State of Missouri Department of Social Services

Missouri Medicaid Audit and Compliance Unit

END OF YEAR REPORT

SFY-2018

MMAC Activities

Dale Carr - Director

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MMAC MISSION STATEMENT

We protect the integrity of the Missouri State Medicaid Program by detecting and preventing fraud, waste, and abuse, and recovering improperly expended Medicaid Funds, while ensuring high quality care for Missouri citizens.

MMAC's RESPONSIBILITIES

MMAC is responsible for oversight of audit and compliance measures of Missouri Medicaid providers and participants. We are responsible for detecting, investigating, and preventing fraud against the Missouri Medicaid program.

MMAC'S FUNCTIONS

MMAC 's functions include enrolling eligible Missouri Medicaid fee-for-service and managed care providers, administering the Participant Lock-in Program, auditing and educating fee-for–service providers, conducting investigations into allegations of fraud and abuse, auditing Program Integrity related provisions of contracted health plans (managed care organizations) and sanctioning providers who have failed to adhere to applicable laws and regulations.

MMAC also oversees the operations of the Unified Program Integrity Contractor, certain activities of the Third Party Liability contractor (specifically Credit Balance Audits and the disallowance project) and the Electronic Health Records Incentive Program Contractor.

Dale Carr
Director, MMAC
July 31, 2018

PROVIDER ENROLLMENT

PROVIDER ENROLLMENT AND CASE MANAGEMENT TECHNOLOGY

During SFY2018, MMAC continued efforts to implement a complete enrollment solution to include an automated system to screen, monitor, and enroll Medicaid providers. A Request for Proposal (RFP) for a 100% electronic provider enrollment solution was drafted and is currently undergoing internal review. In the interim, MMAC has utilized Lexis-Nexis' services to provide automated screening and monthly monitoring of new and currently enrolled fee-for-service (FFS) and managed care network providers.

During SFY2018, enhancements were made to the Lexis-Nexis screening and monitoring program to expand the number of professional licenses and sanctions provided to MMAC.

During SFY2018, MMAC modified existing provider type categories and began enrolling all Managed Care Organization (MCO) network providers belonging to the three MCO's contracted with MO HealthNet Division.

PROVIDER SCREENING AND ENROLLMENT REQUIREMENTS

Effective January 1, 2018, the 21st Century Cures Act requires all Managed Care Organization (MCO) network providers to be enrolled with the State Medicaid Agency (SMA) within 120 days of contracting with the MCO, or their contract must be terminated. MCO network providers have the option of enrolling as a performing or billing provider with the ability to submit claims to MO HealthNet for services provided to FFS participants, or as a MCO Network Provider that cannot submit FFS claims. During SFY2018, MMAC conducted outreach to the MCOs and their network providers to facilitate the required enrollments. MMAC implemented a new, streamlined MCO network provider enrollment application and began providing regular reports to the contracted MCOs regarding any active, pending, or recently terminated providers.

Federal regulations at 42 CFR § 455, Subpart E, require that all Medicaid providers must "revalidate" their enrollment records at least every five years. During SFY2018, MMAC continued it efforts to revalidate all providers that were due.

Federal regulations require all newly enrolling and revalidating providers be screened according to categorical risk levels, and site visits must be conducted on moderate and high level providers. To conserve state resources and speed up the revalidations process, MMAC began coordinating with other state departments, such as the Department of Mental Health, to leverage site visits they may have conducted.

Federal regulations at 42 CFR § 455.410(b) require all ordering, prescribing, and referring (OPR) professionals be enrolled as participating providers. 42 CFR § 455.440 requires the National Provider Identifier (NPI) of the OPR professional to be listed on all claims for items and services. During SFY2018, system edits were implemented to deny claims submitted by durable medical equipment (DME), independent labs, imaging, and home health providers if the NPI of the OPR provider was not present on the claim, or if the OPR provider was not enrolled. Systems work continued to capture the NPI requirements on all other institutional claims.

In SFY2018, MMAC's Provider Enrollment unit continued working closely with the Provider Review and Investigations units. This was achieved by regular meetings involving all units to discuss suspicious enrollment materials and provider billing, along with external reports and complaints received by the various units. During SFY2018, MMAC enhanced this relationship and collaboration by tasking Provider Review staff with the responsibility of answering emails from Home and Community Based Services (HCBS) providers. This not only provided support for the Provider Enrollment staff, but allowed the Provider Review analysts who audit the HCBS program to gain a broader view of the providers they are auditing.

DEFICIT REDUCTION ACT (DRA) ATTESTATIONS

The Employee Education Provision of the Deficit Reduction Act of 2005 directs states to provide that any entity receiving or making annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, to establish written policies providing detailed information about the federal False Claims Act and any State laws pertaining to civil or criminal penalties for false claims. Requirements include the provider maintaining an employee handbook.

During SFY-2018, MMAC saw 100% compliance with this requirement. MMAC coordinated closely with the Department of Mental Health to ensure compliance of mental health providers.

PROVIDER FINANCIAL REPORTS

Certain Missouri Medicaid Home and Community Based Services providers are required to submit quarterly service and financial reports to MMAC, and annual service reports and financial audits.

During SFY2017, MMAC began a process to notify non-compliant providers that they failed to submit reports. During SFY2018, MMAC began imposing administrative sanctions on non-compliant providers.

HOME AND COMMUNITY BASED PROVIDER DESIGNATED MANAGER TRAINING

MMAC conducts yearly designated manager training for home and community based services providers. During SFY2015, MMAC updated the designated manager training materials and processes. On-line training materials were rewritten, an online registration for training and testing was created and implemented, and a three hour classroom training course was designed and implemented. MMAC increased the number of classes presented. Attendees' pass rate increased from 50% to 85-

90%. During SFY 2018, MMAC held four training/testing sessions in Jefferson City attended by a total of 312 individuals.

HOME AND COMMUNITY BASED PROVIDER UPDATE TRAINING

MMAC conducts regular home and community based services provider update training. MMAC is committed to incorporating provider feedback to continually enhance update training to provide current and pertinent information to providers.

In SFY2015, MMAC added a video presentation, additional speakers, and new hand-out materials to the training. In SFY2016, MMAC began posting materials presented at the update training on its website. In SFY 2017, MMAC incorporated feedback from providers regarding reformatting the training and requesting presenters make their presentations "scenario-based" or "case study-based". During SFY-2018, MMAC presented six provider update sessions which were attended by a total of 1,289 provider representatives.

PROVIDER UPDATES AND BAD ADDRESSES

Enrolled providers are required to update MMAC when changes occur. However, this does not always occur and in SFY 2017 MMAC committed to updating/ correcting "bad" physical addresses by focusing on Home and Community Based providers, and through revalidation efforts. As well, MMAC met with the MO HealthNet Division to coordinate with contractors that do mailings for the department, in order to identify appropriate processes that will cut down on "bad" addresses.

STATISTICS

During SFY2018, MMAC continued its efforts to maintain quick turnaround time for new applications and updates, with an additional emphasis on increasing the number of revalidation and MCO application finalizations. MMAC Provider Enrollment Unit employees completed 10,566 new enrollments, 18,585 updates, rejected 765 MO HealthNet enrollment applications and 55 proposals for HCBS contracts, processed 8,055 revalidations, and answered 49,934 email messages.

FINANCE

MMAC's review of aged Account Receivables (ARs) in SFY2017 resulted in 36 accounts being referred to the Attorney General's Office (AGO) for collection, and receiving an updated case status on previously referred cases. During SFY2018, MMAC referred 18 problem or old accounts to the AGO for collection.

MMAC's tax intercept program with the Department of Revenue began in SFY2015 with ten accounts being referred to DOR for potential tax intercepts. During SFY2017, MMAC referred 21 accounts to DOR for potential tax intercept. During SFY2018, MMAC referred 18 accounts to DOR for potential tax intercept.

Provider "self-disclosures" continue to trend upward. The chart below shows provider self-disclosure amounts submitted to MMAC for the past five fiscal years:

Provider self-disclosures				
SFY2014	SFY2015	SFY2016	SFY2017	SFY2018
$1,046,307	$2,305,693	$2,767,072	$3,648,402	$5,125,743

PROVIDER REVIEW

PROVIDER REVIEW GROUPS

MMAC has four areas in its Provider Review section, each responsible for auditing certain provider types. Each group has broad responsibilities and therefore, each year the groups' focus areas are reviewed and updated for the coming year.

- Clinical Services Reviews during SFY2018
    - Completed a special project for in-patient hospital services where part of the in-patient days were denied on the in-patient certification. The providers were supposed to bill these as non-covered days on claims. MMAC recouped on in-patient days which were paid but considered non-covered. Improper payments of $218,721.92 were identified. A systems edit is now in place to stop providers from getting paid for non-covered days.
    - Completed audits of Independent Laboratories: Three were completed with $222,027 in improper payments identified.
    - Completed a special project regarding Hospice overlaps with $401,220 recovered for improperly paid claims.
    - Completed a special project regarding providers billing of more than 24 hours in observation status which in a patient was in an outpatient hospital setting. There were 77 providers reviewed with $116,268 identified as improper billing.
    - Completed a special project on dental providers who were billing more than four periapical s-rays after the initial one was billed. There were 106 providers reviewed and $93,051 in improper billing was identified.
    - Conducted a special project focusing on Behavioral Health providers billing for more family units than allowed. There was $33,820 in improper billing identified.
    - Processed 1,241 self-disclosures resulting in $5,125,743 being returned to the state.
    - Completed other clinical services audits and special projects.

- Department of Mental Health provider reviews during SFY2018
    - MMAC's DMH audit group completed special projects with an emphasis on inpatient hospital and skilled nursing home overlaps with the Developmental Disabilities Waiver, Community Psychiatric Rehab (CPR), and Comprehensive Substance Treatment and Rehab (CSTAR) programs. MMAC reviews resulted in $604,132 being returned to the state.

  - Validated 219 Individualized Supported Living (ISL) Variance self-disclosures, resulting in $2,026,451 being returned to the state.
  - Dedicated an analyst to identify services billed after a Medicaid participant's date of death, resulting in $410,559 being returned to the state in SFY2018.
  - Completed audits of other DMH providers.

- Home and Community Based Services provider reviews in SFY2018
  - MMAC's HCBS group completed 139 audits of In-Home and Consumer Directed Services providers, as well as Adult Day Care and Residential Care providers. Aide/attendant training records were reviewed, and MMAC reviewed CDS payroll taxes to ensure payroll taxes were filed; and, MMAC verified in-home services providers' insurance certificates.
  - Dedicated an analyst to be the Electronic Visit Verification (EVV) liaison.
  - Assigned an analyst to conduct a special audit, along with investigations, regarding EVV compliance. The special audit was completed at the end of SFY2017 with analysis and sanction consideration to be completed in early 2018.
  - Dedicated an analyst to be the HCBS Settings Requirements liaison and this analyst reviewed potential "heightened scrutiny" providers and continues to work with DHSS on the heightened scrutiny component of the settings requirements.
  - Completed a special project to reveal overlapping State Plan & Waiver services and overlapping hospital services billed by personal care providers (In-Home and CDS). A total of $374,129 in improper billing was identified.
  - Processed 44 provider self-disclosures with a recovered amount of $131,753.
  - Presented information at provider update trainings and association conferences.

- Behavioral Health Providers SFY2018
  - MMAC completed 46 audits of psychologists, licensed clinical social workers and licensed counselors representing 117 providers, with $237,420 in improper billing identified.
  - During SFY2017, a new provider type for Behavior Analysis was authorized. During SFY2018, MMAC completed two audits of Behavior Analysts treating Autism Spectrum Disorders representing two providers. There was $9,935 in improper billing identified.

See Provider Review statistics in the Statistics section.

ELECTRONIC HEALTH RECORDS INCENTIVE CONTRACTOR

Beginning in 2012, the Health Information Technology and Clinical Health Act (HITECH) offered incentive payments to encourage eligible professionals and hospitals to adopt certified Electronic Health Records (EHRs). The rule established the basis on which eligible hospitals and professionals participating in the MO HealthNet Program were eligible to receive payments when they successfully demonstrated that they had adopted, implemented, or upgraded to certified EHR technology during the first year, and met "meaningfully use" standards in subsequent years.

During SFY2018, Brown Smith Wallace LLC (BSW) was contracted to perform post-payment audits of provider eligibility as set forth in 42 CFR Part 495 subpart D.

In FFY 2018, $20,119,103.00 was paid to eligible professionals and $5,625,255.52 was paid to eligible hospitals in various stages of the program.

During SFY2018, MMAC recovered $10,440.78 as a result of HER audits completed by BSW.

For SFY2019, the EHR audit contract was awarded to Myers & Stauffer LLC.

MANAGED CARE HEALTH PLANS AND PROVIDER AUDITS

State Medicaid agencies contract with Managed Care Organizations to provide health services in return for a capitated payment. In 2015, MMAC completed audits of Missouri's three health plans which focused on the plans' compliance with the Fraud, Waste, and Abuse sections of their contracts with Missouri Medicaid.

In 2016, MMAC completed follow up audits of Missouri's health plans to ensure corrective action plans were in place where deficiencies were noted, and to further investigate whether or not the plans properly identified and addressed potential fraud and abuse incidents.

CMS Comprehensive Medicaid Integrity Plan, Fiscal Years 2014-2018, section 3.2 states, to improve financial accountability of Medicaid managed care organizations, "We (CMS) will be conducting more detailed reviews of these contracts, identifying area for in-depth examination by CMS actuaries and audit contractors, and determining whether additional steps are necessary to ensure rates are efficient and support the necessary contract terms to deliver high value, high quality service to enrollees." Managed care oversight is also referenced in the CMS Annual Summary Report of Comprehensive Program Integrity Reviews (June 2014), from its Center for Program Integrity, and states "the states should provide closer oversight of the program integrity policies and activities in managed care programs."

MMAC's SFY2017 audits of the three plans began with readiness reviews because the state had entered into new contracts. First, the plans' policies and procedures were reviewed, and then, processes were reviewed. MMAC's SFY2018 audits reviewed MCO network provider screening, monitoring, and self-disclosure collection; as well as FWA provision adherence, and the plans' "lock-in" programs.

MMAC conducted quarterly meetings with health plans and MO HealthNet during SFY2017 and SFY2018. Those meetings will continue in SFY-2019.

UNIFIED PROGRAM INTEGRITY CONTRACTOR (UPIC)

UPICs perform fraud, waste, and abuse detection, deterrence and prevention activities for Medicare and Medicaid claims processed in the United States. Specifically, the UPICs perform integrity related activities associated with Medicare Parts A, B, Durable Medical Equipment (DME), Home Health and Hospice (HH+H), Medicaid, and the Medicare-Medicaid data match program (Medi-Medi). The UPIC contracts operate in five (5) separate geographical jurisdictions in the United States. AdvanceMed Corporation, a NCI company, has been the UPIC for IL, IN, IA, KS, KY, MI, MN, MO, NE, OH, and WI since October 2016.

MMAC has found AdvanceMed to be a strong partner in efforts to identify fraud in Missouri's Medicaid program. Additionally, AdvanceMed has provided MMAC access to expert healthcare consultants for questions on claims and they agreed to have a statistics consultant review MMAC's audits that utilize a Disproportionate Stratified Sampling Technique on claims reviews allowed under state regulation.

During SFY2018, UPIC provided MMAC with the results of studies involving:

- Risk-prone place of service payments
- Aberrant Utilization of Laboratory Services
- Rare Procedures
- Home and Community Based Services during Long Term Care Stays
- Excessive/High Frequency of Services per Beneficiaries
- Unbundling of Varicose Vein Treatment
- Unbundling of Fluoroscopic Guidance from Facet Joint Injections
- Ambulance provider billing
- Outpatient/ inpatient billing for dual-eligibles
- Hospice services related to dual-eligibles
- Services received from suspended or revoked providers
- Professional and Physician-Based Services
- Inpatient Hospital Claims
- Durable Medical Equipment
- Medicare/Medicaid Crossover Claims

RECOVERY AUDIT CONTRACTOR

THE RECOVERY AUDIT CONTRACTOR (RAC)

Section 6411 of the Affordable Care Act, Expansion of Recovery Audit Contractor (RAC) Program, amends section 1902(a)(42) of the Social Security Act and requires states to contract with a RAC vendor and allows states to reimburse contractors who assist in the identification and recovery of improper payments. The Recovery Audit Contractor is tasked with identifying and correcting improper payments, and collecting those overpayments.

MISSOURI'S RAC

For calendar years 2016 and 2017, Missouri was granted a waiver by CMS, exempting it from its requirements to contract with a RAC. The exemption was granted due to a variety of factors, including MMAC's own recoveries, certain claims being outside the RAC's purview (managed care), and utilizing the TPL contractor to pursue credit balance (patient account) audit.

CMS recently granted Missouri's request for an extension to the RAC waiver for calendar years 2018 and 2019.

PARTICIPANT LOCK-IN PROGRAM

MMAC is responsible for reviewing participants who may be subjecting the Medicaid program to fraud, waste and abuse. This includes a review of a variety of factors which include:

- The number of physicians prescribing services to a particular participant;
- The number of pharmacies used to obtain prescriptions;
- The frequency of refills or overlapping prescriptions;
- The number of emergency room visits, and
- The services received.

If a MO HealthNet participant is found to be misutilizing MO HealthNet benefits, the individual can be restricted to a physician/clinic, pharmacy, or both in accordance with 13 CSR 70-4.070, and may also be referred to the appropriate authorities for possible healthcare fraud investigation and prosecution.

MMAC is committed to keeping the community apprised of its efforts and activities and will continue to publish Lock-In information on the MMAC website. This information will continue to be updated monthly.

During SFY2017, MMAC Lock-In personnel opened 649 new Lock-in cases. See a complete listing of Lock-in statistics in the Statistics section.

INVESTIGATIONS

MMAC Investigations is responsible for conducting investigations into allegations of fraud, waste, and abuse by providers and participants. Investigators conduct interviews with witnesses as well as those suspected of violating state regulation, state statute and federal regulation.

In the event the investigation reveals a credible allegation of fraud by a provider, MMAC will forward the information to the Medicaid Fraud Control Unit (MFCU) with the State of Missouri Attorney General's Office or other prosecutorial entity for review.

During SFY2018, MMAC Investigations took a proactive approach to deterring fraud through education of providers, as well, at provider update trainings, conferences, and during meetings with the providers. Investigations also helped focus on HCBS provider issues such as EVV and payroll taxes by investigating these factors during their HCBS investigations.

During SFY2018, MMAC Investigations served as the MMAC coordination point for Medi-Medi and UPIC activities. The unit also reviewed provider compliance training resources compiled by the Department of Health and Human Services (HHS) Office of Inspector General (OIG) Health Care Fraud Prevention and Enforcement Action Team (HEAT).

During SFY2018, MMAC Investigations received department approval for and successfully joined the Healthcare Fraud Prevention Partnership (HFPP) and attended an HFPP Regional Information Sharing Session at the Medicaid Integrity Institute (MII). Additionally, MMAC Investigations utilized MII for training and provided experienced investigators as subject matter experts to instruct for other MII training courses.

During SFY2018, MMAC Investigations opened 104 cases for investigation, closed 145 cases, received 331 hotline calls, and made 63 fraud referrals to the Missouri Attorney General's Office (AGO) Medicaid Fraud Control Unit (MFCU).

TERMINATIONS AND SANCTIONS

In the event a provider is deemed to be in violation of a provider manual, state statute, state regulation or federal regulation, MMAC is responsible for determining whether or not to impose a sanction on the provider. In determining an appropriate sanction, MMAC takes into account aggravating and/or mitigating circumstances in accordance with 13 CSR 70-3.030 and may determine to impose any one of the following sanctions:

- Education
- Overpayment
- Prepayment Review
- Payment Suspension
- Suspension
- Termination

MMAC has made available on its website a list of providers who have had their enrollment in the Missouri Medicaid program terminated “for cause,” and the reasons for the terminations. MMAC will continue to publish this information during SFY2018.

In SFY2017, Terminations took part in the revalidation process by following up with non-responsive providers, and effecting terminations when appropriate. Also in SFY2017, Terminations began a new process of reviewing and processing closed businesses and expired licenses, deceased provider notifications and criminal history “hits” as MMAC began utilizing automated provider screening and monitoring.

In SFY2018, Terminations continued to review results of the automated provider monitoring system as well as processing terminations and suspensions from many sources. Terminations reviewed and processed a record number of Termination/Suspensions letters.

Terminations’ two Medicaid Specialists, along with the help of Investigation’s Administrative Analyst, completed 2,820 terminations in SFY2018, with thirty (30) being “for cause.” They also completed thirteen (13) full payment suspensions.

STATISTICS

Provider Enrollment

	SFY2017	SFY2018
New Providers Enrolled	10,435	10,566
Revalidations Processed	7,356	8,055
Applications Rejected	755	765
Updates Processed	20,240	18,585
Email Inquiries	37,836	45,934

Provider Enrollment Home and Community Based Contracts

New Proposals & Applications Received	Proposals & Applications Returned/ Rejected	Proposals & Applications Pending	Executed Participation Agreements/ Enrolled	Terminated or Placed on Closed-End	# of Agencies Currently Enrolled	
197	47	116	147	5	645	Consumer Directed SFY2017
157	44	99	130	15	769	Consumer Directed SFY2018
75	26	47	45	16	481	In-Home Agencies SFY2017
77	31	51	47	15	517	In-Home Agencies SFY2018
10	3	2	11	7	126	Adult Day Care SFY2017
14	0	1	12	16	121	Adult Day Care SFY2018

Participant Lock-In Program

Participant Reviews	SFY2017	SFY2018
Number of No-Abuse Cases reviewed	58	117
Lock-In Participants (new cases)	593	500
Biennial Reviews Completed (Two-year follow up)	584	553
Watch Cases	84	149
Watch Cases at six-month follow up	525	540
Total Participant Reviews	1,844	1859

Cost Avoidance (Provider Review and Participant Lock-In:

	SFY2017	SFY2018
Denied Claims (actual claims denied due to pre-payment reviews)	5,506,699	5,172,402
Provider Audits and Special Projects (calculation based on projected cost savings over a period of one year, taking into consideration actions MMAC has taken)	20,275.401	14,248,955
Participant Reviews (actual claims denied due to lock-in program)	6,938.315	7,153,539
Total	32,720,415	26,574,896

Provider Review Audits, Special Projects, and Self Disclosures

	SFY2017	SFY2018
Recoveries from Audits and Special Projects	4,536,508	4,340,318
Recoveries from Self Disclosures	3,648,402	5,125,743
Recoveries from Credit Balance Audits	458,399	3,856,109
Recoveries from the RAC	14,086	0
Recoveries from the MIC	149,072	0
Recoveries from the AGO (MMAC cases)	126,577	21,122
MO HealthNet Pharmacy Administration	191,926	0
DSS Total	9,124,970	13,143,292
AGO non-MMAC related recoveries	1,982,482	4,603,929
Total	11,107,452	17,746,584

Investigations

	SFY2017	SFY2018
Investigations Completed	157	145
Medicaid Fraud Control Unit Referrals	69	63
Hotline Calls Received	518	331
Provider Education Presentations	9	8

Provider Terminations and Payment Suspensions

	SFY2017	SFY2018
Provider Terminations	2,237	2,820
Provider Payment Suspensions	10	14

Contact Information

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MMAC Fraud Hotline: 573-751-3285

MMAC Report Fraud: MMAC.ReportFraud@dss.mo.gov