DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

February 4, 2011

Report Number: A-07-10-03153

Mr. Ronald J. Levy
Director
Missouri Department of Social Services
Broadway State Office Building
P.O. Box 1527
Jefferson City, MO 65102-1527

Dear Mr. Levy:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicaid Excluded Providers in Missouri*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, or contact Greg Tambke, Audit Manager, at (573) 893-8338, extension 30, or through email at Greg.Tambke@oig.hhs.gov. Please refer to report number A-07-10-03153 in all correspondence.

Sincerely,

/Patrick J. Cogley/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicaid and Medicare Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID EXCLUDED PROVIDERS IN MISSOURI

Daniel R. Levinson
Inspector General

February 2011
A-07-10-03153

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

CMS reimburses State Medicaid agencies based on the Federal medical assistance percentage for claimed Medicaid expenditures, including Medicaid expenditures for items and services furnished, ordered, or prescribed by providers enrolled in the State's Medicaid program.

The U.S. Department of Health & Human Services, Office of Inspector General (OIG), under Congressional mandate, established a program to exclude individuals and entities affected by various legal authorities contained in sections 1128 and 1128A of the Act. The effect of an exclusion (not being able to participate) is that no payment will be made by the Medicaid program for any items and services furnished, ordered, or prescribed by an excluded individual or entity. This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider where the excluded person provides services, and anyone else. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person. There is a limited exception to exclusions for the provision of certain emergency items or services not provided in a hospital emergency room.

In Missouri, the Department of Social Services, Missouri HealthNet Division (State agency), administers the Medicaid program, in part by developing and maintaining internal controls. Within the State agency, the Provider Enrollment Unit is responsible for enrolling new providers and maintaining provider records for all Missouri Medicaid provider types. Billing providers file Medicaid claims with the State agency. The Medicaid line item for each claim may include additional provider identification numbers for other providers (performing, prescribing, and/or miscellaneous (such as ordering) providers) involved in that claim.

OBJECTIVE

Our objective was to determine whether the State agency's internal controls were adequate to prevent Medicaid payments for any items and services furnished, ordered, or prescribed by an excluded individual or entity for the period January 1, 2007, through December 31, 2009.

SUMMARY OF FINDINGS

The State agency did not have adequate internal controls to prevent some Medicaid payments for items and services furnished, ordered, or prescribed by an excluded individual or entity.

Specifically, for the period January 1, 2007, through December 31, 2009, the State agency did not have policies and procedures to prevent Medicaid payments when claim lines were for items and services ordered or prescribed by an excluded individual. As a result, the State agency made $22,257 ($14,607 Federal share) in improper payments for the period January 1, 2007, through December 31, 2009.

In addition, the State agency did not have policies and procedures to notify OIG when a Medicaid provider's application was denied by the State agency. Moreover, some of the State agency's policies and procedures were not documented.

State agency officials stated that they did not have policies and procedures to prevent these improper Medicaid payments because they were unaware that the payments were unallowable. State agency officials also said that they did not have policies and procedures regarding OIG notification because they were unaware of the Federal regulation. Furthermore, State agency officials stated that some of their policies and procedures were not documented because they were part of their daily operations.

RECOMMENDATIONS

We recommend that the State agency:

- refund $14,607 to the Federal Government for the improper Medicaid payments for items and services ordered or prescribed by excluded individuals; and

- strengthen internal controls to prevent excluded providers from participating in the Medicaid program, specifically:

    - develop and implement policies and procedures to prevent Medicaid payments when claim line items include an excluded provider;

    - develop and implement policies and procedures to notify OIG when a Medicaid provider's application is denied by the State agency; and

    - document all policies and procedures to prevent excluded providers from participating in the Medicaid program.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency partially concurred with both of our recommendations and described corrective actions that it planned to take. The State agency said that it will conduct a review of the provider records for the claims identified as improperly paid, after which it will return improperly paid funds. With respect to our second recommendation, the State agency said that it will establish and implement formal policies and procedures regarding internal controls to prevent excluded providers from participating in the Medicaid fee-for-service program, develop procedures to notify OIG when a Medicaid provider's application is denied, and incorporate exclusion policies and procedures into the appropriate State manuals.

The State agency's comments appear in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

Nothing in the State agency's written comments caused us to change our findings or our recommendations.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

CMS reimburses State Medicaid agencies based on the Federal medical assistance percentage for claimed Medicaid expenditures, including Medicaid expenditures for items and services furnished, ordered, or prescribed by providers enrolled in the State's Medicaid program.

Excluded Providers

The U.S. Department of Health & Human Services, Office of Inspector General (OIG), under Congressional mandate, established a program to exclude individuals and entities affected by various legal authorities contained in sections 1128 and 1128A of the Act. The effect of an exclusion (not being able to participate) is that no payment will be made by the Medicaid program for any items and services furnished, ordered, or prescribed by an excluded individual or entity. This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider where the excluded person provides services, and anyone else. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person. There is a limited exception to exclusions for the provision of certain emergency items or services not provided in a hospital emergency room.

Federal regulations at 42 CFR § 1001 specify certain bases upon which OIG may, or in some cases must, exclude individuals and entities from participation in Medicaid and other Federal health care programs. Federal regulations at 42 CFR § 1002 specify the authority of State agencies to exclude individuals and entities from participation in their respective Medicaid programs.

To administer this program, OIG maintains a database of all currently excluded parties called the List of Excluded Individuals/Entities (LEIE). In addition, CMS maintains a database called the Medicare Exclusion Database (MED). Pursuant to a CMS State Medicaid Directors Letter dated June 12, 2008, States should conduct searches monthly via the LEIE or the MED to capture exclusions and reinstatements that have occurred since the last search.

List of Excluded Individuals/Entities

The LEIE is a database that provides information about parties excluded from participation in Medicare, Medicaid, and other Federal health care programs. The LEIE is available on the OIG's website in two formats: an online search engine and a downloadable version of the database. The online search engine identifies currently excluded individuals and entities. When a match is identified, it is possible for the searcher to verify the accuracy of the match using the Social Security Number (SSN) or Employer Identification Number (EIN). The downloadable version of the database may also be compared against State agency provider enrollment files. However, unlike the online search engine, the downloadable version of the database does not contain SSNs or EINs.

Medicare Exclusion Database

In 2002, CMS developed the MED to collect and retrieve information that aided in ensuring that no payments are made to excluded individuals and entities for services furnished during a provider's exclusion period. Two of the information sources used in populating the MED are the LEIE and the Social Security Administration. MED files contain a variety of identifiable and general information including name, SSN, and National Provider Identifier (NPI). CMS provides the MED files to State Medicaid agencies every month.

Missouri Medicaid Program

In Missouri, the Department of Social Services, Missouri HealthNet Division (State agency) administers the Medicaid program, in part by developing and maintaining internal controls. Within the State agency, the Provider Enrollment Unit is responsible for enrolling new providers and maintaining provider records for all Missouri Medicaid provider types. Billing providers file Medicaid claims with the State agency. The Medicaid line item for each claim may include additional provider identification numbers for other providers (performing, prescribing, and/or miscellaneous (such as ordering) providers) involved in that claim.

The State agency contracts with Infocrossing to maintain its Medicaid Management Information System (MMIS), a computerized payment and information reporting system that processes Missouri's Medicaid claims. The State agency retains overall responsibility for developing and maintaining internal controls to help administer the Medicaid program. The State agency uses both the LEIE and the MED to help administer the State's Medicaid program.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency's internal controls were adequate to prevent Medicaid payments for any items and services furnished, ordered, or prescribed by an excluded individual or entity for the period January 1, 2007, through December 31, 2009.

Scope

We reviewed Medicaid claim line items processed by the State agency with dates of services from January 1, 2007, through December 31, 2009. We did not review the overall internal control structure of the State agency or the Medicaid program because our objective did not require us to do so. Rather, we reviewed only the internal controls that pertained to our objective.

We performed fieldwork at the State agency's offices in Jefferson City, Missouri, from June to October 2010.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations and guidance;
- held discussions with State agency officials to gain an understanding of State agency policies, procedures, and guidance;
- obtained the LEIE (as of May 31, 2009) and MED (as of April 2010) databases;
- obtained the State agency's Medicaid provider database;
- matched the MED[1] to the State agency's Medicaid provider database on the basis of SSNs and NPIs;
- obtained the Medicaid line items (for the Medicaid providers that matched to the MED) for claims that were processed by the State agency with dates of services from January 1, 2007, through December 31, 2009, if the Medicaid provider identification number was included in the line item as the billing, performing, prescribing, and/or miscellaneous (ordering) provider;
- calculated the Medicaid payments (for each type of provider on the claim line item) that were made during that provider's exclusion period by the State agency;
- determined whether any of the excluded providers involved in the Medicaid payments had been granted waivers of their exclusion by OIG; and
- discussed our findings with State agency officials on October 6, 2010.

[1] We used the MED in our analysis because it contained SSNs and NPIs, both of which also appeared in the State agency's provider database. The LEIE downloadable database did not contain SSNs or NPIs.

We calculated the Federal share of the improper payments using the applicable Federal medical assistance percentage (61.60 percent to 74.43 percent) for the quarter.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

The State agency did not have adequate internal controls to prevent some Medicaid payments for items and services furnished, ordered, or prescribed by an excluded individual or entity. Specifically, for the period January 1, 2007, through December 31, 2009, the State agency did not have policies and procedures to prevent Medicaid payments when claim lines were for items and services ordered or prescribed by an excluded individual. As a result, the State agency made $22,257 ($14,607 Federal share) in improper payments for the period January 1, 2007, through December 31, 2009.

In addition, the State agency did not have policies and procedures to notify OIG when a Medicaid provider's application was denied by the State agency. Moreover, some of the State agency's policies and procedures were not documented.

State agency officials stated that they did not have policies and procedures to prevent these improper Medicaid payments because they were unaware that the payments were unallowable. State agency officials also said that they do not have policies and procedures regarding OIG notification because they were unaware of the Federal regulation. Furthermore, State agency officials stated that some of their policies and procedures were not documented because they were part of their daily operations.

WEAKNESSES IN POLICIES AND PROCEDURES

Improper Medicaid Payments

Pursuant to 42 CFR § 1001.2: "*Exclusion* means that items and services furnished, ordered or prescribed by a specified individual or entity will not be reimbursed under Medicare, Medicaid and all other Federal health care programs until the individual or entity is reinstated by the OIG." (Italics in original.)

With respect to these reimbursements, or payments, 42 CFR § 1002.211(a) states:

> [N]o payment may be made by the State agency for any item or service furnished on or after the effective date specified in the notice by an excluded individual or entity, or at the medical direction or on the prescription of a physician who is excluded when a person furnishing such item or service knew, or had reason to know, of the exclusion.

Contrary to these Federal requirements, the State agency did not have policies and procedures to prevent Medicaid payments when claim lines were for items and services ordered or prescribed by an excluded individual. As a result, the State agency made $22,257 ($14,607 Federal share) in improper payments for the period January 1, 2007, through December 31, 2009. See Table 1.

Table 1

Provider	Number of Claim Line Items	Number of Providers	Improper Payments	Federal Share
Prescribing	319	8	$14,558	$9,214
Miscellaneous[2]	79	5	$7,699	$5,393
Total	**398**	**13***	**$22,257**	**$14,607**

***There were 11 unique total providers. Two providers appeared in both the prescribing and miscellaneous count above.

State agency officials stated that they did not have policies and procedures to prevent these improper Medicaid payments because they were unaware that the payments were unallowable.

Inspector General Notification

Pursuant to 42 CFR § 1002.3(b)(2), a State agency "… must promptly notify the Inspector General of any action it takes on the provider's application for participation in the [Medicaid] program."

The State agency did not have policies and procedures to notify OIG when a Medicaid provider's application was denied by the State agency. Because it did not have policies and procedures regarding OIG notification in denied applications, the State agency was putting the Medicaid program and other Federal health care programs, such as Medicare, at risk of reimbursing providers that should not be participating in any Federal health care program.

State agency officials stated that they did not have policies and procedures regarding OIG notification because they were unaware of the Federal regulation.

Undocumented Policies and Procedures

2 CFR pt. 225, *Cost Principles for State, Local and Indian Tribal Governments* (formerly Office of Management and Budget Circular A-87), Attachment A, § A.2.a.(1) states: "Governmental units are responsible for the efficient and effective administration of Federal awards through the application of sound management practices."

[2] Claim line items in which the ordering provider referred the beneficiary to another physician/specialist who was not an excluded provider were not counted as improper payments.

The Government Accountability Office's *Standards for Internal Control in the Federal Government* identifies sound management practices that can be applied by non-Federal entities. It states (in the "Control Activities" section, page 11): "Internal control activities help ensure that management's directives are carried out" and (in the Examples of Control Activities section, page 15): "Internal control … and other significant events need to be clearly documented, and the documentation should be readily available for examination. The documentation should appear in management directives, administrative policies, or operating manuals…."

The State agency had informal, undocumented policies and procedures in place to prevent some excluded providers (billing and performing) from participating in the Medicaid program. In addition, the State agency had informal, undocumented policies and procedures to notify OIG when a Medicaid provider was suspended by the State agency. However, the State agency had not documented any of these policies and procedures.

Documenting policies and procedures would increase the likelihood that future claims for Medicaid funds would qualify for reimbursement. Documenting operational policies and procedures helps ensure that operations are performed effectively and efficiently by reducing the possibility of oversights and by giving new personnel sufficiently detailed instructions, by assuring continuity, and by specifying quality assurance functions.

State agency officials stated that these policies and procedures had not been documented because the provider enrollment process and the provider suspension process were part of their daily operations.

RECOMMENDATIONS

We recommend that the State agency:

- refund $14,607 to the Federal Government for the improper Medicaid payments for items and services ordered or prescribed by excluded individuals; and

- strengthen internal controls to prevent excluded providers from participating in the Medicaid program, specifically:

    - develop and implement policies and procedures to prevent Medicaid payments when claim line items include an excluded provider;

    - develop and implement policies and procedures to notify OIG when a Medicaid provider's application is denied by the State agency; and

    - document all policies and procedures to prevent excluded providers from participating in the Medicaid program.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency partially concurred with both of our recommendations and described corrective actions that it planned to take. The State agency said that it will conduct a review of the provider records for the claims identified as improperly paid, after which it will return improperly paid funds. With respect to our second recommendation, the State agency said that it will establish and implement formal policies and procedures regarding internal controls to prevent excluded providers from participating in the Medicaid fee-for-service program, develop procedures to notify OIG when a Medicaid provider's application is denied, and incorporate exclusion policies and procedures into the appropriate State manuals.

The State agency's comments appear in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

Nothing in the State agency's written comments caused us to change our findings or our recommendations.

APPENDIX

APPENDIX: STATE AGENCY COMMENTS

Missouri Department of
SOCIAL SERVICES
Your Potential. Our Support.

JEREMIAH W. (JAY) NIXON, GOVERNOR • RONALD J. LEVY, DIRECTOR

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January 5, 2011

Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Inspector General
Federal Office Building
601 East 12th Street, Room 429
Kansas City, MO 64106

Dear Mr. Cogley:

This is in response to the Office of Inspector General's (OIG) draft report entitled "Review of Medicaid Excluded Providers in Missouri," Report Number A-07-10-03153. The objective of the audit was to determine whether the Missouri Department of Social Services (State agency) had adequate internal controls to prevent providers that had been excluded from participating in Federal health care programs by the U.S. Department of Health and Human Services (HHS) from being paid by the Medicaid program. The audit covered Medicaid expenditures for the period January 1, 2007 through December 31, 2009. The OIG recommendations and Department of Social Services (DSS) MO HealthNet Division (MHD) responses follow.

Recommendation: Refund $14,607 to the Federal Government for the improper payments for items and services ordered or prescribed by excluded individuals.

Response: DSS/MHD partially concurs. MHD will conduct a review of the provider records for the claims identified as improperly paid. It is MHD's position that many of the services were billed with incorrect provider numbers. After review, MHD will return the funds that were improperly paid. MHD will work to ensure system edits are in place to deny payment when inactive or excluded providers are performing, referring or prescribing services.

Recommendation: Strengthen internal controls to prevent excluded providers from participating in the Medicaid program, specifically:

- Develop and implement policies and procedures to prevent Medicaid payments when claim line items include an excluded provider.

Patrick J. Cogley
Page 2

Response: DSS/MHD partially concurs. MHD will establish and implement formal policies and procedures regarding internal controls to prevent excluded providers from participating in the Fee-for-Service Medicaid Program.

Per section 2.33.14 of the MO HealthNet Managed Care contract, the health plans are prohibited from using MO HealthNet Managed Care funds for non-emergency services provided by or under the direction of an excluded individual.

- Develop and implement policies and procedures to notify OIG when a Medicaid provider's application is denied by the State agency.

Response: DSS/MHD concurs. MHD will develop procedures to notify OIG when a Medicaid provider's application is denied. Before developing these procedures, MHD requests clarification from OIG on which application denials should be submitted to the OIG. Many provider applications are denied because the required documentation is not provided by the applicant; MHD assumes the OIG does not want to be notified of these type of application denials.

MHD will amend the MO HealthNet Managed Care contract within the current contract period to require the MO HealthNet Managed Care health plans to notify the MO HealthNet Division when a health plan provider's application is denied by the health plan.

- Document all policies and procedures to prevent excluded providers from participating in the Medicaid program.

Response: DSS/MHD concurs. Exclusion policy and procedures will be incorporated into the updated Program Integrity Unit manual and Provider Enrollment Unit policies for the Medicaid Fee-for-Service providers. The MO HealthNet Division will ensure the MO HealthNet Managed Care health plans' policies and procedures are documented and reflective of MO HealthNet Fee-For-Service.

Please contact Ian McCaslin, M.D., M.P.H., Director, MO HealthNet Division at 573/751-6922 if you have any further questions.

Sincerely,

Ronald J. Levy
Director

RJL:lh