DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION VII
601 EAST 12TH STREET, ROOM 0429
KANSAS CITY, MO 64106

July 18, 2012

Report Number: A-07-11-06026

Ms. Susan E. Birch
Executive Director
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Dear Ms. Birch:

Enclosed is the U.S. Department of Health and Human Services, Office of Inspector General (OIG), final report entitled *Colorado Did Not Always Identify or Prevent Excluded Providers From Participating in the Medicaid Program*. 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 Dan Bittner, Audit Manager, at (515) 284-4674, extension 23, or through email at Dan.Bittner@oig.hhs.gov. Please refer to report number A-07-11-06026 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 Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

COLORADO DID NOT ALWAYS IDENTIFY OR PREVENT EXCLUDED PROVIDERS FROM PARTICIPATING IN THE MEDICAID PROGRAM

Daniel R. Levinson
Inspector General

July 2012
A-07-11-06026

Office of Inspector General

http://oig.hhs.gov

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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 and 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, and any hospital or other provider where the excluded person provides services. 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 Colorado, the Department of Health Care Policy and Financing (State agency) administers the Medicaid program, in part by developing and maintaining internal controls. The State agency is responsible for enrolling new providers and maintaining provider records for all Colorado Medicaid provider types. Billing providers file Medicaid claims with the State agency.

For the period October 1, 2009, through September 30, 2010, the State agency claimed Federal reimbursement for Medicaid expenditures totaling $3.4 billion ($2.1 billion Federal share).

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 October 1, 2009, through September 30, 2010.

SUMMARY OF FINDING

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

Although the State agency implemented internal controls to prevent Medicaid payments to excluded individuals or entities, the controls did not address all of the excluded individuals or entities that we identified on Medicaid claims. For the period October 1, 2009, through September 30, 2010, the State agency made $12,747 ($7,851 Federal share) in unallowable payments for items and services furnished, ordered or prescribed by excluded providers.

The State agency's internal controls were designed to prevent a claim from being paid if an attending or billing provider was an excluded provider. However, the State agency's policies and procedures did not always make provisions to prevent unallowable Medicaid payments for items and services referred, rendered, or prescribed by excluded providers. Thus, the State agency's controls did not always prevent these items and services from being claimed for Federal reimbursement. These limitations in the State agency's internal controls could allow individuals or entities to participate in the Medicaid program after they have been excluded, which could undermine the safety and integrity of the program.

RECOMMENDATIONS

We recommend that the State agency:

- refund $7,851 to the Federal Government for the unallowable Medicaid payments for items and services provided or prescribed by excluded individuals; and

- strengthen internal controls to prevent excluded providers from participating in the Medicaid program, specifically by developing and implementing policies and procedures to ensure that payments are not made for any items and services furnished, ordered, or prescribed by an excluded individual or entity.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and described corrective actions that it planned to implement.

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

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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 (FMAP) 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 and 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, and any hospital or other provider where the excluded person provides services. 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 all 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, EIN, and National Provider Identifier (NPI). CMS provides the MED files to State Medicaid agencies every month.

Colorado Medicaid Program

In Colorado, the Department of Health Care Policy and Financing (State agency) administers the Medicaid program, in part by developing and maintaining internal controls. The State agency is responsible for enrolling new providers and maintaining provider records for all Colorado Medicaid provider types. Billing providers file Medicaid claims with the State agency.

The State agency contracts the operations of the Medicaid Management Information System (MMIS), a computerized payment and information reporting system that processes Colorado Medicaid claims, to Affiliated Computer Services, Inc. (ACS). 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.

For Federal fiscal year (FY) 2010 (October 1, 2009, through September 30, 2010), the State agency claimed Federal reimbursement for Medicaid expenditures totaling $3.4 billion ($2.1 billion Federal share). The FMAP for Colorado's Medicaid payments was 61.59 percent in FY 2010.

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 October 1, 2009, through September 30, 2010.

Scope

Our review covered 26.6 million claim lines associated with 24.7 million Medicaid claims totaling $3.4 billion ($2.1 billion Federal share) that the State agency paid for the period October 1, 2009, through September 30, 2010. 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 relevant to our audit objective.

We performed fieldwork at the State agency in Denver, Colorado, from October 2010 to October 2011.

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 and MED databases (as of September 2010);
- obtained the State agency's Medicaid provider database;
- identified the State Medicaid identification number for excluded providers by matching the MED[1] to the State agency's Medicaid provider database using the provider's SSN;
- obtained the Medicaid claim-level detail information (for the Medicaid providers that matched to the MED) for claims that were paid by the State agency from October 1, 2009, through September 30, 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 automated systems. The LEIE downloadable database did not contain SSNs or NPIs. We will separately review whether the State agency was appropriately requiring provider identification numbers to be submitted and whether the identification numbers that were submitted were valid.

- matched the State Medicaid identification number and NPI associated with excluded providers with the Medicaid claim level detail information;

- obtained and reviewed the supporting documentation for each claim for which the State agency had denied payment because a provider associated with the claim was excluded;

- calculated the Medicaid payments that the State agency made during that provider's exclusion period;

- 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 January 26, 2012.

We calculated the Federal share of the expenditures using the FMAP rate (61.59 percent) that was in effect for the time period of our review.[2]

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 finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

The State agency did not have adequate internal controls to prevent all Medicaid payments for items and services furnished, ordered, or prescribed by an excluded individual or entity. Although the State agency implemented internal controls to prevent Medicaid payments to excluded individuals or entities, the controls did not address all of the excluded individuals or entities that we identified on Medicaid claims. For the period October 1, 2009, through September 30, 2010, the State agency made $12,747 ($7,851 Federal share) in unallowable payments for items and services furnished, ordered or prescribed by excluded providers.

The State agency's internal controls were designed to prevent a claim from being paid if an attending or billing provider was an excluded provider. However, the State agency's policies and procedures did not always make provisions to prevent unallowable Medicaid payments for items and services referred, rendered, or prescribed by excluded providers.[3] Thus, the State

[2] Although our audit period fell within the recession adjustment period (October 1, 2008, through December 31, 2010) within which, pursuant to the American Recovery and Reinvestment Act of 2009 (P.L. No. 111-5), States received additional Medicaid funding based on temporary increases in their FMAPs, the State agency's FMAP rate did not change during our audit period.

[3] The "attending" provider is the physician having primary responsibility for the patient's medical care and treatment. This designation cannot be assigned to a group or clinic. For clients enrolled in the Primary Care Physician (PCP) program, the "referring" provider is the primary care physician who referred the client to another provider for services requiring a PCP referral. Finally, the "rendering" provider is the physician who actually

agency's controls did not always prevent these items and services from being claimed for Federal reimbursement. These limitations in the State agency's internal controls could allow individuals or entities to participate in the Medicaid program after they have been excluded, which could undermine the safety and integrity of the program.

UNALLOWABLE MEDICAID PAYMENTS ASSOCIATED WITH EXCLUDED PROVIDERS

Federal regulations (42 CFR § 1001.2) state: "*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.

The State agency did not always have adequate internal controls in place to prevent Medicaid payments for items and services furnished, ordered, or prescribed by an excluded individual or entity. As a result, for the period October 1, 2009, through September 30, 2010, the State agency made $12,747 ($7,851 Federal share) in unallowable payments for items and services furnished, ordered or prescribed by excluded providers.

For example, a physician's license to practice medicine was suspended on September 21, 2007, because the physician was accused of sexually assaulting two patients. On November 29, 2007, the Colorado State Board of Medical Examiners referred the matter to the State Attorney General for disciplinary proceedings. In addition, in May 2008 the same physician pleaded guilty to Federal charges of dispensing anabolic steroids outside the course of professional practice. On November 19, 2009, OIG excluded this physician from participation in Medicaid and other Federal health care programs. Nevertheless, after the exclusion had taken effect (and most recently in July 2010), the State agency paid four claims that listed this excluded physician as the prescribing provider. The State agency paid these claims because its controls were not always adequate to prevent payment of claims that listed an excluded prescribing provider.

The State agency's internal controls were designed to prevent a claim from being paid if an attending or billing provider was an excluded provider. However, the State agency's policies and procedures did not always make provisions to prevent unallowable Medicaid payments for items and services referred, rendered, or prescribed by excluded providers. The internal controls, through which the State agency sought to identify excluded providers and prevent them from receiving payment for their Medicaid claims, used Medicaid identification numbers (which a

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performed or rendered the billed services (however, the rendering provider may not necessarily be the provider who bills for the services). As with "attending" provider, this designation cannot be assigned to a group or clinic.

State Medicaid agency assigns to a provider when that provider enrolls in the Medicaid program) rather than NPI numbers. Because the State agency did not make a provision for the use of NPI numbers in its internal controls, it could not consistently and accurately identify all of the excluded providers that may have furnished, ordered or prescribed an item or service. Furthermore, there were several instances in which a claim was paid because the State agency did not update the provider's enrollment status in a timely manner. These limitations in the State agency's internal controls could allow individuals or entities to participate in the Medicaid program after they have been excluded, which could undermine the safety and integrity of the program.

RECOMMENDATIONS

We recommend that the State agency:

- refund $7,851 to the Federal Government for the unallowable Medicaid payments for items and services provided or prescribed by excluded individuals; and

- strengthen internal controls to prevent excluded providers from participating in the Medicaid program, specifically by developing and implementing policies and procedures to ensure that payments are not made for any items and services furnished, ordered, or prescribed by an excluded individual or entity.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and described corrective actions that it planned to implement. Specifically, the State agency said that it would refund to the Federal Government the $7,851 (Federal share) identified in our first recommendation.

With respect to our second recommendation, the State agency said that it would make system and process changes as part of its implementation of the Affordable Care Act[4] Provider Screening Rules, which it plans to complete by March 2016. The State agency added that it would implement these rules as part of a re-procurement, currently in progress, of its Medicaid Management Information System (MMIS) and fiscal agent services. The State agency said that it expects the replacement MMIS to be operational by July 2016.

The State Agency's comments are included in their entirety as the Appendix.

[4] The Patient Protection and Affordable Care Act, P.L. No. 111-148.

APPENDIX

APPENDIX: STATE AGENCY COMMENTS

COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING
1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax • (303) 866-3883 TTY
John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

June 18, 2012

Patrick J. Cogley, Regional Inspector General for Audit Services
Office of the Inspector General
Office of Audit Services, Region VII
601 E. 12th St., Room 0429
Kansas City, MO 64106

Mr. Cogley:

Please see the attached document that contains the Department of Health Care Policy and Financing's submission of responses to the draft report entitled *Colorado Did Not Always Indentify or Prevent Excluded Providers From Participating in the Medicaid Program* (Report Number A-07-11-06026).

If you have any questions or comments, please contact Kim Nguyen at 303-866-6575 or kim.nguyen@state.co.us.

Sincerely:

Susan E. Birch MBA, BSN, RN
Executive Director

SB:ktn

cc: Kim Nguyen, Audit Tracker and Analyst, Department of Health Care Policy and Financing
Greg Tanner, Controller, Department of Health Care Policy and Financing
Dan Bittner, Audit Manager, Office of Inspector General
Michael Chacon, Senior Auditor, Office of Inspector General

Enclosure

Department of Health Care Policy and Financing's
Initial Response to the
Department of Health & Human Services
Office of Inspector General
Colorado Did Not Always Identify or Prevent Excluded Providers from Participating in the Medicaid Program
Control Number A-07-11-06026
May 2012

RECOMMENDATIONS

We recommend that the State Agency:

- **refund $7,851 to the Federal Government for the unallowable Medicaid payments for items and services provided by excluded individuals.**

Response: *Concur.*

The Department will utilize the spreadsheet provided by the Office of the Inspector General auditors which identifies excluded providers showing as rendering or prescribing on claims, in order to send demand letters by June 15, 2012 for repayment of those claims.

The Department will return federal financial participation in the amount of $7,851 and will report this repayment on the CMS-64 for the quarter ending June 30, 2012.

We recommend that the State Agency:

- **strengthen internal controls to prevent excluded providers from participating in the Medicaid program, specifically by developing and implementing policies and procedures to ensure that payments are not made for any items and services furnished, ordered, or prescribed by an excluded individual or entity.**

Response: *Concur.*

The Department agrees that it is important to prevent excluded providers participating in the Medicaid program.

The Department will make system and process changes to address this finding as part of its implementation of the Affordable Care Act Provider Screening Rules, 42 CFR Parts 405, 424, 447 et al., specifically § 455.440. The rule requires that the State Medicaid agency require all claims for payment for items and services that were ordered or referred to contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services. The Department will implement these rules as part of a re-procurement of its Medicaid Management Information System (MMIS) and fiscal agent services. This re-procurement is currently in progress and the replacement MMIS is expected to be operational by July 2016, while the Department's implementation of the Affordable Care Act Provider Screening Rules will be completed by March 2016.