Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

West Virginia Focused Program Integrity Review

Final Report

June 2017

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of West Virginia 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 managed care organizations (MCOs) 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 2013.

Background: State Medicaid Program Overview

The Bureau for Medical Services (BMS) administers the West Virginia Medicaid program. In May 2013, West Virginia became an expansion state extending coverage to an additional 91,500 state residents. As of March 2016, the West Virginia Medicaid program served approximately 535,000 beneficiaries. Of that total, approximately 160,500 beneficiaries (or 30 percent) were served on a fee-for-service (FFS) basis and the remaining 374,500 beneficiaries (or 70 percent) were enrolled in one of the four MCOs. West Virginia's total Medicaid expenditures for fiscal year 2015 totaled $3.7 billion; this total includes FFS expenditures of $3.1 billion and MCO expenditures of $604.6 million. The Federal Medical Assistance Percentage for West Virginia for federal fiscal year (FFY) 2015 was 71.35 percent. At the time of application for Medicaid, the beneficiary is requested to choose the MCO of their preference. If the beneficiary does not choose an MCO, the beneficiary will be automatically assigned to one.

Methodology of the Review

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

During the week of April 25, 2016, the CMS review team visited the West Virginia Department of Health and Human Resources' Bureau for Medical Services (BMS), Office of Quality and Program Integrity (OQPI). It conducted interviews with numerous state staff involved in program integrity and managed care. The CMS review team also conducted interviews with three MCOs and their special investigations units (SIUs). In addition, the CMS review team conducted sampling of program integrity cases and other primary data to validate the state and the selected MCOs' 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 374,500 beneficiaries, or 70 percent of the state's Medicaid population, were enrolled in four MCOs during FFY 2015. The state spent approximately $604.6 million on managed care contracts in FFY 2015.

Summary Information on the Plans Reviewed

The CMS review team interviewed three MCOs as part of its review.

The Health Plan (THP) was established in 1979 as a federally qualified and state-certified, 501(c)(3) nonprofit health maintenance organization (HMO). The THP is West Virginia's first and largest HMO, and is a licensed health insuring corporation in Ohio with a total service area encompassing 76 counties. The THP operates in West Virginia and Ohio. The THP's SIU consists of three FTEs in the St. Clairsville office, and both the Charleston and Morgantown offices have no program integrity staff. The THP's SIU services all lines of business. The SIU has three FTEs fully dedicated to program integrity activities in West Virginia; another investigator position was recently added. The current positions include a manager/analyst, a health data analyst, and an ancillary investigator.

CoventryCares of West Virginia (CCWV), which changed its name from Carelink in the spring of 2013, is a subsidiary of Coventry Health Care. Aetna acquired Coventry Health Care, Inc. on May 7, 2013. Aetna Medicaid owns or administers Medicaid managed health care plans under the names of Aetna Better Health, CoventryCares, and other affiliate names. The CCWV has worked with BMS since 1996. Together, these plans serve more than three million people in 16 states. The MCO generally contracts with hospitals, physicians, and ancillary providers on a capitated basis. The SIU services Medicare, Medicaid, and commercial lines of business. The Medicaid SIU is comprised of 13 employees which provide fraud, waste, and abuse investigative services to Medicaid health plans in the following states: Arizona, Florida, Illinois, Kentucky, Louisiana, Maryland, Michigan, Missouri, Nebraska, New Jersey, New York, Ohio, Pennsylvania, Virginia, West Virginia, and Texas. In addition Coventry contracts with various subcontractors to perform additional specialty services.

West Virginia Family Health (WVFH) is a provider sponsored network that operates exclusively in the state of West Virginia and is majority-owned by providers in the state. The WVFH is comprised of 22 federally qualified health centers, two West Virginia clinics, and the West Virginia Primary Care Association, all of which jointly own 55 percent of the WVFH stock. In addition, two of the major acute hospitals in West Virginia each own one percent of the stock of WVFH. The remaining 43 percent of the stock of WVFH is owned by Highmark Blue Cross Blue Shield of West Virginia (Highmark) which also provides all operational services and management oversight, and all capital funding for WVFH. Medicaid is the WVFH's only line of business. The WVFH began providing services in all 55 counties in September 2014, with 38 self-selected members who are rendering providers. The WVFH also partners with Gateway to perform their claims processing. Gateway is 50 percent owned by Highmark. Highmark

conducts provider credentialing for Gateway. Argus is the pharmacy benefit manager for WVFH and oversees the program integrity activities for pharmacy lines of business. Beacon is the behavioral health partner and Scion is responsible for handling WVFH dental benefits. Gateway has 12 staff members in its SIU. The SIU staff is comprised of one compliance person, one training liaison, two fraud investigators, two senior fraud investigators, two associate fraud investigators, two directors, and one primary and one secondary fraud investigator dedicated to the West Virginia Medicaid program. Five of these investigators are registered nurses. The SIU utilizes LexisNexis for their case management system. The fraud hotline is monitored by Gateway and beneficiaries are contacted to verify pharmacy and medical services. The activities are conducted on a daily basis and reported monthly. Beacon has 14 FTEs nationally and has two directors. Beacon has four staff in West Virginia and one program integrity coordinator.

Enrollment information for each MCO as of March 2016 is summarized below:

Table 1.

	THP	**CCWV**	**WVFH**
Beneficiary enrollment total	68,571	121,750	55,000
Provider enrollment total	6,235 Providers	8,075 Providers 2,109 Facilities	6,362 Providers 441 Facilities
Year originally contracted	1996	1996	2014
Size of SIU	3 FTEs	13 FTEs	2 FTEs
National/local plan	Local	National	Local

Total Medicaid expenditure information for each MCO as of March 2016 is summarized below:

Table 2.

MCOs	**FFY 2013**	**FFY 2014**	**FFY 2015**
THP	$60.0 million	$83.3 million	$141.3 million
CCWV	$142.3 million	$181.8 million	$213.2 million
WVFH	N/A*	$1.5 million	$84.0 million

*The MCO contracted with the state in FFY 2014 and did not do business with the state during this year.

State Oversight of MCO Program Integrity Activities

The BMS's Office of Managed Care is responsible for program oversight. The managed care unit consists of two members which are equivalent to 1.5 fully dedicated FTEs. The managed care unit coordinates with other units located in the BMS as well as with the Lewin Group. The Lewin Group contracts with the state to provide managed care program integrity oversight.

In addition, the BMS contracts with Delmarva for external quality review organization (EQRO) services. This contract is also overseen by the BMS's Office of Managed Care, The EQRO vendor does not handle fraud, waste, and abuse activities; however, it does conduct quality-related site visits on behalf of the state. The fraud, waste, and abuse function is delegated specifically to the BMS's OQPI. During interviews with the state, the review team was informed that the OQPI does not perform MCO compliance site visits to verify MCO compliance with

fraud and abuse contract requirements. It was also learned that the state's monitoring of the MCOs is limited to reviewing the monthly reports.

According to BMS's contract requirements for internal fraud and abuse plans, the MCOs require internal controls, policies, and procedures in place to prevent and detect fraud and abuse. Each MCO's formal fraud and abuse plan must have clear goals, assignments, measurements, and milestones. The MCO's fraud and abuse plan will include the following seven mandatory elements: written policies, procedures, and standards of conduct; the designation of a compliance officer and a compliance committee accountable to senior management; effective training and education for the compliance officer and the organization's employees; effective lines of communication; enforcement of standards through well-publicized disciplinary guidelines; provision of internal monitoring and auditing, and provision for prompt response to detected offenses; and development of corrective action initiatives.

Also, the BMS requires each MCO to monitor providers for potential fraud committed through underutilization of services, and potential beneficiary/provider fraud committed through overutilization of services. Monitoring should include identifying provider fraud and abuse, and benefit fraud. The MCO is required to submit a report summarizing their program integrity activities and the results of those monitoring analyses for the current state fiscal year; the report is due to BMS by June 15th of each year.

The plan should also include procedures for conducting regular reviews and audits of operations to guard against fraud and abuse, and verifying receipt of services with a member sample and documentation of verification results. During the interview with CCWV, the MCO stated that statistically valid samples of paid claims are extracted each quarter. For each randomly selected claim, a validation of services letter is sent to the member. This letter includes a request to contact customer services if they did not receive care. During FFYs 2011 through 2015, CCWV stated that that they had a zero percent return rate from members.

Finally, BMS disclosed during the interview that their oversight of the managed care program was very limited due to vacancies in state staffing. As a result of low staffing levels, BMS relies heavily on the Lewin Group to perform program integrity oversight activities of the MCOs. According to the state, staffing levels are at 60 percent and several key program integrity oversight positions are vacant. This staffing issue was identified during previous reviews and remains unaddressed. The state indicated that it lacks policies, procedures, and interagency agreements that outline which state unit is responsible for oversight, review guides, review protocol, or a checklist to monitor the MCOs program integrity/SIU operations.

MCO Investigations of Fraud, Waste, and Abuse

As required by 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 MCOs.
West Virginia's MCO contract states, "The MCO must work with BMS, the Medicaid Fraud Control Unit (MFCU), the Office of the Inspector General (OIG), and CMS to administer effective fraud and abuse practices. The MCO must take part in coordination activities within the

state to maximize resources for fraud and abuse issues. The MCO must meet regularly with BMS, the MFCU, and the EQRO to discuss plans of action, and attend fraud and abuse training sessions as scheduled by the state. The MCO reporting procedures and timelines for abuse complaints and outcomes must meet state-established guidelines."

The BMS requires the MCOs to submit fraud and abuse reports detailing any suspected fraud and abuse cases identified during the prior calendar month; these reports are due by the fifteenth day of each month. The report must include the following information for each case that warrants investigation: provider name; National Provider Identifier number; MCO identification number; date that the case was initiated; source of complaint; type of provider; nature of complaint; approximate dollars involved; legal and administrative disposition of the case; and status of the reported case. If no cases of suspected fraud or abuse are identified during the prior month, the MCO must still submit the report stating this fact.

In addition, the BMS requires the MCOs to submit provider termination reports for all in-network terminations for cause, and provider credentialing denials for cause during the prior calendar month; these reports are due by the fifteenth day of each month. If the MCO refers suspected Medicaid fraud, waste, or abuse cases to any other entity, the MCO must notify BMS of the referral.

Also, the contract requires the MCOs to cooperate and assist the BMS or any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud, abuse, or waste. The MCO is responsible for investigating suspected fraud, waste, and abuse for all services including those that the MCO subcontracts to outside entities.

If the MCO identifies that fraud or abuse has occurred in the Medicaid program, the OQPI must be immediately notified. If the OQPI accepts the case for investigation, the MCO may no longer engage in investigation efforts, other than coordination efforts with the state. The OQPI must notify the MCO regarding the case's acceptance status no later than the tenth business day after the referral date. The MCO may move forward with the investigation or payment recovery efforts, once notice from the OQPI and/or the MFCU has been received and indicates that the MCO is authorized to proceed with a case. If the OQPI or the MFCU has assumed responsibility for completion of the investigation and of final disposition of any administrative, civil, or criminal action taken by the state or federal government, the OQPI or MFCU will direct the collection of any overpayment by the MCO. The MCOs submit monthly reports of fraud, waste, and abuse activity to the Lewin Group, which is then sent to the OQPI for review. The contract does include language that requires the MCO to report suspected provider fraud, waste, or abuse to the MFCU.

The THP**'s** SIU monitors potentially suspicious patterns or behaviors reported via the THP fraud hotline. The THP fraud hotline is maintained by the SIU. Tips are received electronically and by telephone. Reporting methods allow for anonymous submission of information. Tips are triaged and recorded in the centralized *Compliance and the Fraud, Waste, and Abuse Log*; a case tracking number is assigned and a date is automatically recorded by the system upon entry. A case may be closed within the SIU, if no fraudulent activity is determined to be present or flagged for monitoring. If review is deemed necessary, the case is presented to the Fraud, Waste,

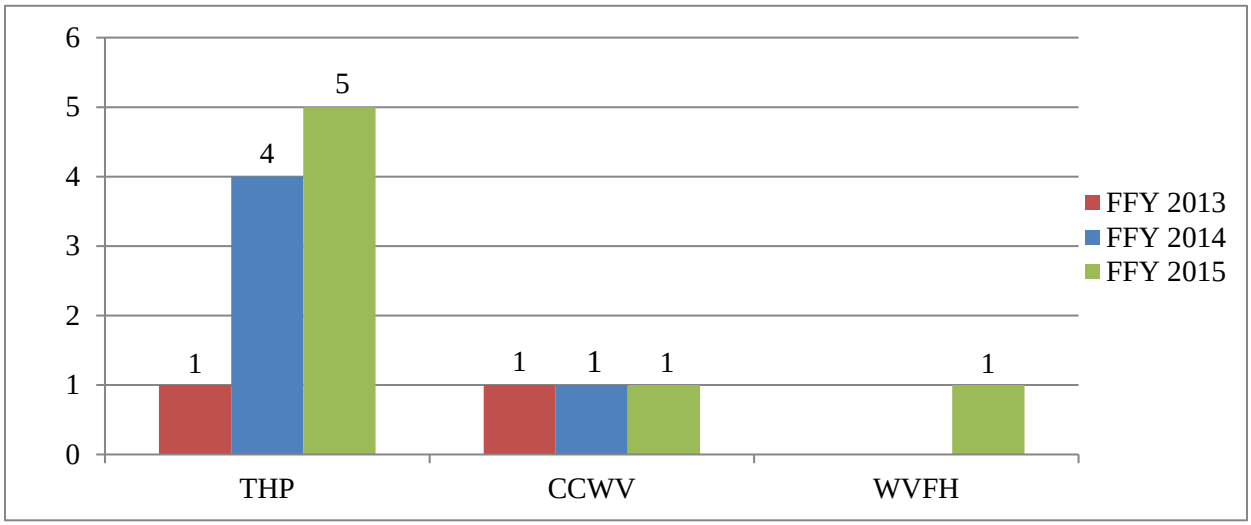
and Abuse Committee upon completion of the review. Recommendations for action may include, but are not limited to: referral to outside entities; imposing preauthorization requirements; requesting documentation; or provider/member education. The Fraud, Waste, and Abuse Committee meets at least quarterly and on an ad hoc basis. The SIU manager implements any case actions, or additional steps approved or suggested by the Fraud, Waste, and Abuse Committee. At the beginning of each year, both the SIU manager and director develop an SIU work plan that sets goals both for the department as well as identifying areas of potential risk that may require data mining review. The OIG work plan is also incorporated into these projects. The SIU and compliance department are responsible for employee compliance and fraud, waste, and abuse education. They develop an annual mandatory training module and conduct various educational activities for employees throughout the year.

The CCWV's data mining plan utilizes the Verisk Analytics' Fraud Finder Pro investigative tool. Fraud Finder Pro conducts peer-to-peer analysis as well as running targeted ad hoc reports to detect outliers, anomalies, and patterns within large data sets identified through the utilization of known schemes; the results are sent to the SIU daily for prepayment review. The CCWV employs STARS*Sentinel* to proactively identify providers exhibiting billing behaviors that differ significantly from those of their peers. Providers are profiled by peer group, specialty, product, and geography.

The WVFH utilizes a case management system to capture referrals from multiple sources, such as the fraud hotline, emails, and regulatory requests, and subsequently assigns them for investigation. Case-related activities are documented in this system and updated on a daily basis and/or every thirty days, as required. The WVFH fraud plan details staffing; the process for investigating referrals; how training and education are conducted; and raising public awareness to promote the reporting of fraud, waste, and abuse; information on reporting fraud internally; training and monitoring of activities for delegates; required reporting; and record retention**.**

Table 3 lists the number of referrals that the SIUs for THP, CCWV, and the WVHP made to the state in the last three FFYs. Overall, the number of Medicaid provider investigations and referrals by each of the MCOs is low, compared to the size of the plan. The level of investigative activity has changed over time.

Table 3.



During the last three FFYs, the THP submitted ten referrals to BMS; the CCWV submitted three referrals; and the WVFH submitted one referral. The total number of referrals is low compared to the size of the plans. The BMS stated that although they received some referrals from the MCOs, the quality of referrals received was substandard and lacked the necessary information to warrant further investigation by the state. The BMS also indicated that this was an area that needed improvement and said that the MCOs should have been provided with better direction for improving the quality of the referrals submitted.

MCO Compliance Plans

The BMS does require its MCOs 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. As required by 42 CFR 438.608, the state does review the MCOs' compliance plans and communicates approval/disapproval to the MCOs annually.

West Virginia's MCO contract states, "The MCO must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse. The procedures must include a method to verify with a sample of enrollees whether billed services were received. The MCO must submit its compliance plan by October 1st of each contract year to the department."

The review of the compliance plans revealed minimal issues. All of the MCOs provided the review team with copies 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, with the exception of THP. The THP did not have a compliance plan specifically for the Medicaid line of business and

submitted the plan used for the Medicare line of business. The MCO was utilizing its compliance plan interchangeably for their other lines of business, instead of creating separate compliance plans for each line of business. According to BMS staff, compliance plans are reviewed annually and should be specific to each line of business.

Encounter Data

The MCO must regularly submit encounter data as requested by BMS as well as other data specified by the reporting requirements in Article III, Section 5.11 of the model contract. The OQPI does not data mine or conduct an analysis of MCO encounter data, and in the past has relied on the Lewin Group or CMS to process encounter data. The BMS just implemented a new Medicaid Management Information System (MMIS) that should provide them with the ability to data mine in the future.

Overpayment Recoveries, Audit Activity, and Return on Investment

The state does not require MCOs to return to the state or report on overpayments recovered from providers as a result of MCO fraud and abuse investigations or audits.

The BMS does not specify a process for identifying, collecting, and reporting overpayments in its MCO contract. The BMS has an 85 percent Medical Loss Ratio (MLR) requirement. Any monies collected cannot be added to the numerator in the MLR calculation, therefore, recovery efforts would drive down MLR and have a direct impact on the rate setting process. In the last four FFYs, the BMS stated that the MCOs did not return overpayments to the state directly; rate reductions may potentially occur, depending on significance of collection on overall MLR.

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

Table 4-A.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013	36	33	*	*
2014	27	30	*	*
2015	74	54	$18,716	$12,157

*Results were not formally tracked for these years. Tracking began during FFY 2015.

The THP's overpayments and recoveries are not tracked in a reportable fashion by each line of business. The MCO collects payments only when deemed appropriate; however, the amounts were not formally tracked until FFY 2015. The THP stated that future reports will be created allowing for extraction of overpayment/recovery data from the log entries. During FFYs 2014 through 2015, the increase in full investigations was attributed to staff education and evaluating overall trends and patterns, rather than single instances. Referrals made to BMS were low compared to full investigations, because cases are only referred when there is a direct connection with a Medicaid claim or member. Currently, BMS's Medicaid contract does not require

reporting of information, unless recoveries are requested by BMS on a case and the MFCU accepts a reported case for investigation.

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

Table 4-B.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013	45	20	$0	$0
2014	33	9	$27	$27
2015	44	7	$43	$43

The CCWV's overpayments and recoveries totaled approximately $70 for FFYs 2013 through 2015. The CCWV acknowledged that recoveries are low due to moving away from the pay and chase to a prepayment model; however the MCO did not provide any documentation in support of this claim. The CCWV stated that under their current prepayment review model; they are reviewing about 96 percent of provider claims.

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

Table 4-C.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013	*	*	*	*
2014	0**	0**	$0**	$0**
2015	8	8	$2,667	$2,667

*The MCO was not contracted with the state during this time period.
**The MCO stated that insufficient data existed to analyze and conduct program integrity activities. The MCO contracted with the state during FFY 2014.

The WVFH has no documented overpayments, recoveries, or preliminary and full investigation activities for FFY 2013, since they did not contract with the BMS until FFY 2014. The WVFH staff also stated that, due to the short period of time that the MCO was contracted with the BMS, there was not enough claims data available to analyze in FFY 2014; this resulted in no investigative or recovery activities occurring during the year.

Overall, the three MCOs have combined expenditures that total approximately $438.5 million, but a combined recovery amount of $14,894; this results in an extremely low return on investment resulting from MCO program integrity activities. During the last three FFYs, a total of 14 referred cases were submitted to BMS by all three MCOs; this figure is very low when compared to the 161 full investigations reported by all three MCO's during the same timeframe.

Payment Suspensions

In West Virginia, Medicaid MCOs are contractually required to suspend payments to providers at the state's request. The BMS confirmed that there is contract language mirroring the payment suspension regulation at 42 CFR 455.23, which requires the state Medicaid agency to, "suspend all Medicaid 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 against an individual or entity, unless the agency has good cause not to suspend payments or suspend payment only in part. The rules governing payment suspensions based upon pending investigations of credible allegations of fraud apply to Medicaid managed care entities."

The contract requires the MCOs to cooperate with the state, when payment suspensions are imposed against a provider by the department for credible allegations of fraud. When the state sends notice that payments to a provider have been suspended, the MCO must also suspend payments to the provider within one business day, if the provider is in the MCO network and receives payments. When the MCO receives notice from the state, the MCO must respond within three business days and inform the state that the suspension has been implemented.

In addition, the state is responsible for evaluating allegations of fraud and imposing payment suspensions for MCO providers who are a part of the state FFS network. The MCO is responsible for initiating payment suspensions based on a credible allegation of fraud for its in-network providers who are not a part the state FFS network. For payment suspensions initiated by the MCO, the MCO must comply with all requirements of 42 CFR 455.23. The MCO must report the following information to the state within one business day after suspension: the nature of the suspected fraud; the basis for the suspension; the date the suspension was imposed; the date the suspension was discontinued; the reason for discontinuing the suspension; the outcome of any appeals; the amount of payment withheld; and, if applicable, the good cause rationale for imposing a partial payment suspension.

The MCO must also report all of the following information for suspended providers to the state on a monthly basis: provider name; date of suspension; suspension discontinuation date; the reason for discontinuation; amount of payments withheld; and the good cause rationale for not suspending payment or imposing a partial payment suspension, if applicable. If the MCO does not suspend payments to the provider, the state may impose contractual remedies.

The CCWV and WVFH complied with all contractual requirements of 42 CFR 455.23, but discussion with THP revealed that they do not have policies or procedures in place to suspend providers; they do have procedures for provider termination. When the THP receives notices of a suspension from the state, they will flag the system to deny that provider's claims; if the suspension is reversed, those claims will then be paid. The THP stated that they did not have a tracking system for suspended providers; however, they do confirm that the payments were stopped.

Terminated Providers and Adverse Action Reporting

The state MCO contract states, "The MCO must submit to BMS by the 15th of each month the provider termination report for all in-network terminations for cause and provider credentialing

denials for cause during the prior calendar month." In addition, information provided during the interview with the BMS staff regarding provider terminations outlines that the MCOs report on a weekly basis and include both disenrolled and for cause terminations. The BMS did not submit these provider terminations to TIBCO, but as of January 2016, contacted CMS to gain access to become compliant.

When the THP terminates providers for cause, the provider service and credentialing team sends notification to the BMS's manager of government programs. This information is sent via a report on the fifteenth day of each month and the information contains any primary care physicians (PCP) terminated from the plan. When the BMS terminates providers for cause, they send notification to the manager and/or director of the Medicaid program. Upon receipt of the notification letter, it is forwarded to the director of credentialing. Exclusion reports found on the website are reviewed by the credentialing specialist; if the provider is in the MCO system, the provider is removed from the directory and a "deny pay class" is added to assure that no payments are made. If the provider is a PCP, obstetrician/gynecologist, or high volume specialist, and the provider has Medicaid members assigned to them, a letter is sent to those members letting them know that the provider is no longer a participating provider with the plan. The THP submitted a list of 35 providers that received termination notices and the actions were documented using a tracking report.

The CCWV termination of providers for cause begins when BMS notification is sent to the MCO via email along with a copy of the letter sent to the provider. The provider relations department will identify any Medicaid provider changes made and notify the compliance officer/reporting manager. The compliance officer/reporting manager will distribute the provider change and the service area affected to the enrollment department. The enrollment department will send a letter to the affected members' households in the service area, no later than 30 calendar days from the effective date of the change.

The WVFH submits the terminated provider's information to the BMS via a monthly report.

Finally, the BMS does not encourage THP, CCWV, or WVFH to share terminated, decredentialed, or disenrolled network provider information with each other.

Table 5:

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		Total # of Providers Terminated For Cause in Last 3 Completed FFYs	
THP	2013 2014 2015	9 7 22	2013 2014 2015	5 5
CCVW	2013 2014 2015	264 131 280	2013 2014 2015	8 2 2
WVFH	2013 2014 2015	0 0 176*	2013 2014 2015	0 0 176

*The WVFH only terminates their providers for cause.

Overall, the number of providers terminated for cause by all of the plans appears to be low, compared to the number of providers in each of the MCOs networks and compared to the number of providers disenrolled or terminated for any reason. The BMS requires the MCOs to submit the provider termination report for all in-network terminations for cause and provider credentialing denials for cause during the prior calendar month by the fifteenth day of each month.

Federal Database Checks

The regulation at 42 CFR 455.436 requires that the state Medicaid agency must check the exclusion status of the provider or persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE); the Excluded Parties List System (EPLS) on the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); the National Plan and Provider Enumeration System upon enrollment and reenrollment, and check the LEIE and EPLS no less frequently than monthly.

The BMS staff stated that disclosures for MCO providers are captured by the MCOs and the BMS maintains a separate database on the FFS side to capture disclosure information for FFS providers. The BMS also stated that they do not follow-up with the MCOs to verify that the HHS-OIG's LEIE, the EPLS, the SSA-DMF, and the NPPES were being performed by the MCOs at the appropriate intervals. However, all three MCOs confirmed with the onsite review team that they are checking the HHS-OIG's LEIE, the EPLS, the SSA-DMF, and the NPPES at the appropriate intervals.

Recommendations for Improvement

- The state should consider the inclusion of contract language requiring MCOs to conduct annual provider onsite visits. Regular onsite visits would provide increased oversight by the state Medicaid agency, in addition to existing tools.
- The state should ensure that both the BMS and the MCOs are allocating sufficient resources to the prevention, detection, investigation, and referral of suspected provider fraud, in an effort to increase the volume of provider investigations, referrals, recoveries, and terminations.
- The state should develop written policies and procedures, or an interagency agreement(s) outlining the state unit(s) responsible for program integrity activities and the related oversight functions.
- The state should monitor the MCOs' processes for verifying receipt of services by beneficiaries.
- The state should work with the MCOs to develop specific program integrity training to develop and enhance the quality of case referrals from the MCOs; provide more frequent feedback to the plans on the cases they refer to the state; and ensure that all SIU staff receive appropriate training in identifying and investigating potential fraudulent billing practices by providers.
- The state should develop policies and procedures to review the MCOs' compliance plans on an annual basis.
- The state should continue efforts to improve their ability to analyze encounter data and perform data mining activities to identify fraud, waste, and abuse issues with MCO network providers.
- The state should verify that all identified and collected overpayments are reported by the MCOs and are incorporated into the rate setting process, along with the overpayments determined by state-initiated reviews.
- The state should work with MCOs to develop policies consistent with the payment suspension requirements in the federal regulation at 42 CFR 455.23. The state should provide training to its contracted MCOs on the circumstances in which payment suspensions and should require the reporting of plan-initiated payment suspensions based on credible allegations of fraud.
- The state should monitor the MCOs' compliance with contractual requirements for conducting monthly checks on the exclusion status of providers, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the LEIE, EPLS, SSA-DMF, NPPES upon enrollment and reenrollment; and check the LEIE and EPLS no less frequently than monthly.
- The state should make sure excluded providers are submitted into TIBCO database
- The state should develop a comprehensive process to initiate more frequent information sharing within its contracted MCOs regarding provider terminations and decredentialed or disenrolled network providers.
- The state should develop a formal oversight check list or other assessment tool to measure performances of the MCO plans and program integrity efforts.
- The state should confirm that MCOs have developed written fraud, waste, abuse, and suspension policies and procedures that are required by the state contract.

- The state should obtain evidence from its MCOs in support of any statements attributing a decline in overpayments as the direct result of cost avoidance activities or proactive measures in place Some tangible examples of cost avoidance include a walk-through of the MMIS edits; written policies and procedures specifically addressing cost avoidance activities; documentation from contractors regarding measures instituted and resulting in cost avoidance; screenshots, documentation, tracking spreadsheets, samples, etc. from systems that demonstrate cost avoidance measures; or an explanation of any methodology employed that has resulted in deterring overpayments to providers.

Section 2: Status of Corrective Action Plan

West Virginia's last CMS program integrity review was in May 2012, and the report for this review was issued in January 2013. The report contained eight findings and seven vulnerabilities. During the onsite review in April 2016, the CMS review team conducted a thorough review of the corrective actions taken by West Virginia to address all issues reported in calendar year 2013. The findings of this review are described below.

Findings –

1. ***The state does not suspend payments in cases of credible allegations of fraud.***

   Status at time of the review: Not corrected

   The state conducts ongoing fraud and abuse suspension meetings and has incorporated discussions of individual cases into the regular monthly MFCU/OQPI meetings, but official notes are not taken. The onsite review team provided staff with a template to assist in correcting this issue; however, the state still needs to take action to implement a process to suspend payments in cases of credible allegations of fraud.

2. ***The state does not have administrative procedures to initiate exclusions for any reason for which the HHS-OIG could exclude a provider.***

   Status at time of the review: Not corrected

   The BMS provided the review teams with copies of the proposed *Provider Participation Policy 2016* and *Chapter 300 (Revision 2012)* containing the procedures which resolve this finding. Both documents referenced were reviewed and contained administrative procedures for initiating exclusions. At the time of the onsite review, the documents were in the proposal phase and not yet adopted to correct this finding.

3. ***The state made payment to an excluded provider for an item or service ordered or referred by an excluded provider.***

   Status at time of the review: Corrected

   The BMS provided an email from the BMS Finance Unit stating that the $45,242.76 overpayment was returned during December 2012.

4. ***The state does not conduct complete searches for individuals and entities excluded from participating in Medicaid.***

   Status at time of the review: Corrected

   The BMS provided the disclosure requirements which are contained within the current enrollment application on the provider enrollment portal. The BMS fiscal agent is charged with completion of the required searches, as mandated in the provider screening and enrollment regulations. In addition, when a provider answers "yes" to any adverse action/criminal disclosure question, the application is pended and forwarded to BMS staff for review, and approval or declination. This process is still undergoing some transition, as it is migrated from the legacy MMIS to the new MMIS.

5. ***The state does not capture all required ownership and control disclosures from disclosing entities.***

   Status at time of the review: Corrected

   The BMS provided the combined *Medicaid/CHIP Provider Enrollment Application* and the *Medicaid Provider Enrollment Application* which have been amended to include language that now captures all required ownership and control disclosures from disclosing entities.

6. ***The state does not adequately address business transaction disclosure requirements in its MCO contract.***

   Status at time of the review: Corrected

   The BMS amended the MCO contract language to address business transaction disclosure requirements.

7. ***The state does not capture criminal conviction disclosures from providers or contractors.***

   Status at time of the review: Corrected

   The BMS provided the combined *Medicaid/CHIP Provider Enrollment Application* and *Medicaid Provider Enrollment Application*, both of which now capture criminal conviction disclosures from providers and/or contractors.

8. The state does not comply with its state plan amendment regarding False Claims Act education monitoring.

Status at time of the review: Corrected

The OQPI has completed the monitoring for state fiscal year 2011. Providers are reviewed for compliance and now require annual attestations to the *False Claims Act* education requirement.

Vulnerabilities –

1. Inadequate resources to accomplish core program integrity functions.

Status at time of the review: Corrected

The BMS has been unable to procure a recovery audit contractor due to the state's existing purchasing mandates. The BMS continues to accept request for proposals which currently are with the state for review, approval, and issuance. There are currently 58 preliminary investigation cases within i-Sight, a system which allows the management of multiple cases across locations. The state attested to an ongoing contract with Truven (IBM Watson) for a data warehouse and a decision support system that includes the following tools: DataProbe, Advantage Suite, J-SURS, and ArcGIS. The state also supplied i-Sight's report of open cases.

2. Limited program integrity oversight of the state's managed care and waiver programs.

Status at time of the review: Not Corrected

The state continues to exercise limited program integrity oversight over its managed care and waiver programs. However, during the onsite review, the state did discuss the following proposed enhancements to improve oversight:

- The BMS will work to improve coordination between the OQPI, and the Office of Managed Care and Procurement Services.
- An OQPI team member will continue to routinely serve on the committee tasked with oversight of waiver of contracts and specific audits.
- After the issuance of a demand letters, the state will collect recoveries based on the findings and results of audits by implementing payment holds, liens, disenrollments, etc.
- The state will increase data mining and analysis efforts.
- The state will work collaboratively with the MFCU and the MCOs to develop and implement coordination of fraud referrals.
- In February 2013, an OQPI staff member attended a class at Medicaid Integrity Institute (MII) related to oversight of MCOs. The value of the MII as a technical training resource was addressed with the state.

4. ***Not conducting searches for individuals and entities excluded from participating in Medicaid.***

   Status at time of the review: Corrected

   The review team confirmed that the HHS-OIG's LEIE, the EPLS, the SSA-DMF, and the NPPES are being checked for excluded individuals and entities, at the appropriate intervals required.

5. ***Not verifying all out-of-state provider licenses during the enrollment process.***

   Status at time of the review: Corrected

   The BMS provided desk level procedures for provider enrollment to the review team, which satisfied this vulnerability.

6. ***Not capturing ownership and control disclosures from network providers.***

   Status at time of the review: Corrected

   The BMS amended the MCO model contract to capture ownership and control disclosures from network providers.

7. ***Not adequately addressing business transaction disclosures in-network contracts.***

   Status at time of the review: Corrected

   The BMS amended the MCO model contract to capture business transaction disclosures.

8. ***Not capturing criminal conviction disclosures from network providers.***

   Status at time of the review: Corrected

   The BMS submitted files to the review team detailing the changes implemented to correct not capturing criminal conviction disclosures. The changes provided by the BMS included the final and approved version of the amended MCO contract which contained guidance and timelines for capturing criminal conviction disclosures from network providers at the time of enrolment and periodically thereafter.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for West Virginia 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 West Virginia 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. 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 CAP should identify those corrections as well.

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

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Jim Justice
Governor

Bill J. Crouch
Cabinet Secretary

November 6, 2017

Laurie Battaglia
Director of the Division of State Program Integrity
Centers for Medicare & Medicaid Services
Center for Program Integrity
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Dear Ms. Battaglia:

The West Virginia Department of Health and Human Resources and the Bureau for Medical Services (Bureau), the single state agency, offers the following Corrective Action Plan to the: "West Virginia Focused Program Integrity Review Final Report dated January, 2017".

Findings –

1. The state does not suspend payments in cases of credible allegations of fraud.

Status at time of the review: Not corrected

The state conducts ongoing fraud and abuse suspension meetings and has incorporated discussions of individual cases into the regular monthly MFCU/OQPI meetings, but official notes are not taken. The onsite review team provided staff with a template to assist in correcting this issue; however, the state still needs to take action to implement a process to suspend payments in cases of credible allegations of fraud.

BMS and OPI have instituted a fraud suspension process effective March 1, 2013. OPI is working collaboratively with BMS General Counsel and Commissioner to ensure proper implementation of all suspension of payments where warranted.

2. The state does not have administrative procedures to initiate exclusions for any reason for which the HHS-OIG could exclude a provider.

Status at time of the review: Not corrected

The BMS provided the review teams with copies of the proposed Provider Participation Policy 2016 and Chapter 300 (Revision 2012) containing the procedures which resolve this finding.