conducting complete searches for individuals and entities excluded from participating in Medicaid.

12. Not monitoring provider compliance with the False Claims Act.

Status at time of the review: Corrected

The state monitors this through it contract with its EQRO.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Utah 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 Utah are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- 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 training of managed care staff in program integrity issues. The CMS annual report of program

integrity reviews includes highlights of states that have been cited for noteworthy and effective practices in managed care. These reports can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html

- 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

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. Utah should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

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

State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lt. Governor

Utah Department of Health
JOSEPH K. MINER, MD, MSPH, FACPM
Executive Director

Division of Medicaid and Health Financing
NATE CHECKETTS
Deputy Director, Utah Department of Health Director, Division of Medicaid and Health Financing

July 14, 2017

Mark Majestic
Director, Investigations and Audits Group
Centers for Medicare & Medicaid Services
7500 Security Blvd

Dear Mr. Majestic:

Thank you for the opportunity to provide a corrective action plan for the report entitled *Utah Focused Program Integrity Review.* We appreciate the effort and professionalism of you and your staff in this review. Likewise, our staff spent time collecting information for your review, answering questions, and planning changes to improve the program. We believe that the results of our combined efforts will make a better, more efficient program.

Our corrective action plan describes the actions the State plans to take to implement the recommendations. The State is committed to the efficient and effective use of taxpayer funds and values the insight this report provides on areas that need improvement.

Sincerely,

Nate Checketts
Deputy Director, Department of Health
Director, Medicaid and Health Financing

288 North 1460 West · Salt Lake City, UT
Mailing Address: P.O. Box 143101 · Salt Lake City, UT 84114-3101 Telephone (801) 538-6689 · Facsimile (801) 538-6478 ·
www.health.utah.gov